



**EUROPEAN COMMISSION**  
DIRECTORATE-GENERAL FOR HUMANITARIAN AID - ECHO

## **DG ECHO HIV GUIDELINES**

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## **GLOSSARY**

AIDS	Acquired Immune Deficiency Syndrome
ART	Antiretroviral Therapy
ARV	Antiretroviral Drugs
DG ECHO	Directorate General for Humanitarian Aid
EC	European Commission
GBV	Gender Based Violence
GFATM	Global Fund for AIDS –TB-Malaria
HBC	Home Based Care
HIV	Human Immunodeficiency Virus
IASC	United Nations Inter-Agency Standing Committee
IEC	Information, Education and Communication
IFIs	International Financial Institutions
LRRD	Linking Relief, rehabilitation and Development
MISP	Minimum Initial Service Package
MSM	Men who have sex with Men
NFIs	Non Food Items
OI	Opportunistic Infections
OVC	Orphans and other Vulnerable Children
PEP	Post Exposure Prophylaxis
PLHIV	Persons Living With HIV (and AIDS)
PMTCT	Prevention of Mother to Child Transmission
SFP	Supplementary Feeding Programme
SSA	Sub Saharan Africa
STI	Sexually Transmitted Infections
TB	Tuberculosis
TFP	Therapeutic Feeding Programme
UNFPA	United Nations Population Fund
UNHCR	United Nations High Commissioner for Refugees
VCT	Voluntary Counselling and Testing
WASH	Water, Sanitation and Hygiene
WHO	World Health Organization

## SECTION I: BACKGROUND

These policy guidelines are to provide guidance on responding to HIV/AIDS in humanitarian actions. They are structured in the following way: Section I gives a background, including an overview of the pandemic; HIV/AIDS and emergency settings and a chapter recalling DG ECHO's specific mandate and strengths in the context of HIV/AIDS. Section II provides a practical overview of DG ECHO's response, which should i. Promote adherence to best practice and policies; ii. Promote, where appropriate, mainstreaming of HIV-related activities as much as possible in DG ECHO funded activities; and iii. Provide specific funding guidance for interventions. The last chapter is a summary of the main provisions of these guidelines and provides a summary table.

The reader who is looking for guidance only may skip section 1 and move directly to section II and the summary table.

### 1. INTRODUCTION AND OBJECTIVE

Apart from often reducing (access to) health services and infrastructure, emergencies (man-made and natural disasters) are also major accelerators of HIV transmission. Rapid and high rates of transmission are often associated with contexts of armed conflict and natural disasters. In situations where people are displaced, there is a higher level of sexual violence and women are often forced to trade sex for food, protection or other basic needs.

The main objective of these guidelines is to recall the necessary precautions and prevention measures and to provide a coherent DG ECHO funding approach regarding HIV-related activities. They aim at guiding DG ECHO policy makers, field staff and – where appropriate – partners, in deciding on HIV-related activities. The guidelines should help finding the best possible match between the great needs created by the pandemic and the specific nature of DG ECHO operations (short term emergency funding) as well as providing a set of guiding principles for *funding*, which are:

- (1) Incorporation of existing international policies on the issue that are considered particularly relevant for its operations: they should be followed in as much as they are in line with DG ECHO's mandate.
- (2) Mainstreaming of minimum HIV-related activities wherever possible and feasible in all DG ECHO funded operations. This consists of a number of basic measures that should be applied universally by DG ECHO partners. These measures aim at helping to slow down the further spread of the virus and at promoting awareness of the pandemic. Their implementation should be monitored in all projects so as to ensure basic adherence and quality.
- (3) Implementation of conditions for financing specific HIV-related operations in sectors where DG ECHO is most often confronted with the pandemic, such as health and food assistance (related to the amount of funding).

## 2. RATIONALE

Support to the Global Fund for AIDS, Tuberculosis and Malaria (GFATM), and other activities financed through different instruments<sup>1</sup> from other Commission Services remain the main response of the European Commission to the AIDS pandemic. However, DG ECHO has a responsibility to contribute to the fight against this global pandemic within its mandate and within the limits set by the emergency context, bearing in mind the need for careful prioritisation of its support in view of its budget constraints. This responsibility is reflected in the 'Communication on a European Programme for Action to Confront HIV/AIDS, Malaria and Tuberculosis through External Action (2007-2011)'. This Communication stresses among others that 'the EC Humanitarian Office will help reduce the transmission of the three diseases, and the human distress and mortality they cause by mainstreaming basic HIV preventive and palliative measures'.<sup>2</sup>

Four years have passed since DG ECHO launched its first HIV/AIDS concept paper and guidelines.<sup>3</sup> However, as a recent health evaluation<sup>4</sup> found, partners are sometimes not fully aware of eligibility of funding for HIV-related activities and DG ECHO has been contacted by partners with queries on the eligibility of certain activities, in particular the provision of ARV (Anti-Retroviral Drugs) among refugees and other populations. At the same time, DG ECHO has observed that operational partners in the field sometimes ignore simple universal mandatory precautions and prevention measures. Moreover, Heads of the EC Delegations in Southern Africa recently called upon DG ECHO to examine further how it could enhance the mainstreaming of HIV activities in its programmes.

The present guidelines follow the recommendation of the health evaluation that they "should include DG ECHO's recommendations on HIV/AIDS [...] which will require endorsement from DG ECHO management as they have funding implications." They also reflect the encouragement in the recently conducted Real Time Evaluation of DG ECHO's intervention in Zimbabwe<sup>5</sup> "to continue with the elaboration of DG ECHO's role and potential approaches as to HIV/AIDS and to aim at formalisation in an official EC policy statement, to base guidelines on an endorsement of the overall outlines of the Inter-Agency Standing Committee framework; maintain the position that HIV per se will not serve as an entry point, and elaborate on the interventions eligible for DG ECHO funding."

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1 Including a variety of instruments such as European Development Fund (EDF) and Development Cooperation Instrument (DCI) including country specific programmes and thematic programmes (Health, Food Security) as well as through different modalities, including budget support.

2 (COM (2005) 179 final) of 27 April 2005 following the Commission Communication on 'A Coherent European Policy Framework for External Action to Confront HIV/AIDS, Malaria and Tuberculosis' (COM (2004) 726 final/2).

3 A review of DG ECHO's Approach to HIV/AIDS, Concept Paper and Model Guidelines (Prolog Consult Belgium, October 2004).

4 Evaluation of DG ECHO funded health sector activities, ETC Crystal, October 2007.

5 Real-Time Evaluation of DG ECHO financed action of CARE International Germany in Zimbabwe. Particip GmbH (Annemarie Hoogendoorn and Munhamo Chisvo), January 2008.

