# Chapter 13: Emergency Response

## Sector-Specific Program Design Considerations

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Key Concepts

# In This Chapter

As is true for many aspects of food assistance programming in the context of HIV, effective program design for emergencies is still evolving. Much of the literature on HIV and emergencies is focused on conflict and refugee situations, with very little on natural disasters.

This chapter offers guidance to help plan and implement emergency responses in a variety of settings where HIV-related challenges and opportunities should be considered. The chapter first looks at modifications to food assistance program design and implementation needed to ensure that the food security needs of PLHIV and affected households are appropriately addressed. It then outlines specific guidelines for HIV interventions in emergency settings.

This chapter identifies approaches that could be employed in quick-onset emergencies where international organizations and government are likely to provide large amounts of food assistance to refugee camps, the internally displaced or communities affected by conflict or natural disaster. For slow-onset emergencies, the guidance provided in other sector-specific chapters (**Chapter 10: Health and Nutrition**, **Chapter 11: Education** and **Chapter 12: Livelihood Strategies and Social Protection**) can be applied.

The chapter also discusses specific program design steps and key considerations in developing or adapting food assistance programs in high HIV prevalence contexts. These include the importance of conducting HIV rapid risk and vulnerability assessments to fully understand the local context, as well as the need to reconnect the HIV-affected to services.

13.1 Key Concept

# Applying an HIV Lens to Emergency Food Assistance Programs

Applying an HIV lens to food assistance programs in emergency situations helps to address the constraints and needs PLHIV and HIV-affected households face and supports food security outcomes in a high-prevalence context. This is especially important because PLHIV and affected households may be more vulnerable during emergencies. For example, emergencies often aggravate the vulnerability of children affected by HIV. In addition, displaced people and refugees may become more vulnerable to HIV and its impact because of changes in social structures and livelihoods caused by emergencies.

Relief operations and other emergency settings provide unique opportunities to implement tailored interventions to directly address the vicious cycle of HIV, AIDS and vulnerability. Because refugee or displaced people interact with their host communities in one way or another, it is crucial to establish programs that take this interaction into account and are in line with host government protocols, guidelines and strategic plans.

When designing interventions for emergency settings program managers have several opportunities to modify food assistance programs to address HIV considerations and needs. Some are listed in the UNHCR/WFP publication ***Development of Programme Strategies for Integration of HIV, Food and Nutrition Activities in Refugee Settings***, including:[2]

- Support to enable and encourage participation in PLHIV groups
- Modification of a general food distribution program to better meet the nutritional needs of people affected by HIV
- Modification of a SFP or TFP to better meet the nutritional needs of HIV-affected subgroups
- Support for OVC by providing complementary rations to foster families and orphanages
- Awareness campaigns and prevention education at distribution sites

The prevailing context within the country or region, as well as situation and capacity assessments, will help determine how these interventions can be implemented and which additional HIV responses are needed.

WFP defines emergencies as "urgent situations in which there is clear evidence that an event or series of events has occurred which causes human suffering or imminently threatens human lives or livelihoods and which the government concerned has not the means to remedy; and it is a demonstrably abnormal event or series of events which produces dislocation in the life of a community on an exceptional scale."[1]

## Key Actions for Responding to HIV in Emergencies

The ***Guidelines for HIV/AIDS Interventions in Emergency Settings***, produced by the UN Interagency Standing Committee (IASC) in 2003, include a matrix that establishes key actions for responding to HIV in emergencies by program sector (see Table 1). The matrix is divided into three parts: emergency preparedness, minimum response and comprehensive response. The country's or region's situation and capacity assessment will help determine which additional HIV responses are needed.

The matrix covers the requisite design steps for responding to HIV in emergencies. For more detail on the emergency preparedness steps, and/or comprehensive response steps, the full IASC Guidelines are on the IASC website: www.humanitarianinfo.org/iasc/content/products/docs/FinalGuidelines17Nov2003.pdf.

