Global Fund to Fight AIDS, Tuberculosis & Malaria

Working on TBC and HIV/AIDS in Humanitarian Emergencies

Discussion paper prepared for the Italian NGDOs Platform

(comments to: gianni.rufini@intersos.org)

DRAFT

Working in emergency

Working in emergency situations while coping with TBC is relatively common for humanitarian organisations, given the high relevance of such disease in correspondence with food scarcity and extraordinarily difficult living conditions. Although humanitarian operations provide working with highly transmissible diseases and epidemics, TBC remains among the highest concerns for its treatment usually overrides the average duration of a humanitarian project (six months), and humanitarian organisations are not normally in conditions to ensure the full therapeutic coverage and follow up. Therefore, many of the constrains affecting HIV/AIDS treatment and assistance in emergencies are also valid for TBC.

On the other hand, Malaria does not represent a specific issue for humanitarian crises.

Little experience exists in working with HIV/AIDS affected people, albeit one-third of the most affected countries (those with a HIV rate above 4%) currently host humanitarian operations.

Working on TBC and HIV/AIDS in the framework of a humanitarian crisis has specific implications:

a) working under **extreme pressure**, with little or no possibility to examine individual cases or timely identifying affected people;

b) **minimal hygienic conditions** are seldom assured;

c) **priority** is always given to surgery and first aid, together with prevention of epidemics; problems like STDs and drugs can receive little attention;

d) working with **large numbers of people** in very poor conditions and under extreme stress;

e) **security conditions** are often very critical for personnel and victims;

f) logistic difficulties, insufficient information and little time for assessment, favors a **"standardized" approach**, which prevents from addressing specific needs;

g) **local capacity** is little available. Whatever the disaster, local organizations are often disrupted and concerned people directly affected by it, and incapable to contribute substantively to operations; communities are usually torn down as well as traditional authorities.

h) the **changing environment** imposes continuous adjusting to new conditions: number of beneficiaries, type of needs, priorisation of actions, etc.;

i) Humanitarian operations are often **short-term** and close down in a few months (usually six). In most cases it is very difficult to ensure continuity between the assistance patterns delivered during the emergency and the following period.

Assistance to refugees

Most humanitarian crises, nowadays, involve a large number of displaced people who represent the most critical environment for the spread of HIV/AIDS.

In situations where people depend on aid on a daily basis, monitoring the spread of diseases should be relatively easier but emergency programmes do not normally provide such an extension into what is considered long-term assistance.
No scientific studies into the prevalence of HIV/AIDS infection among refugees has been carried out so far, but experts assume that the refugees and internally displaced persons (today estimated at 35 million worldwide) are among the world's most vulnerable people. NomadNet reports that i.e. in Somalia "there is a six times greater risk of contracting HIV in a refugee camp than in the general population".
Population Reports (Population Information Program, The Johns Hopkins School of Public Health, 1996) identifies the following causes for such vulnerability:

1. **Contraceptive access and use are limited.**
2. **Risks of HIV/AIDS and other sexually transmitted diseases are high.** The disruption of family and community life during moves, especially in situations of poverty and crisis, increases risky sexual behavior and exposure to STDs.
3. **Safe motherhood is difficult.** Among refugees and internally displaced persons, childbearing can be life-threatening. During emergencies women often lack adequate food, shelter, and sanitation. Prenatal and delivery care often are minimal, and emergency care may be hours away.
4. **Violence against women is frequent.** Among refugees, rapes occur frequently. Some women may have no choice but to trade sex for protection, money, and food.

Moreover, the refugee population has so far being excluded from interventions aimed at slowing down the rate of HIV-infection. A concerted campaign targeted at the youth in Zambia that is credited with curbing the rate of HIV-infection among urban teenagers, for example, has not been extended to the refugee camps.

At the same time, in refugee camps little attention is normally paid to general health education, prevention and treatment of STDs. When attention is paid, it is often on a case by case basis—for example, after being identified during pregnancy or childbirth.

The refugee population also represents a major agent for diffusion on the medium-long term. Some examples:

- Liberian refugees in Côte d'Ivoire and Guinea, Rwandan and Ugandan refugees in the former Zaire, Laotian and Cambodian refugees in Thailand, Sudanese refugees in Uganda, and Ethiopian refugees in Sudan have carried HIV home with them, after having been infected during their flight.
- When nearly 2 million refugees who had fled in the 1980s to Malawi, which has a high HIV rate, returned home to Mozambique, the incidence of HIV began rising in Mozambique, where it was previously rare.
- The director of Burundi's national AIDS and sexually transmitted diseases control programme, Dr. Joseph Wakana, declared that "Concentration of internally-displaced people (IDPs) in camps and promiscuity are to blame for the increasing rate of HIV infection in Burundi's population, and the camps have become new centres of high infection rates in the countryside".