They also follow the recently adopted European Consensus on Humanitarian Aid,<sup>6</sup> proposing that "*the Community will promote value-added sectoral policies based on international best practice.*" Consistency with the guidance provided by the IASC-guidelines for HIV interventions in emergency settings<sup>7</sup> has been ensured through a consultation roundtable and follow-up contacts with the responsible task force lead.

### 3. HIV/AIDS AND EMERGENCY SETTINGS<sup>8</sup>

While the overall picture of the AIDS pandemic is expected to continue to change in the coming years, the most recent figures are as follows:

- According to the latest figures of the UNAIDS/WHO 2007 AIDS Epidemic Update, an estimated 33.2 million people are living with HIV. There were 2.5 million new infections in 2006 with 1.7 million (68%) of these occurring in sub-Saharan Africa and important increases in Eastern Europe and Central Asia, where there are some indications that infection rates have risen by more than 150% since 2001 (currently 1.6 million). In 2007, 2.1 million people died of HIV-related illnesses.
- Fewer than one in five people at high risk of infection have access to effective prevention.
- UNFPA, the largest public-sector purchaser of male condoms, estimates the global annual supply of public-sector condoms to be below 50% of adequate condom coverage, the gap between supply and actual need totalling 8.3 billion condoms.
- There is only 34% coverage for prevention of mother to child transmission. Of the estimated 2.5 million HIV-infected children under the age of 15, well over 90% are thought to have been infected through mother to child transmission.
- Of the approximately 10 million people living with HIV in low and middle income countries and in need of ARV medication, only 30% (approximately 3 million) have access to ARV.
- Worldwide, it is estimated that more than 15 million children under 18 have been orphaned as a result of AIDS (cumulative figure up to 2005), of which more than 11 million are in Sub Saharan Africa, where it is estimated that 9% of all children have lost at least one parent to AIDS.

In the past, little attention was given to the spread of HIV/AIDS in emergency settings since the focus was on immediate life-saving measures and HIV was not considered a direct threat to life. Since 2000 however, there are increased efforts to analyse how HIV spreads in emergency settings.<sup>9</sup> The Declaration of Commitment

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6 Joint Statement by the Council and the Representatives of the Governments of the Member States meeting within the Council, the European Parliament and the European Commission (2008/C 25/01), adopted on 18 December 2007.

7 IASC Guidelines for HIV/AIDS Interventions in emergency settings (2004), currently under revision.

8 This section is based on the IASC Guidelines for HIV/AIDS Interventions in emergency settings (2004). Figures among others from UNAIDS reports 2006 (Towards Universal Access progress report) and 2007 (Aids epidemic update, December 2007); Joint United Nations Programme on HIV/AIDS (UNAIDS); and World Health Organization (WHO), 2007.

9 Such as Security Council Resolution 1308 on HIV/AIDS and Peacekeepers

on HIV/AIDS adopted unanimously at the UN General Assembly's Special Session on HIV/AIDS in 2001 recognized that populations affected by emergencies face increased risk of HIV exposure.<sup>10</sup> The subsequent adoption of the Inter-Agency Standing Committee (IASC) guidelines for HIV/AIDS interventions in emergency settings recognised that factors such as war and displacement - especially in high-prevalence areas<sup>11</sup> - accelerate transmission rates. Services are also needed for disaster-related and non-displaced populations. The IASC provided guidance for addressing HIV/AIDS in different sectors. They recognised that persons living with HIV/AIDS (PLHIV) tend to suffer disproportionately when faced with emergency situations: They are at greater risk of physically deteriorating during emergencies because they are more prone to suffer diseases and death when facing limited access to food, clean water and good hygiene and health facilities. Caretakers might also be killed or injured leaving behind children already made vulnerable by infection.

In times of crisis, health care services are often severely affected and easily disrupted and health coverage diminishes. Lack of coordination, at times due to an overwhelming multitude of partners, security constraints and competing priorities contribute to widening the gap between expanding needs and diminishing resources. As HIV-transmission through transfusion of infected blood is close to 100%,<sup>12</sup> safe blood supply is extremely important as well as ensuring that universal precautions are adhered to. Similarly, other Sexually Transmitted Infections (STI) spread faster where there is instability and violence and should be managed by prevention measures and by reducing the prevalence of curable STI, as well as provision of condoms. Especially the provision of Antiretroviral Drugs (ARVs) in emergencies is to be considered. Although Antiretroviral Treatment (ART) is not a cure and there are many side-effects and concerns about resistance, ARVs greatly improve the quality of life by reducing morbidity and mortality among PLHIV and numerous initiatives exist to increase access to (life-long) treatments. In the context of emergencies, however, considerations related to the life-long needs of treatment need to be taken into account against the short-term availability of emergency funding, necessarily focusing on short term interventions with a certain impact. For instance, this can include the continuation of treatment for those already under ARVs, Post Exposure Prophylaxis (PEP) and the Prevention of Mother to Child Transmission (PMTCT). Opportunistic infections should be given attention during emergencies, especially those that are relatively easy to treat.

Conditions that define a complex emergency (conflict, social instability, poverty, powerlessness) also favour the rapid spread of HIV/AIDS and other STI: rape and sexual violence, severe impoverishment that often leads women and girls to exchange sex for survival, mass displacement, relocation and lack of security; broken school and communication systems that were used for prevention; limited access to health structures and thus to condoms and treatments of STI. Sexual and gender based violence (SGBV) intensifies in conflict, post-conflict **and** natural disaster situations, adding to the risks faced by refugees, returnees, internally

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10 S-26/2. Declaration of Commitment on HIV/AIDS The General Assembly Resolution, Declaration of Commitment on (HIV/AIDS), 27 June 2001

11 For high prevalence countries, see for instance UNAIDS AIDS epidemic update

12 IASC-guidelines 2003

displaced persons and other persons affected by emergency situations. In response, protection of women and children in situations of humanitarian crises needs to be strengthened, which means, among others, appropriate camp management and community involvement and sensitivity in dealing with communities.

As for food security and nutrition in emergency situations, they generally have a critical impact on HIV, and vice versa: HIV can be a cause of food insecurity – for example through reduced productivity, diminished incomes, increased expenditure on health care and funerals/burial, loss of productive assets and reduced educational opportunities. Collectively, these factors have an impact on both household-level food access and general agricultural production. HIV can also undermine the capacity of food-insecure populations to cope with crises. Food insecurity may put poor people at greater risk of being exposed to HIV – for example through forced migration to find work, or through poverty-fuelled adoption of transactional sex as a “survival” strategy. Nutrition is known to interact with the immune function. Good nutrition can delay the development of AIDS and opportunistic infections through preventing weight loss, maintaining muscle mass and generally better health – with the corollary that malnutrition leads to the earlier on-set of AIDS. Ensuring a reasonable nutrition condition prior to and during the start-up phase of ART increases the effectiveness of the treatment.