Table 1: Matrix of Guidelines for HIV Interventions in Emergency Settings

| Sectoral Response | Emergency Preparedness | Minimum Response (to be conducted even in the midst of an emergency) | Comprehensive Response (stabilized phase) |
|---|---|---|---|
| **1. Coordination** | ▶ Determine coordination structures<br>▶ Identify and list partners<br>▶ Establish network of resource persons<br>▶ Raise funds<br>▶ Prepare contingency plans<br>▶ Include HIV in humanitarian action plans and train accordingly relief workers | 1.1 Establish coordination mechanism | ▶ Continue fundraising<br>▶ Strengthen networks<br>▶ Enhance information sharing<br>▶ Build human capacity<br>▶ Link HIV emergency activities with development activities<br>▶ Work with authorities<br>▶ Assist government and non-state entities to promote and protect human rights |
| **2. Assessment and Monitoring** | ▶ Conduct capacity and situation analysis<br>▶ Develop indicators and tools<br>▶ Involve local institutions and beneficiaries | 2.1 Assess baseline data<br>2.2 Set up and manage a shared database<br>2.3 Monitor activities | ▶ Maintain database<br>▶ Monitor and evaluate all programs<br>▶ Assess data on prevalence, knowledge attitudes and practice, and impact of HIV<br>▶ Draw lessons from evaluations |
| **3. Protection** | ▶ Review existing protection laws and policies<br>▶ Promote human rights and best practices<br>▶ Ensure that humanitarian activities minimize the risk of sexual violence, exploitation, and HIV-related discrimination<br>▶ Train uniformed forces and humanitarian workers on HIV and sexual violence<br>▶ Train staff on HIV, gender and non-discrimination | 3.1 Prevent and respond to sexual violence and exploitation<br>3.2 Protect orphans and separated children<br>3.3 Ensure access to condoms for peacekeepers, military and humanitarian staff | ▶ Involve authorities to reduce HIV-related discrimination<br>▶ Expand prevention and response to sexual violence and exploitation<br>▶ Strengthen protection for orphans, separated children and young people<br>▶ Institutionalize training for uniformed forces on HIV, sexual violence and exploitation, and non-discrimination<br>▶ Put in place HIV-related services for demobilized personnel<br>▶ Strengthen IDP/refugee response |
| **4. Water and Sanitation** | ▶ Train staff on HIV, sexual violence, gender and non-discrimination | 4.1 Include HIV considerations in water/sanitation planning | ▶ Establish water/sanitation management committees<br>▶ Organize awareness campaigns on hygiene and sanitation, targeting people affected by HIV |
| **5. Food Security** | ▶ Contingency planning/pre-position supplies<br>▶ Train staff on special needs of HIV-affected populations<br>▶ Include information on nutritional care and support of PLHIV in community nutrition education programs<br>▶ Support food security of HIV-affected households | 5.1 Target food assistance to affected and at-risk households and communities<br>5.2 Plan nutrition and food needs for populations with high HIV prevalence<br>5.3 Promote appropriate care and feeding practices for PLHIV<br>5.4 Support and protect food security of HIV-affected and at-risk households and communities<br>5.5 Distribute food assistance to affected households and communities | ▶ Develop strategy to protect long-term food security of HIV-affected people<br>▶ Develop strategies and target vulnerable groups for agricultural extension programs<br>▶ Collaborate with community and home-based care programs in providing nutritional support<br>▶ Assist the government in fulfilling its obligation to respect the human right to food |
| **6. Shelter and Site Planning** | ▶ Ensure safety of potential sites | 6.1 Establish safely designed sites | ▶ Plan orderly movement of displaced |