Problems for GF action in Humanitarian Emergency

Differently from other processes within the GF, the case of humanitarian emergency related projects must consider specific aspects:

Assessment and Planning

1. the tight timeframe may prevent normal consultation and planning processes;
2. proper coordination must be ensured with organisations such as the UNHCR, WFP, OCHA, the Red Cross, who often play the role of coordinating bodies in crises; and major humanitarian donors like ECHO and OFDA/USAID, the Governments of EU, Japan, Norway, Canada and Australia;

Questions

Should the Fund develop specific capacities for the assessment and planning in humanitarian crises or rather rely on other institutions? If so, which ones?

Should the Fund finance own projects in humanitarian crises or integrate broader humanitarian actions by financing ad-hoc HIV/AIDS components within larger projects?

Relations with Countries

3. sometimes conflicts are associated with the dissolution of states and there may be no governmental interlocutor (i.e. Somalia), or the national government may be one of the warring parties;
4. humanitarian aid is by definition neutral and independent from governmental/political influences;
5. operations and coordination are mainly carried out by international bodies, while national authorities usually have little capacity in the given situation.

Questions

How should the Fund relate to national governments and or other parties involved in a conflict?

What type of consultation process could be enabled for such cases?

Role of NGOs

6. about 70% of humanitarian operational capacity relies on NGOs worldwide, and most of it on northern NGOs;
7. the existence of well established NGO networks and coordination in this field can be an advantage for consultation and implementation;

Questions

Should specific mechanisms for consultation or coordination with NGOs be enforced to ensure timely and effective action?

Should a roster of organisations be selected - at national and international level – and partnership relations be established between them and the Fund?

Working in transitions

8. The traditional difficulty in linking emergency relief with reconstruction and development, may be fatal when dealing with long-term or chronic diseases, as no continuity can be ensured in treatment and assistance.

Questions

Should the Fund design specific strategies in order to bridge gaps during transitional periods?

Working in long-term crises

9. some countries are in situations of chronic crisis, characterised by a certain stability (stall in combats, long-term environmental disasters, etc.) and the development of appropriated social structures (i.e. war economy, transitional governments, etc.). In such countries planning is possible, as well as the design of specific strategies.
10. the main focus for HIV/AIDS is the displaced population which is settled in refugee camps either where the crisis occurs or in neighboring host countries. Their situation may last for decades;

Questions

Should the Fund provide specific guidelines on work in chronic crises?

To what extent could normal country consultation processes be carried out in such countries?

Administrative issues

In humanitarian situations procedures and administrative tools must have the capacity to allow a prompt reaction to crises and address specific needs under extremely difficult conditions. Moreover, the changing environment of humanitarian emergencies requires mechanisms assuring flexibility and adjustment.

Several International organisations working on humanitarian emergencies have enforced a Framework Partnership Agreement (FPA) ruling the relations between donor and implementing agency. This type of agreement is conceived in order to select a group of partners whose capacities are prior verified, and establish a regulatory framework aimed at reducing the time required for decisions.

In practice this allows i.e. ECHO (the largest donor in this field) to make a decision and release funds 48 hours after the application is presented, when an acute emergency strikes.

Similar mechanisms have been adopted by the UNHCR and the WFP as well as by many governments. It is increasingly used also for funding non-emergency projects as it allows flexibility, control and timeliness. The experience carried out in the last ten years testifies the effectiveness of such an instrument to ensure prompt reaction to emergencies and suggests the adoption of an FPA for the Fund, elaborated on the basis of one of the existing ones, the most recently reviewed and broadly experimented being ECHO's.

Questions

Should a specific partnership agreement be adopted for work with NGOs and other humanitarian bodies?

What other procedures and administrative tools are needed?

Access to funding

Eligibility should be considered for:

1. projects - or activities within projects - to assist HIV-infected victims of natural disasters and conflicts
2. actions in favour of people living in situations of protracted crises
3. activities for refugees and internally displaced persons
4. projects aimed at building or strengthening local capacities and preparedness for work in emergencies
5. setting up of early warning and information exchange systems
6. development of methodologies and diffusion of best practices
7. training

Criteria for Funding

1. existence of specific conditions of HIV/AIDS relevance
2. coordination with the broader humanitarian response
3. compatibility with operational priorities
4. capacity of the implementing organisation to work in situations of emergency and/or protracted humanitarian crisis
5. current state of operations

Processes for Application for Funding

Applicants may be:

1. National or International NGOs with a track of work in emergency situations
2. NGOs operating in countries struck by disasters or conflicts or countries hosting refugee settlements
3. NGOs operating in highly vulnerable countries

The enforcement of a Framework Partnership Agreement model, may allow a fast track for decisions concerning emergency projects. For timeframe and coordination reasons, it is commendable that applications' submittal and decision making remain concentrated mainly in the International Secretariat.