The nature and extent of these interactions justify that special consideration be given to the design and implementation of emergency assistance programmes in the context of high HIV-prevalence. Specific consideration is warranted for how humanitarian programming can contribute towards, and be influenced by, the core pillars of an HIV-response, including prevention, treatment, and care and mitigation.

#### **4. MANDATE AND COMPARATIVE ADVANTAGES DG ECHO**

The European Union’s mandate to DG ECHO<sup>13</sup> is to provide emergency assistance and relief to the victims of natural disasters or conflict outside the European Union. The aid must go directly to those in need, irrespective of race, religion or political convictions.

The main concern regarding HIV in emergencies is not so much that there is a lack of funding, but rather that the traditional sources of funding such as the Global Fund or the PEPFAR or other EC instruments have serious constraints to commit financial resources within a typical emergency setting. These settings are often characterised by a combination of factors including geographical access restraints, lack of implementing partners, government counterparts and / or governmental interest to include emergency areas in their applications to these funds. They also often include a lack of health facilities and qualified personnel as potential cornerstones of a framework for preventive or curative HIV activities. Regarding levels of funding, the current annual resource availability to tackle the HIV-pandemic has risen significantly from below \$2 billion in 2001, to close to \$10 billion in 2007.<sup>14</sup> The problem is therefore less to gather more funds for HIV-related

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13 Regulation (CE) n° 1257/96

14 Note that the need for resources has also risen considerably



interventions, but rather to use the funds from emergency donors in the most efficient way and only in situations where other traditional (and much bigger sources of funding) cannot be utilised. For example, instead of DG ECHO financing PMTCT in Lesotho, where the GFATM or PEPFAR or EC instruments can easily intervene, it should rather use scarce funding for basic HIV preventive and curative activities in situations like Darfur or DRC. DG ECHO's funding role should therefore be in line with its comparative (dis-) advantages.

#### *Comparative advantages*

- Strict neutrality, impartiality and independence
- Rapidity of fund mobilisation and flexibility, potential bridging of gaps
- Specific focus on forgotten crises
- Dense network of field expertise, proximity to the field
- Vast network of partners, guaranteeing close connection at grassroots level, implementation possible even if no governmental institutions
- Application of the project approach, possibility to focus on gaps

#### *Comparative disadvantages*

- Short financing cycle, necessitating clear exit strategies
- Working modalities adapted to emergency settings and not to long term interventions, e.g. weak interaction with governmental structures, less structural approach
- Short term emergency orientation of some of DG ECHO partners
- Limited budget and many urgent humanitarian needs beyond the HIV-related ones

Against this background, DG ECHO will contribute to the alleviation of the pandemic - and consider activities following a solid analysis and judgement - along the following logic:

- (1) **Financing:** As DG ECHO has certain comparative disadvantages, HIV/AIDS in itself will not be considered an entry point for DG ECHO funding. However, DG ECHO will consider funding HIV-related interventions and activities in critical circumstances when its comparative advantage is clearly established, especially in comparison with other funding instruments and where beneficiaries are targeted on the basis of humanitarian need and risk. DG ECHO's contribution to specific HIV/AIDS interventions can only be limited in time and DG ECHO should not be the gap filler "by default",
- (2) **Best practice:** Partners should follow as much as possible internationally recognised policies on HIV in emergencies. HIV activities should be mainstreamed into DG ECHO funded humanitarian programmes wherever possible and appropriate.

## SECTION II: DG ECHO GUIDANCE

### 5. ADHERENCE TO INTERNATIONAL POLICIES

DG ECHO does not want to duplicate existing, internationally accepted policies on HIV, and sees its role first of all to ensure that funded interventions are in line with other EU and international policies. Therefore, reference is made here to a non-exhaustive selection of relevant policies that DG ECHO partners are invited to consider when drafting proposals and implementing activities in the field.

- European Commission Communication on a **"European Programme for Action to Confront HIV/AIDS, Malaria and Tuberculosis through External Action (2007-2011)"** aims at making up the financing shortfall to meet the sixth Millennium Development Goal (i.e. to combat HIV/AIDS and other diseases) and at scaling up the interventions that can achieve the best results. [http://ec.europa.eu/development/icenter/repository/Programme\\_for\\_Action\\_en.pdf](http://ec.europa.eu/development/icenter/repository/Programme_for_Action_en.pdf)
- DG ECHO staff working document on **"Children in Emergency and Crisis Situations"**, which is part of the 2008 Communication **"A Special Place for Children in EU External Action"**<sup>15</sup> aims at defining a framework for community humanitarian actions towards specific needs of children. [http://www.cc.cec.sg\\_vista/cgi-bin/repository/getdoc/COMM\\_PDF\\_SEC\\_2008\\_0135\\_1\\_EN\\_DOCUMENTDETRAVAIL.pdf](http://www.cc.cec.sg_vista/cgi-bin/repository/getdoc/COMM_PDF_SEC_2008_0135_1_EN_DOCUMENTDETRAVAIL.pdf)
- **"IASC Guidelines for HIV/AIDS interventions in emergency settings" (2004)** are being revised at the moment and as soon as adopted should form the main international guidance on HIV/AIDS operations in emergencies. The IASC-guidelines are also specifically relevant for activities in sectors that are not described in detail in the present DG ECHO guidelines (such as camp management and settlement, WASH, education, livelihood). <http://www.humanitarianinfo.org/iasc/content/products/docs/FinalGuidelines17Nov2003.pdf>
- WHO et. al. **"Consensus Statement on Delivering Antiretroviral Drugs in Emergencies"** (2007) calls for specific interventions to be prioritized during emergencies (i.e. the availability of ARVs for prevention and for maintaining the treatment of patients who were previously on ART). [http://www.who.int/hac/techguidance/pht/HIV\\_AIDS\\_101106\\_arvemergencies.pdf](http://www.who.int/hac/techguidance/pht/HIV_AIDS_101106_arvemergencies.pdf)
- UNHCR **"Antiretroviral Medication Policy for Refugees"** (2007) provides standards on the provision of ARVs in refugee settings, and outlines the scope of engagement and responsibilities of UNHCR offices and its partners. <http://www.unhcr.org/publ/PUBL/45b479642.pdf>
- UNAIDS/WHO **"Policy statement on HIV testing"** gives principles on how to provide proper testing and counselling. <http://www.who.int/hiv/pub/vct/en/hivtestingpolicy04.pdf>