| | | | |
|---|---|---|---|
| **7. Health** | ▶ Map current services and practices<br>▶ Plan and stock medical and reproductive health supplies<br>▶ Adapt/develop protocols<br>▶ Train health personnel<br>▶ Plan quality assurance mechanisms<br>▶ Train staff on the issue of sexual and gender-based violence (SGBV) and the link with HIV<br>▶ Determine prevalence of injecting drug use<br>▶ Develop instruction leaflets on cleaning injecting materials<br>▶ Map and support prevention and care initiatives<br>▶ Train staff and peer educators<br>▶ Train health staff on RH issues linked with emergencies and the use of RH kits<br>▶ Assess current practices in the application of universal precautions | 7.1 Ensure access to basic health care for the most vulnerable<br><br>7.2 Ensure a safe blood supply<br><br>7.3 Provide condoms and establish condom supplies<br><br>7.4 Establish syndromic STI treatment<br><br>7.5 Ensure appropriate care for injecting drug users<br><br>7.6 Manage the consequences of SGBV<br><br>7.7 Ensure safe deliveries<br><br>7.8 Universal precautions | ▶ Forecast longer-term needs; secure regular supplies; ensure appropriate training of the staff<br>▶ Palliative care and home-based care<br>▶ Treatment of opportunistic infections and TB control programs<br>▶ Provision of ARV treatment<br><br>▶ Safe blood transfusion services<br><br>▶ Ensure regular supplies, include condoms with other RH activities<br>▶ Reassess condoms based on demand<br><br>▶ Management of STI including condoms<br>▶ Comprehensive sexual violence programs<br><br>▶ Control drug trafficking in camp settings<br>▶ Use peer educators to provide counseling and education on risk reduction strategies<br><br>▶ Voluntary counseling and testing<br>▶ Reproductive health services for young people<br><br>▶ Prevention of mother-to-child transmission<br><br>▶ Enable/monitor/reinforce universal precautions in health care |
| **8. Education** | ▶ Determine emergency education options for boys and girls<br>▶ Train teachers on HIV and sexual violence and exploitation | 8.1 Ensure children's access to education | ▶ Educate girls and boys (formal and non-formal)<br>▶ Provide life-skills-based HIV education<br>▶ Monitor and respond to sexual violence and exploitation in educational settings |
| **9. Behavior Change Communication and Information, Education and Communication** | ▶ Prepare culturally appropriate messages in local languages<br>▶ Prepare a basic BCC/IEC strategy<br>▶ Involve key beneficiaries<br>▶ Conduct awareness campaigns<br>▶ Store key documents outside potential emergency areas | 9.1 Provide information on HIV prevention and care | ▶ Scale up BCC/IEC<br>▶ Monitor and evaluate activities |
| **10. HIV in the Workplace** | ▶ Review personnel policies regarding the management of PLHIV who work in humanitarian operations<br>▶ Develop policies when there are none, aimed at minimizing the potential for discrimination<br>▶ Stock materials for post-exposure prophylaxis | 10.1 Prevent discrimination by HIV status in staff management<br><br>10.2 Make post-exposure prophylaxis available for humanitarian staff | ▶ Build capacity of supporting groups for PLHIV and their families<br>▶ Establish workplace policies to eliminate discrimination against PLHIV<br><br>▶ Post-exposure prophylaxis for all humanitarian workers available on regular basis |

Source: Inter-Agency Standing Committee Task Force on HIV/AIDS in Emergency Settings (IASC TF). ***Guidelines for HIV/AIDS Interventions in Emergency Settings***, 2003.

13.2 Key Concept

# Programming Emergency Food Assistance in High HIV Prevalence Contexts

## Assessing the Local Context

Historically, food assistance is used in emergencies to prevent increases in malnutrition and unnecessary deaths. While these objectives will always apply, the food assistance response strategy will depend on the nature of the crisis and its impact on people, their livelihoods and assets.

Understanding the ecology of HIV in crises and emergencies is important for effective programming. In fact, some of the same factors that cause food insecurity and humanitarian emergencies drive the HIV epidemic. In addition to standard emergency assessments, programs should conduct an HIV rapid risk and vulnerability assessment to identify risk groups, assess existing risks and determine specific factors that make the risk groups more vulnerable to HIV transmission. This information will guide program design and policy implementation. As much as possible, agencies should agree on standardized terminology, survey methodologies, definitions and forms, and they should develop a common database that respects confidentiality.