Recommendations

Information. Lack of data on relevance of the disease in refugee camps and disaster prone areas limits the preparedness capacity and prevents the design of ad-hoc projects;

Training. To humanitarian agencies in assistance to HIV-infected victims; to specialised HIV/AIDS organisations in working in emergency; to local organisations in coping with crisis situations; strengthening capacities in work with TBC.

Developing strategies for long-term crises. Whereas the crisis is protracted or chronic, and the situation relatively stable, specific actions can be carried out for the long term assistance to affected communities. This also concerns the conditions in many refugee settlements;

Bridge gaps in transitions. There is need for developing strategies to ensure continuity in assistance between the emergency relief phase and the following reconstruction/rehabilitation period, whenever a sufficient level of stability is reached in the country or area of operation;

Complementing normal operations with specific resources aimed at integrating the HIV/AIDS and TBC dimension.

Developing methodologies. Promoting research and pilot projects, diffusing best practices, encouraging inter-sectoral cooperation and networking.

ANNEXES

1. UNGASS 26-27 June 2001 - Declaration of Commitment on Hiv/Aids (abstract)
2. UN Security Council Meeting 28 June 2001 - Presidential Statement
3. Table: HIV/AIDS estimates in countries with HIV prevalence rates: countries in crisis
4. Table: Tuberculosis situation in the 22 high burden countries in the world (1999): countries in crisis

United Nations General Assembly Special Session on HIV/AIDS

DECLARATION OF COMMITMENT ON HIV/AIDS

"Global Crisis – Global Action"

New York, 25 - 27 June 2001

ABSTRACT

… … …

HIV/AIDS in conflict and disaster affected regions

Conflicts and disasters contribute to the spread of HIV/AIDS

75. By 2003, develop and begin to implement national strategies that incorporate HIV/AIDS awareness, prevention, care and treatment elements into programmes or actions that respond to emergency situations, recognizing that populations destabilized by armed conflict, humanitarian emergencies and natural disasters, including refugees, internally displaced persons and in particular, women and children, are at increased risk of exposure to HIV infection; and, where appropriate, factor HIV/AIDS components into international assistance programmes;

76. Call on all United Nations agencies, regional and international organizations, as well as non-governmental organizations involved with the provision and delivery of international assistance to countries and regions affected by conflicts, humanitarian crises or natural disasters, to incorporate as a matter of urgency HIV/AIDS prevention, care and awareness elements into their plans and programmes and provide HIV/AIDS awareness and training to their personnel;

77. By 2003, have in place national strategies to address the spread of HIV among national uniformed services, where this is required, including armed forces and civil defence force and consider ways of using personnel from these services who are educated and trained in HIV/AIDS awareness and prevention to assist with HIV/ AIDS awareness and prevention activities including participation in emergency, humanitarian, disaster relief and rehabilitation assistance;

78. By 2003, ensure the inclusion of HIV/AIDS awareness and training, including a gender component, into guidelines designed for use by defence personnel and other personnel involved in international peacekeeping operations while also continuing with ongoing education and prevention efforts, including pre-deployment orientation, for these personnel;

… … …

Security Council
4339th Meeting (AM)
28 June 2001

Presidential Statement

Following is the full text of Presidential statement S/PRST/16 (2001):

"The Security Council welcomes the successful holding of the twenty-sixth special session of the General Assembly on HIV/AIDS, and encourages further action to address the problem of HIV/AIDS.

"The Security Council recalls its resolution 1308 (2000) of 17 July 2000, in which the Council, bearing in mind its primary responsibility for the maintenance of international peace and security, and emphasizing the important roles of the General Assembly and the Economic and Social Council in addressing the social and economic factors that lead to the spread of HIV/AIDS, inter alia, recognized that the HIV/AIDS pandemic is also exacerbated by conditions of violence and instability, and stressed that the HIV/AIDS pandemic, if unchecked, may pose a risk to stability and security.

"The Security Council therefore welcomes the fact that the declaration adopted at the twenty-sixth special session of the General Assembly addresses HIV/AIDS in conflict and disaster affected regions, and contains a number of practical measures at the national and international levels, to be met within given timeframes, to reduce the impact of conflict and disasters on the spread of HIV/AIDS, including the provision of awareness and training for personnel employed by United Nations agencies and other relevant organizations, the development of national strategies to address the spread of HIV amongst national uniformed services, as required, and the inclusion of HIV/AIDS awareness and training into guidelines designed for personnel involved in international peacekeeping operations.