- FANTA, "**Food Assistance Programming in the Context of HIV**" (2007) and UNHCR & WFP "**Integration of HIV/AIDS activities with food and nutrition support in refugee settings**" (2004) provide practical and technical guidance on food and nutrition interventions. [http://www.fantaproject.org/downloads/pdfs/Food\\_Assistance\\_Context\\_of\\_HIV\\_Oct\\_2007.pdf](http://www.fantaproject.org/downloads/pdfs/Food_Assistance_Context_of_HIV_Oct_2007.pdf) and [http://data.unaids.org/pub/Manual/2004/integration\\_hiv\\_nutrition\\_strategies\\_manual.pdf](http://data.unaids.org/pub/Manual/2004/integration_hiv_nutrition_strategies_manual.pdf)
- "**IASC Guidelines for Gender Based Violence interventions**" (2005) is a tool aimed at field actors to help to establish a multisectoral coordinated approach to gender-based violence. [http://www.humanitarianinfo.org/iasc/content/products/docs/tfgender\\_GBVGuidelines2005.pdf](http://www.humanitarianinfo.org/iasc/content/products/docs/tfgender_GBVGuidelines2005.pdf)
- WHO "**Clinical Management for Rape Survivors**" (2005) presents the specific protocols and steps to be developed and used by implementing agencies with refugee and IDP populations. [http://www.who.int/reproductive-health/publications/clinical\\_mngt\\_rapesurvivors/clinical\\_mngt\\_rapesurvivors.pdf](http://www.who.int/reproductive-health/publications/clinical_mngt_rapesurvivors/clinical_mngt_rapesurvivors.pdf)
- "**Renewing our voices: Code of Good Practice for NGOs responding to HIV/AIDS**" (2004) provides guiding principles to be followed by signatories during interventions (differentiating contexts and strategies in development and humanitarian interventions). [http://www.aidsalliance.org/graphics/secretariat/publications/NGO\\_code\\_of\\_practice.pdf](http://www.aidsalliance.org/graphics/secretariat/publications/NGO_code_of_practice.pdf)

## 6. MAINSTREAMING HIV IN ECHO-FUNDED ACTIONS

The purpose of mainstreaming a set of minimum HIV-activities in DG ECHO funded actions is to prevent the spread of the virus by negligence, as well as taking into consideration basic specific needs of PLHIV in designing and implementing actions. Such activities are based on "do no harm" principles and a desire to prevent and mitigate exposure to HIV during emergencies, whether the emergency occurs in a low or high HIV-prevalence setting. These activities focus on precaution, awareness and prevention as well as protection at all levels.

### 6.1. Minimum Activities related to Partners and their Staff

The Commission would expect partners to:

Inform and educate their staff (expatriate and local) about the HIV pandemic, its preventive measures and its significance.

Ensure that all staff is covered under a health insurance policy that includes PEP, VCT, PMTCT and ARV/ART treatment.

Ensure that condoms are available to staff.

Where feasible and practical, Participate in HIV coordination fora at all levels.

Provide training to staff (expatriate and local) and where appropriate training on special needs related to PLHIV.

## **6.2. Minimum Activities for Beneficiaries**

### *6.2.1. Universal precautions and safe blood transfusions*

A beneficiary should never receive an unsafe blood transfusion or be exposed to clinical contamination. Therefore, partners should impeccably apply the universal precautions and standard criteria for safe blood transfusions as listed below.

#### *Universal Precautions*

- Using clear protocols to reduce unnecessary medical procedures (e.g. avoiding injections where possible).
- Disinfecting and sterilising all medical equipment and materials, keeping the health clinic environment clean.
- Training staff in replacing protocols from injectable to oral medication.
- Using disposable and where possible auto disabling needles.
- Using protective barriers such as gloves (single use), goggles, masks; and have sufficient clean water and soap at health facilities for frequent hand washing, etc.
- Supplying containers for sharp objects; installing incinerators and training staff for safe disposal of sharps and clinical waste management.
- Advocating against unsafe medical practices in the private sector.

#### *Standard criteria for safe blood transfusions<sup>16</sup>*

- Reduce the need for blood transfusion as much as possible by training health staff to use volume replacements solutions where possible (e.g. Haemacel).
- When blood transfusions are implemented develop proper systems and hold appropriate personnel accountable for the transfusions.
- Ensure that all blood for transfusion is safe by ensuring that it is screened for HIV and other blood-borne diseases (Hepatitis B and C, Syphilis).

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16 As adapted from WHO-defined criteria. See for instance 'WHO The Clinical Use of Blood Handbook' on [http://www.who.int/bloodsafety/clinical\\_use/en](http://www.who.int/bloodsafety/clinical_use/en)

- Train medical staff in the above measures.

#### 6.2.2. *HIV/AIDS awareness and prevention*

- Partners should take every opportunity to include information, education and communication (IEC) activities in their projects to – among others - inform about methods of HIV transmission, to promote prevention of sexual transmission of HIV and to encourage voluntary testing and use of PMTCT wherever the beneficiaries can have access to those services. Whenever possible, distribution points for food and other items should be used to disseminate prevention messages. Prevention activities will be considered for funding by DG ECHO, depending on the specific project context.
- Specific awareness and prevention activities targeting other uninformed groups (militaries, police, truck drivers, etc.) could be considered for funding. Such funding will depend on the context of emergency and specific vulnerability and need assessments done by potential implementing partners.
- Partners will provide free condoms in DG ECHO sponsored relief and distribution activities or settings accompanied by education on condom use. Clear and understandable information in the usage of condoms will be made accessible to beneficiaries.

### 6.3. **Mainstreaming actions to protect vulnerable groups**

Specific activities targeting the most vulnerable groups, in particular women and children should contribute to reducing the risk of exposure to HIV by:

- Whenever possible, involving communities, in particular women organisations in the design of such activities.
- Ensuring that special needs of PLHIV are fully taken into consideration in the design of projects in all sectors (i.e. site planning, shelter, water and sanitation and hygiene distribution schemes of food and non-food items, etc.) and that specific protection and advocacy activities are implemented to reduce their vulnerability. Particular attention should be given to most vulnerable groups such as women and orphans and other vulnerable children (OVC).
- Ensuring needs of most-at-risk populations such as sex workers and their clients, drug injectors and men who have sex with men (MSM) are addressed in emergencies. Even though they are most vulnerable, they may in lower prevalence regions be the only ones at real risk of infections.
- Ensuring non-discriminatory access to all facilities and services and enforce the respect for confidentiality and privacy.

- Integrating protection and protection mechanisms in actions: activities aiming at prevention of sexual and gender based violence, treatment, care and support to victims of such violence (such as access to palliative packages to rape victims, including PEP, emergency contraception, care for wounds and injuries, treatment of STI, psycho-social support and counselling) should be integrated and treatment mainstreamed as much as possible in DG ECHO funded actions, as long as implementing partners are sufficiently qualified to engage in technical issues of sexual violence prevention, care.
- Ensuring that special attention given to PLHIV in different sectors does not lead to stigmatisation and that PLHIV are consulted prior and during the design of activities that targets them.