An assessment of the local epidemiology of HIV—in both the displaced population and the host communities—and how it interacts with the current and anticipated food security situation should underpin the design and implementation of interventions. The epidemiology of HIV varies widely in displaced-population settings, with some populations exhibiting a low HIV prevalence except in defined high-risk groups, while other populations struggle with a more generalized epidemic. HIV epidemics may also be associated with different patterns of food and nutritional insecurity among vulnerable groups. In situations involving displaced populations, both the displaced population and the host communities should be assessed. Initial HIV-prevalence rates and the nature of displaced populations' interactions with host communities can be significant determinants of HIV risk in both populations. UNHCR/WFP's ***Integration of HIV/AIDS Activities with Food and Nutrition Support in Refugee Settings*** describes outputs that should be included in a situational assessment:[3]

- Epidemiological patterns of disease and identification of high-risk groups
- Risks associated with refugee-host interaction
- Principal routes of transmission
- Roles of knowledge and behaviors
- Identification of priority strategies for HIV interventions, including prevention, care and support for affected families, health care and treatment interventions

## Key Considerations for Program Design in High HIV Prevalence Contexts

These considerations should be taken into account when programming food assistance in high HIV prevalence emergency settings:[4]

**Unintended consequences.** Programs should follow the principle of "First, do no harm." Effective emergency programming requires consideration of both short- and long-term consequences to make sure that expedient responses today do not create problems in the future. To help avoid unintended consequences, all phases of an emergency response plan should include HIV technical support and cross-sectoral approaches. Whenever possible, large-scale distribution activities should be linked to sensitization, prevention awareness and stigma reduction.

**Avoiding stigmatization.** It cannot be overemphasized that avoidance of stigma and discrimination should be a priority at every stage of a program. Particularly in an emergency context, providing humanitarian assistance, whether it be food rations or training in vocational skills, can contribute to the stigmatization of PLHIV and HIV-affected households or be seen as giving preferential treatment to these groups. Programs should engage the community to dispel the fear and myths that fuel stigma and denial; in particular, PLHIV and their families can play a key role in deciding how to design sensitive programming that addresses stigma. In addition, wherever possible, assistance should be provided based on transparent, multiple-vulnerability criteria and in ways that do not single out PLHIV or affected families.

**Aligning humanitarian strategies with host community norms.** While ensuring at least minimum standards of prevention activity, provision of HIV-specific care and support services, and access to appropriate treatment to primary beneficiaries, be mindful of the HIV response in the local community. Providing services to refugee populations and not to host populations may spark tensions or hostility between the groups. Working toward parity with the host community in service availability and quality is very important and will help avoid creating a double standard that marginalizes one group over the other.

**Effective collaboration mechanisms.** Effective collaboration and coordination mechanisms are key to the success of any emergency response, especially one implemented amid the complexities of HIV. For example, ensuring a continuum of care for PLHIV, their families and at-risk groups during an emergency requires interagency collaboration, a common agenda and the authority and political will to deliver. As a mandatory first step, programs must ensure collaboration at the regional, national and local levels between UN agencies, NGOs and government bodies, and establish point persons for different aspects of the response.

**Facilitating linkages across sectors.** Collaboration is essential within agencies to bridge the "inter-sectoral divide." Emergency response arms of UN agencies and NGOs traditionally do not have HIV specialists on staff, and the responsibility for addressing HIV is often

## Serving Refugees and the Community in Zambia

Where possible and practical, extremely vulnerable host populations can be considered for programmes provided to refugees that combine food and HIV prevention, treatment, care and support. In northern Zambia, for example, host community members living near the Kala and Mwange refugee camps are eligible for free care, integrated maternal and child health (MCH) services and VCT services at health clinics in the refugee camps.