"The Security Council also recalls its open debate on 19 January 2001, taking stock of progress made since the adoption of resolution 1308 (2000). The Council notes the progress made in the implementation of the resolution, and commends the increased cooperation in this regard between the Department of Peacekeeping Operations (DPKO) and the Joint United Nations Programme on HIV/AIDS (UNAIDS) through the Memorandum of Understanding between them signed in January 2001. Further, the Council welcomes the efforts to develop practical measures, such as the planned joint United Nations field assessment missions to major peacekeeping operations, and the development of the HIV/AIDS Awareness Card for Peacekeeping Operations to be distributed to all peacekeeping operations after testing in the United Nations Mission in Sierra Leone. The Council also welcomes the fact that the cooperation framework signed in May this year between UNAIDS and the United Nations Development Fund for Women (UNIFEM) expresses their intention to cooperate in the follow-up to resolution 1308 (2000), as well as resolution 1325 (2000) of 31 October 2000 on women, peace and security.

"The Security Council recognizes that further efforts are necessary to reduce the negative impact of conflict and disasters on the spread of HIV/AIDS, and to develop the capacity of peacekeepers to become advocates and actors for awareness and prevention of HIV transmission. The Council encourages continued efforts with regard to relevant training for peacekeeping, pre-deployment orientation, and increased international cooperation by interested Member States."

HIV/AIDS estimates in countries with HIV prevalence rates > 4% of adult population, end 1999					
	Country	Adults and children	Adults (15-49)	Adult rate (%)	Orphans cumulative
1	Botswana	290,000	280,000	35.80	66,000
2	Swaziland	130,000	120,000	25.25	12,000
3	Zimbabwe	1,500,000	1,400,000	25.06	900,000
4	Lesotho	240,000	240,000	23.57	35,000
5	Zambia	870,000	830,000	19.95	650,000
6	South Africa	4,200,000	4,100,000	19.94	420,000
7	Namibia	160,000	150,000	19.54	67,000
8	Malawi	800,000	760,000	15.96	390,000
9	Kenya	2,100,000	2,000,000	13.95	730,000
10	Central African Republic	240,000	230,000	13.84	99,000
11	Mozambique	1,200,000	1,100,000	13.22	310,000
12	Djibouti	37,000	35,000	11.75	7,200
13	Burundi	360,000	340,000	11.32	230,000
14	Rwanda	400,000	370,000	11.21	270,000
15	Cote d'Ivoire	760,000	730,000	10.76	420,000
16	Ethiopia	3,000,000	2,900,000	10.63	1,200,000
17	Uganda	820,000	770,000	8.30	1,700,000
18	United Rep. of Tanzania	1,300,000	1,200,000	8.09	1,100,000
19	Cameroon	540,000	520,000	7.73	270,000
20	Burkina Faso	350,000	330,000	6.44	320,000
21	Congo	86,000	82,000	6.43	53,000
22	Togo	130,000	120,000	5.98	95,000
23	Haiti	210,000	200,000	5.17	74,000
24	Dem. Republic of Congo	1,100,000	1,100,000	5.07	680,000
25	Nigeria	2,700,000	2,600,000	5.06	1,400,000
26	Gabon	23,000	22,000	4.16	8,600
27	Bahamas	6,900	6,800	4.13	970
28	Cambodia	220,000	210,000	4.04	13,000

About one-third of the 28 most affected countries are involved in major humanitarian operations following wars, long-term instability or natural disasters *(in yellow)*.

Tuberculosis situation in the 22 high burden countries in the world (1999)				
Rank	Country	Pop (millions)	Number of cases total	Incidence per 100,000
1	India	998	1,857,872	180
2	China	1,267	1,427,042	111
3	Indonesia	209	599,724	279
4	Bangladesh	127	310,607	236
5	Pakistan	152	275,718	171
6	Nigeria	109	265,138	232
7	Philippines (the)	74	228,380	294
8	South Africa	40	174,724	425
9	Russian Federation (the)	147	155,600	106
10	Ethiopia	61	164,111	256
11	Viet Nam	79	148,977	184
12	Democratic Republic of the Congo (the)	50	132,744	251
13	Brazil	168	125,553	73
14	United Republic of Tanzania (the)	33	101,201	296
15	Kenya	30	87,697	286
16	Thailand	61	85,734	138
17	Myanmar	45	81,970	177
18	Afghanistan	22	77,412	337
19	Uganda	21	70,248	314
20	Peru	25	66,867	256
21	Zimbabwe	12	64,570	545
22	Cambodia	11	59,161	517

14 out of 22 TBC high burden countries are involved in humanitarian actions *(in yellow).*