## **7. FUNDING HIV-RELATED INTERVENTIONS**

Under certain conditions and taking into account the comparative advantages compared to other financing sources, DG ECHO will consider funding explicit (so beyond and above the mainstreaming activities above) activities that contribute to preventing any worsening of the impact of the HIV pandemic, saving and preserving life from the effects of HIV during emergencies and their immediate aftermath. These include activities for prevention, treatment, care and mitigation, to be implemented by DG ECHO partners. The appropriateness of DG ECHO funding for these activities will be assessed by – in particular medical - experts and desks following the (conditions of these) guidelines.

DG ECHO funded projects will take into account the special needs of PLHIV in water and sanitation projects, shelter design and site planning, rehabilitation of social structures and security installations. Partners must pay attention to HIV/AIDS IASC guidelines<sup>17</sup> for HIV/AIDS planning in various sectors as well as minimum standards for reproductive health in crisis situations (MISP<sup>18</sup>/ SPHERE), including for instance recruitment of female guards in camps to discourage rape perpetrators and make sure that any special treatment will not have stigmatising effects.

This section starts with conditions and consideration for all HIV-related interventions (other than mainstreaming above). As the health and food assistance sectors are the most concerned, further focus and conditions are given to these.

### **7.1. Conditions and considerations**

HIV/AIDS in itself is not to be considered an entry point for DG ECHO. DG ECHO will consider funding HIV-related interventions only when the following conditions apply and the following considerations have been made:

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<sup>17</sup> Currently under revision.

<sup>18</sup> Minimum Initial Service Package

### *Conditions*

- Beneficiaries to be targeted by DG ECHO funded interventions are part of the population identified as the most vulnerable.
- A humanitarian crisis has led to the temporary suspension of assistance regimes requiring a stop-gap response, with strong prospects for a handover, or for a cessation of need, at the end of the emergency.
- Non-continuation of assistance carries immediate, dramatic and large-scale humanitarian risk (i.e. mortality or malnutrition rates in excess of emergency thresholds at population level).
- DG ECHO and partners have a clear responsibility to take on the project and other sources of funding are clearly less appropriate or less practical.
- Positive outcome is likely within the (short) timeframe of the intervention.
- Interventions would ‘do no harm’ in terms of further marginalizing PLHIV by potentially stigmatising the beneficiaries.
- As aid should be needs based and access to the most vulnerable guaranteed, DG ECHO will, in principle, not support actions that charge user fees, unless duly justified.<sup>19</sup>

### *Considerations*

- The link to government institutions and integration in national programmes in the design of the project (alignment and harmonisation) has been considered.
- A full integration within a broader programme has been considered, taking also into account the need for an exit strategy and Linking Relief, Rehabilitation and Development (LRRD).
- DG ECHO interventions are complementary to those of other Commission Services and other donors.

## **7.2. Health interventions**

The following health-related activities will be considered to address HIV in the acute phase of emergencies.

### *7.2.1. Opportunistic Infections*

Opportunistic infections (OI) are infections that take advantage of a reduced immune system and are thus particularly common and dangerous for PLHIV. These infections are caused by viruses, bacteria, fungi and parasites and can turn into diseases that are highly

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<sup>19</sup> Following among others discussions in the IASC health cluster (June 2007). Specific DG ECHO guidance on user fees is under development.

lethal for PLHIV. Some OIs can be easily managed while others require complicated treatments and are therefore harder to care for during emergencies. DG ECHO will consider funding the continuation and initiation of OI prophylaxis and treatments (such as cotrimoxazole prophylaxis) in order to treat adults and children living with HIV as well as infants born to mothers living with HIV given that such interventions can save lives. This would also postpone the need for prescription of antiretroviral therapies

### 7.2.2. *Anti-Retroviral Drugs*

- Anti-retroviral drugs (ARV) can be used in different ways: as short term preventive treatment for the prevention of mother-to-child transmission (PMTCT), as post-exposure prophylaxis (PEP) to reduce likelihood of HIV transmission after accidental exposure (rape or contact with contaminated blood) and as long term anti-retroviral treatment (ART). ARVs should in principle not be used in isolation but should be seen as part of an integrated HIV-programme, linked to prevention, care and support programmes.
- The following **general pre-conditions** apply for all DG ECHO health funding of ARV:
  - (1) The technical qualification of the implementing partner must always be guaranteed and fulfil the minimum requirements.
  - (2) Back-up services need to be present.<sup>20</sup>
  - (3) Diagnostic and treatment protocols should follow those of the host community whenever relevant.<sup>21</sup>
- DG ECHO will consider the funding of **distribution and delivery. Supply** will also be considered for funding, but the potential of supply of ARVs by longer term providers and funders should be examined. An exit-strategy will need to be provided to reduce the risk of unplanned interruption of ARV-treatment.
- For refugee situations, the antiretroviral medication policy for refugees as drafted by UNHCR<sup>22</sup> will be the reference point for DG ECHO within the framework of its mandate and these guidelines.

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20 Such as lab testing, counselling services (on how to take the drugs and what are consequences of interrupting the medication), potential food intake for optimal absorption, guidance on medical regimen change for health workers, presence of community home-based care groups, etc.

21 Unless they are ineffective, non-evidenced based or do not respect consent and confidentiality.

22 <http://www.unhcr.org/publ/PUBL/45b479642.pdf>



- DG ECHO may consider contributing to preparedness activities in unstable situations to avoid or mitigate the acute unplanned interruption of ARV therapy. This may include activities such as:
  - (1) To organise specific education and training for patients and service providers (before the interruption may take place).<sup>23</sup>
  - (2) To organise a simple system of monitoring, tracking and referring patients, adaptable to the mobility of the patients.
  - (3) To organise contingency plans for procuring and supplying ARVs of good quality and in accordance with national policy (but avoiding stockpiling of ARV drugs).<sup>24</sup>

### **Prevention of Mother-to-Child Transmission**

- DG ECHO recommends **Prevention of Mother-to-Child Transmission** (PMTCT) interventions and PMTCT scale up activities. Such activities can also be considered as a valid strategy against child malnutrition and mortality as progressively more enrolments in therapeutic and supplementary feeding programmes concern children affected through Mother-to-Child transmission of HIV.<sup>25</sup>
- DG ECHO will consider funding ARVs in programmes to prevent HIV transmission to the foetus/newborn, depending on the context. Continuation of therapy for already enrolled mothers will be a priority.
- DG ECHO will be less favourable on funding the establishment of a comprehensive PMTCT programme as this would require a longer term involvement and a close link to governmental institutions.
- PMTCT+ (defined as the continuation of therapy for infected mothers after giving birth to avoid the child to become a premature/early orphan), will be considered for funding with the additional condition of having back-up services and a reasonable possibility to secure longer-term funding.
- Following WHO Consensus, exclusive breastfeeding is recommended for HIV-infected women for the first 6 months of life unless replacement feeding is acceptable, feasible, affordable,

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23 E.g. on how to stop ART safely, how to apply positive prevention measures when a forced treatment interruption occurs.