As with refugee programs, the decision to provide external support to a host population should be based on a needs assessment. Host populations may have lower, equal or higher HIV prevalence rates, and often exhibit poorer health status than stable refugee populations.

delegated to health staff within the development arm of many agencies. Regular inter-sectoral meetings in-house and with partners—including government and civil society—should ensure that humanitarian actions minimize risk of transmission and maximize personnel and resource costs.

**Internal capacity and staff.** Staff must be adequately trained in HIV-related programming as part of an organization's emergency preparedness, and relevant organizational policies must be up to date. Many organizations have regional or global technical resource people who serve a specific region or work in a particular program sector. Field offices should collaborate with these technical advisors to train field staff on programming for PLHIV in emergency response. In addition, the technical advisors should be called on to provide program guidance during an emergency response. Programs also should consider creating point-person positions specifically to manage HIV-related interventions and ensure adequate technical back-stopping. In addition, because staff in any humanitarian response are often stretched thin, additional staff may be needed to implement HIV-related strategies and meet minimum standards for food security program performance. Programs also should recognize that capacity-building should not be limited to the needs of refugee or displaced PLHIV in emergencies. Workplace policies and training in prevention, treatment and care of HIV for all levels of field staff involved in emergency contexts also are an essential part of any emergency response.

**Continuum of care.** Individuals and households must be allowed to move in and out of programs as their circumstances change. Especially where chronic food insecurity and high prevalence of HIV intersect, affected families often face a thin line between relative wellness and illness, chronic malnutrition and acute hunger, chronic poverty and destitution, and coping and not coping. Movement in and out of programs allows them access to a continuum of care that is crucial to their well-being.

**Continuity between emergency and recovery phases.** Where possible, HIV emergency activities should be linked from the outset with development activities and longer-term social protection mechanisms, preferably those that are government-supported. Purposeful capacity-building of local social welfare structures is encouraged.

**Site planning.** Emergency sites may be dispersed settlements, mass accommodation in existing shelters or organized camps. Programs should consider how sites' location and layout affect beneficiaries' safety and the delivery of food. For example, households that have chronically ill members or are headed by children should be placed near the food distribution point and should be ensured safe passage once they collect their rations.

**Sexual and gender-based violence.** The risk of sexual exploitation, abuse and gender-based violence often dramatically increases in emergency situations. Sexual and gender-based violence (SGBV) not only harms its victims, but also often contributes to the spread of HIV during protracted crises.[5] Some important safety-related issues are covered in the IASC Code of Conduct on Sexual Violence and Exploitation (see box on page 274).

**HIV awareness, prevention and care.** IEC and BCC in emergency situations are essential to help people maintain or adopt behaviors that minimize their risk of contracting HIV or accessing services and assistance if they are living with or affected by HIV. Food assistance agencies can collaborate with IEC and BCC specialists to provide information at food distribution sites, as well as to transporters and food distribution staff.

**Meeting dietary and nutrition needs.** As discussed in **Chapter 10: Health and Nutrition**, PLHIV have specific dietary and nutritional needs. HIV can increase rates of malnutrition and mortality in emergencies, raising the importance of nutritional considerations when designing rations for populations with a high prevalence of HIV.

## Sexual Exploitation: Being Part of the Solution, Not the Problem

In 2002, the international community was rocked by allegations of widespread sexual exploitation and abuse of refugee and internally displaced women and children by humanitarian workers and peacekeepers in Liberia, Sierra Leone and Guinea. Human Rights Watch and other NGOs called for a full investigation, action against the perpetrators and comprehensive protection measures to prevent such abuse.