24 This could include organising secure decentralised drug stocks; emergency run away packs and training patients on how effectively to handle their ARV medication.

25 Overall, PMTCT should reach coverage levels of 85% similar to ANC (Anti-Natal-Care) and immunization targets.

sustainable and safe (AFASS) for them and their infants before that time.<sup>26</sup>

### **Continuation of ARV treatment**

- **Funding of ARV** may be accepted in DG ECHO projects when beneficiaries already under therapy lose access to therapy due to displacement, return to home country, conflict or disaster since it will have a strong impact on treatment effectiveness and will help avoid drug resistance.

### **New enrolment in longer-term ARV treatments**

- Where longer term treatment is required, DG ECHO encourages its partners to refer PLHIV to the appropriate HIV-treatment programmes. If this is not feasible, DG ECHO will under certain circumstances consider the funding of **enrolment of new beneficiaries** in longer-term therapies during emergencies as a temporary gap-filling, and with the guarantee that future funding will be available from another donor or from DG ECHO or where the partner can guarantee at least one year continuation of funding before starting implementation of an ART programme<sup>27</sup>. The immediate life-saving impact should be obvious and should outweigh the potential negative impact of an unplanned interruption of the treatment after the funding period.

#### *7.2.3. HIV-testing and diagnosis and treatment of STI*

- Even though DG ECHO does not consider funding integrated programmes for testing (whether voluntary or provider-initiated counselling and testing) as part of its mandate, **HIV-testing** as part of medical diagnostic activities will be considered for funding.
- DG ECHO will also consider funding **diagnosis and treatment of STI** (sexually transmitted infections) in general and, therefore, also for PLHIV. This activity will be fully mainstreamed in the health programmes financed by DG ECHO.

### **7.3. Interventions of Food Assistance, Nutrition and Livelihoods**

This section covers areas in which operations are adapted for high prevalence contexts (context where there is a relative high number of population infected

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26 World Bank (2007) HIV/AIDS, Nutrition and Food Security: What we can do. A synthesis of international guidance, page 22.

27 Following UNHCR recommendations in "Antiretroviral Medication Policy for Refugees" – January 2007

and / or affected by HIV) and areas in which food and nutrition support is provided to support treatment.

### 7.3.1. *Adapting food assistance operations*

In the context of these guidelines, food assistance is broadly defined to include a variety of tools and approaches that promote the physical and economic access to sufficient safe and nutritious food to meet dietary needs and food preferences for an active and healthy life. This includes transfers of in-kind food commodities, cash transfers and near cash alternatives, such as vouchers.

The need for food assistance should be established on the basis of indicators of actual levels of acute food insecurity or malnutrition, at population level. As HIV prevalence rates are not necessarily correlated with levels of food insecurity, they should not be used as a justification for general food assistance. Furthermore, targeting food assistance on the basis of HIV status or related proxy indicators risks large errors of inclusion (those who are HIV affected but remain food secure) and exclusion (those who are food insecure but not affected by HIV/AIDS).

However, within food insecure or malnourished target groups, the needs of HIV-infected and affected populations require special consideration. Any DG ECHO funded food assistance operation in high prevalence contexts should consider, and make provision for, the following:

- **Adapting the food ration composition:** Ration design should take into consideration the impact of HIV on the entire population, i.e. to assume majority of beneficiaries are affected. For example giving special attention to food fortification and the extra energy requirements of HIV/AIDS infected people, particularly those recovering from opportunistic infections. However, it should be noted that calorific supplementation that leads to weight gain beyond stabilisation does not in itself reduce the risk of disease progression.
- **Distribution points:** Distributions need to be accessible for weaker chronically sick beneficiaries. However, care should also be taken not to establish distribution points specifically for PLHIV where this could exacerbate stigma. In such cases, further adaptations, such as allowing caretakers to collect rations, distributing smaller quantities more frequently, or increasing the number and types of sites where food is provided, can be considered. Whenever possible, distributions should also be used as a platform to disseminate HIV awareness and prevention messages, as well as associated nutritional education.

- **Ensuring that demographic profiles<sup>28</sup> are taken into account** so that distribution methods are fair to families with more children and fewer working adults. Special attention should be given to elderly, women and children-headed households.
- Due consideration should also be given to incorporating prevention and awareness activities into all general food assistance programmes. Examples include:
  - (1) **Distribution points:** Food distributions and nutritional programmes should be organized to minimize the risk of transmission of HIV, e.g., through designing safe and proximate distribution points to minimize exposure to sexual violence, or through close monitoring of distributions to ensure that the assistance provided is not abused to negotiate transactional sex.
  - (2) Ensuring that increased transmission risk associated with **trucking of food commodities** are appropriately mitigated for instance through HIV-awareness campaigns for truck drivers.

### 7.3.2. *Adapting nutrition operations*

Where an emergency nutritional programme exists (Supplementary Feeding Programmes and Therapeutic Feeding Programmes), DG ECHO will consider funding the inclusion of orphans and other vulnerable children living with HIV, and PLHIV in nutritional rehabilitation programs. Any DG ECHO funded nutritional intervention in high prevalence areas should consider the following:

- Adaptation of protocols, commodities and exit-strategies may be necessary for, amongst other aspects, poor responders with low weight-gain, abandonment and default, treatment of opportunistic infections, blood transfusion practices, and management of high mortality, all of which require adjustment in contexts where high numbers of children are admitted with acute malnutrition and HIV.
- Linking the programme with development agencies, donors and governments, to ensure that the sustained needs of HIV-positive malnourished individuals are met within an appropriate long-term timeframe.

### 7.3.3. *Emergency livelihood activities*

- Once PLHIV regain their productive capacity, principally through ART, **emergency livelihood support** can assist them to regain

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<sup>28</sup> Demographic profiles may shift in high prevalence contexts, which result in – for instance – a larger numbers of households with a higher ration of children-to-adult ratio.

self-reliance, precluding the need for indefinite food assistance. DG ECHO might consider supporting short-term livelihoods activities targeted at PLHIV exclusively as an exit-strategy from any emergency food assistance, including ARV treatments.

- Emergency livelihoods programmes in high prevalence contexts should mainstream the particular needs of PLHIV and HIV-affected households. Careful analysis is needed of how HIV is affecting the household's range of livelihood assets and pursuits (including labour, knowledge and skills, financial assets, natural, social, political and physical assets) in each specific context. For example, the critical constraint may not be labour, but a lack of cash due to the new financial demands brought by the illness. In considering these activities, child labour should be prevented.

#### 7.3.4. *Food assistance to support ARV treatment*

Good nutrition is required prior to and during ARV treatment, to improve the effectiveness of ARV drugs and reduce their negative side-effects. Increased energy and calorific intake is necessary to recover from opportunistic infections whilst on treatment.

DG ECHO will therefore consider funding complementary food assistance alongside short-term ARV provision as mentioned in the section on health interventions (including PMTCT, PEP and other provisions of ARVs) where, in addition to the criteria mentioned before, the following additional conditions are met:

- There is an acute need for food at individual level due to an external shock / acute food insecurity at population level; and where alternative food sources, whether from household production, safety-nets, or other entitlements, have been temporarily interrupted by a crisis. For example:
  - (a) DG ECHO might consider providing food, to compliment ARV treatment, to IDPs living with HIV who have been displaced by conflict, whose ARV provision has been assured (irrespective of provider), but who can no longer feed themselves adequately due to displacement from their agricultural lands.
  - (b) DG ECHO might consider food support for PLHIV on ARV who, due to a climatic shock or drought, have lost their harvest, or for whom, due to civil conflict, a pre-existing food-based safety-net no longer functions.
- No more appropriate, long-term, sources of food assistance are available.
- Appropriate consideration has been given to meeting the food needs of PLHIV through a general distribution for the entire food-insecure population, before establishing a separate operation for PLHIV.

- Support can be sustained for an optimal period of time, irrespective of DG ECHO funding duration.

Where a complementary role for food-resources might be justified, careful consideration should be given to the nature of the commodities and the calorific and micronutrient composition of food rations, which should be specifically formulated to support ARV programmes.

Careful consideration should be given to whether the food needs of PLHIV (and, depending on context, their households, dependents or caretakers) are most appropriately and cost effectively met through the use of in-kind food transfers, vouchers or cash transfers. In a context with high HIV/AIDS prevalence, cash may be more appropriate where its flexibility allows PLHIV to address a broader basket of needs, for example transport to treatment centres, in addition to household food requirements. Furthermore, DG ECHO does not consider in-kind food aid to be an appropriate incentive for patient adherence to treatment regimes.

#### 7.4. Integrated Interventions

PLHIV need a wide combination of support actions, including access to medical services and medication, good nutrition, access to clean water, livelihoods support, hygiene, social and psychological support. This is best provided through **long term** social protection mechanisms, and as such, DG ECHO will not initiate support to such activities. However, assistance may be financed by DG ECHO to multi-sectoral support, **temporarily**, in particular e.g. Home Based Care (HBC) programmes as part of such broad-spectrum HIV-care. Given the potential scale, the indefinite duration, the multiplicity of beneficiaries (PLHIV, their households, orphans, caretakers etc) and the necessary multi-sectoral approach, DG ECHO will only consider temporary gap-filling of activities for new enrolments on long-term HBC programmes.

The following conditions should be met for such integrated programmes, on top of those mentioned for new ARV-enrolments above:<sup>29</sup>

- Preference should be given to other long term mechanisms better equipped to follow up in the long term.
- Evidence of a coordinated approach that links the delivery of inputs from the medical, water and sanitation, food assistance and livelihood sectors.
- Effective and cost efficient feeding protocols.

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<sup>29</sup> As recommended in the recent Real Time Evaluation that DG ECHO commissioned in Zimbabwe Real-Time Evaluation of DG ECHO financed action of CARE International Germany in Zimbabwe. Particip GmbH (Annemarie Hoogendoorn and Munhamo Chisvo), January 2008.

- Unambiguous entry and exit criteria.

Because of the primarily short term, emergency nature of its support, the humanitarian aid instrument may not be the most appropriate to support **integrated livelihood programmes, including Home Based Care and ART** activities. Therefore, all efforts should be made to ensure commitment from development partners (Government, other Commission Services, other donors, including International Financial Institutions (IFIs) and mechanisms such as the Global Fund) for future continuation of the intervention.

## 8. IMPLEMENTATION

DG ECHO will promote implementation of these guidelines in the following ways:

- Pro-actively inform partners.
- Provide training and information to staff. An internal *Technical Issue Paper* has been distributed to all staff on HIV/AIDS in emergencies.
- Through a checklist to be used by staff to assess programmes' conformity with the guidelines.
- Advocate with stakeholders (including other donors) for a joint – and possibly complementary – approach.

These DG ECHO HIV funding guidelines will need to be adapted regularly to the changing humanitarian environment, emerging technology and innovative aid strategies. Constructive **feedback and lessons learnt** on the practical application from all layers in the organization and external partners is most valuable and needed and should be provided to DG ECHO / 01.

Simultaneously, consultation with other services of the Commission, donors and partners will take place for coordination and joint promotion and advocacy for measures enhancing the overall response to AIDS.

DG ECHO partners are invited to use these guidelines to contribute to contain the pandemic and ensure that, even in emergency settings, everything possible is done to limit the spread and alleviate the consequences of the HIV/AIDS pandemic.

## SUMMARY TABLE

<b>ADHERENCE TO INTERNATIONAL POLICIES (SECTION II – CHAPTER 5)</b>
<b>MAINSTREAMING HIV IN ECHO-FUNDED ACTIONS (SECTION II – CHAPTER 6)</b>
<b>Minimum Activities related to Partners and their Staff</b>
Information and education of staff
Health Insurance Coverage
Condoms availability to staff
Active participation in HIV/AIDS coordination fora
Training of staff on AIDS related activities and special needs for PLHIV
<b>Minimum Activities for Beneficiaries</b>
Full respect for universal precautions and standard criteria for safe blood transfusions
HIV/AIDS awareness and prevention: inclusion of IEC (information, education and communication) on different aspects of HIV prevention, treatment, care and support, also targeting uninformed groups.
Promotion of voluntary testing
Distribution of free condoms in DG ECHO sponsored relief and distribution activities or settings accompanied by education on condom use
<b>Mainstreaming actions to protect vulnerable groups</b>
<p>Ensuring that special needs of PLHIV (in particular for women and orphans and other vulnerable children) are mainstreamed in all concerned sectors (shelter, WASH, distribution schemes, etc). However ensure that while giving special attention to PLHIV, stigmatisation is avoided. This may include:</p> <ul style="list-style-type: none"> <li>- Essential health centres with adapted facilities for PLHIV e.g. detection and treatment of STI and OIs, nutritional programmes;</li> <li>- Awareness and managerial training for camp managers/staff;</li> <li>- Ensuring access for PLHIV to social, health and water facilities, distribution points without stigmatisation and</li> <li>- designing safe water collection points with minimal risk for rape, etc.</li> </ul> <p>Whenever possible, involve communities in the design of such activities.</p>
Integrating protection and protection mechanisms is actions: activities looking at prevention of sexual and gender based violence, treatment, care and support to victims of such violence (such as access to palliative packages to rape victims, including PEP, emergency contraception, psycho-social support and counselling). Note that implementing partner should be sufficiently qualified to engage in technical issues of SGBV prevention, care and treatment.
Provision of PEP (post exposure prophylaxis) kits in medical context or in context of protection programmes such as for SGBV, provided implementing partner sufficiently qualified to engage in technical issues of PEP and confidentiality ensured.
Ensure that needs of most-at-risk populations, such as sex workers and their clients, drug injectors and Men who have sex with men (MSM) are addressed in emergencies.
<b>FUNDING HIV-RELATED INTERVENTIONS (SECTION II – CHAPTER 7)</b>
Conditions and Considerations that apply to all HIV-related interventions are provided in chapter 7.1.



Below are specific additional conditions regarding health, food assistance and integrated programmes.

ACTIVITIES	CONDITIONS
<b>Health Interventions</b>	
<p>Diagnosis and treatment of <b>opportunistic infections and sexually transmitted infections</b></p>	<ul style="list-style-type: none"> <li>• Implementing partner sufficiently qualified to engage in technical issues of treatment of opportunistic infections and STIs.</li> </ul>
<p><b>Anti-Retroviral Drugs</b></p> <ul style="list-style-type: none"> <li>• Continuation of ARV treatment to patients who lost access to previously established therapy (refugees, displacement, returnees, conflict or disaster related loss of access)</li> <li>• <b>PMTCT interventions</b> and PMTCT scale up activities. Also, continuation of ARV treatment in the context of a PMTCT programme to already enrolled mothers (who lost access)</li> </ul> <p>As preparedness activity in unstable situations and to avoid or mitigate the acute interruption of ARV therapy, it will be recommended to look at the following aspects for which DG ECHO may provide funds in the margin of the ARV treatment support:</p> <ul style="list-style-type: none"> <li>• To organise specific education and training for patients and service providers (before the interruption may take place. (E.g. on how to stop ART safely, how to apply positive prevention measures when a forced treatment interruption occurs).</li> <li>• To organise a simple system of monitoring, tracking and referring patients, adaptable to the mobility of then patients.</li> <li>• To organise contingency plans for procuring and supplying ARVs of good quality and in accordance with national policy (but avoid stock piling of ARV drugs). This could include organising secure decentralised drug stocks; emergency run away packs and training patients on how effectively handle their ARV.</li> </ul>	<ul style="list-style-type: none"> <li>• Implementing partner sufficiently qualified to engage in technical issues of an ARV distribution scheme</li> <li>• Back up services are available (some ARVs need refrigeration, counselling services must be available (on how to take the drugs and what are consequences of interrupting the medication), some ARVs need food intake for optimal absorption, health workers might need guidance on medical regimen change, national guidelines must be respected, and lab testing services availability, etc.</li> <li>• Diagnostic and treatment protocols should follow those of the host community (Unless they are ineffective, non-evidence based or do not respect consent and confidentiality).</li> </ul>
<p>Enrolment of <b>new beneficiaries in ARV</b> treatment scheme or in the context of a <b>PMTCT +</b> programme</p>	<ul style="list-style-type: none"> <li>• As a temporary gap filling, with clear identification of follow up funding from ECHO, other donor, Government or partner.</li> <li>• Partner should be able to guarantee at least one year continuation of funding after programme start</li> <li>• Preference should be given to other long term mechanisms better equipped to follow up in the long term.</li> </ul>
<p>Voluntary <b>HIV testing</b> via DG ECHO supported health facility as a diagnostic act</p>	<ul style="list-style-type: none"> <li>• Implementing partner sufficiently qualified to engage in technical issues of HIV testing</li> <li>• Counselling services available in or nearby the testing site with qualified personnel (not necessarily supported by the ECHO supported project)</li> <li>• Voluntary nature of the testing and rules of confidentiality respected</li> </ul>

Interventions of Food Assistance, Nutrition and Livelihoods	
Incorporation of HIV/AIDS prevention and awareness activities in general food assistance programmes.	<ul style="list-style-type: none"> <li>• A <b>humanitarian</b> food security crisis exists.</li> </ul>
Adapting food assistance operations in a high prevalence contexts through: revised ration composition, accounting for changed demographic profiles in ration sizes and making distribution points accessible.	<ul style="list-style-type: none"> <li>• A <b>humanitarian</b> food security crisis exists.</li> <li>• HIV-AIDS prevalence rates in the programme area justify a modified programme</li> <li>• Beneficiaries included on food security status, not HIV-AIDS status</li> <li>•</li> </ul>
Adapting protocols, commodities and exit-strategies for nutrition programmes in high prevalence contexts.	<ul style="list-style-type: none"> <li>• A nutritional problem is evident at the population level, as a consequence of a humanitarian crisis.</li> <li>• SFP and TFP beneficiaries are included on the basis of standard anthropometric criteria, not HIV-AIDS status</li> <li>• Linkages are established to long-term programmes to support HIV+ malnourished individuals.</li> </ul>
Short-term livelihood activities targeted at PLHIV as an exit strategy from food assistance.	<ul style="list-style-type: none"> <li>• Design of activities takes account of the particular impact of HIV on livelihood assets and options.</li> <li>• A clear exit strategy exists</li> </ul>
Food assistance to support ARV treatment:	<ul style="list-style-type: none"> <li>• A <b>humanitarian</b> food security crisis exists</li> <li>• ARV patients require nutritional support at individual level</li> <li>• General food distribution programs, or pre-existing safety nets, cannot be adapted to meet the food needs of those on ARVs</li> <li>• The partner agency is able to guarantee programme continuity for an optimal period of time irrespective of DG ECHO funding.</li> <li>• Effective and cost efficient feeding nutritional supplements are provided</li> <li>• Not used as an incentive for patient adherence to treatment regimes</li> <li>• A clear exit strategy exists</li> </ul>
Integrated Interventions	
<p>Multi-sectoral support to PLHIV, including access to medical services and medication, good nutrition, access to clean water, livelihood support, hygiene and psychological support.</p> <p>Including Home Based Care (HBC) programmes.</p>	<ul style="list-style-type: none"> <li>• All pre-conditions as given under ARV programmes for new enrolments.</li> <li>• Preference should be given to other long term mechanisms better equipped to follow up in the long term</li> <li>• Coherence with national policy frameworks</li> <li>• Evidence of a coordinated approach that links the delivery of inputs from the medical, water and sanitation, food assistance and livelihood sectors.</li> <li>• Effective and cost efficient feeding protocols.</li> <li>• Unambiguous entry and exit criteria.</li> </ul>

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