Because of these events and the obvious implications for HIV infection, it is highly recommended that all humanitarian workers, food distributors, and international, national and local partner organizations receive training on the IASC Code of Conduct on Sexual Violence and Exploitation, whose core elements include: [6]

- Sexual exploitation and abuse by humanitarian workers constitute acts of gross misconduct and are therefore grounds for termination of employment.
- Exchange of money, employment, goods or services for sex, including sexual favors or other forms of humiliating, degrading or exploitative behavior, is prohibited. This includes exchange of assistance that is due to beneficiaries.
- Sexual activity with children (persons under the age of 18) is prohibited, regardless of the age of majority or age of consent locally. Mistaken belief in the age of a child is not a defense.
- Sexual relationships between humanitarian workers and beneficiaries are strongly discouraged because they are based on inherently unequal power dynamics. Such relationships undermine the credibility and integrity of humanitarian aid work.
- Where a humanitarian worker develops concerns or suspicions regarding sexual abuse or exploitation by a fellow worker, whether in the same agency or not, s/he must report such concerns via established agency reporting mechanisms.
- Humanitarian workers are obliged to create/maintain an environment that prevents sexual exploitation and abuse and promotes the implementation of their code of conduct. Managers at all levels have particular responsibilities to support and develop systems that maintain this environment.

For additional information on workplace issues, see Chapter 9: Operational Modalities.

**Modifying ration size and mix.** Where food rations are involved, they should be designed to help meet the special nutritional needs of PLHIV and other household members. Especially where participants are selected because of chronic illness in the household, a fortified, nutrient-dense commodity such as CSB should be included in the ration. (For more information, see **Chapter 6: Ration Design**.)

**Improving food utilization for PLHIV.** Providing food assistance in a high HIV prevalence context should go beyond simply improving access to food. It must also influence food utilization by supporting better hygiene practices, facilitating access to deworming (including adults living with HIV) and sharing information about child feeding and care practices, nutrition and food preparation.

**Prioritizing high-risk groups with targeted interventions.** Programs should remember that in emergencies, certain individuals may be more at risk than others. These are often the same people whose food insecurity is exacerbated by HIV and may include female-, child- and elderly-headed households; families hosting orphans; and families caring for the chronically ill. Where possible, programs should partner with or seek complementary resources from organizations such as schools, orphanages, churches, hospitals, maternal and child health (MCH) clinics and HBC programs already involved with HIV-affected households. In addition, in large-scale emergencies, some agencies map "hot spots"—areas where food insecurity overlaps with other indicators of vulnerability, such as high rates of HIV prevalence—to help prioritize high-risk groups.

## Joint IEC Programming Reaches Swaziland Communities

In Swaziland, WFP and UNFPA, in partnership with the MOE, jointly implemented a project to raise awareness and understanding of HIV and related issues among communities through relief committees (RCs) that are responsible for food distribution and management.

There are 179 RCs, each composed of 11 women and two men. Two leaders each from 163 RCs participated in a five-day training of trainers (TOT) by UNFPA and the MOH, which included participatory methods and videos. The training modules were developed by WFP and UNFPA and covered a range of topics including HIV (including PMTCT and ART), nutrition education, gender issues, SGBV, sexual/reproductive health, family planning, safe motherhood, adolescent health and child abuse. After the TOTs, RC leaders were expected to train their fellow committee members, who were then mandated to educate the general community at food distribution points.

The project also developed IEC materials such as posters on male involvement, family planning, adolescent health and SGBV and disseminated them to clinics.

# Reconnecting the HIV-Affected to Services

When displacement occurs, regardless of whether it is in a rapid or slow-onset emergency, PLHIV and their families are separated from the medical, social and other services that help sustain them. For example, it is difficult to provide ARVs to PLHIV in most post-disaster settings, although this may become more feasible in the future. Where ART is not available, humanitarian response programs should provide basic health care and palliative care to PLHIV. Once the situation has stabilized, humanitarian agencies should also introduce comprehensive surveillance, prevention, treatment, care and support services in conjunction with HIV protection and education programs to reduce stigma and discrimination.

Although typically not feasible in the earliest phase of an emergency response, a stabilized situation provides opportunity for several HIV initiatives, many of which can benefit from the integration of food assistance, including:

- Integration of a supplementary ration, supported by nutrition and PL education, into ART, HBC, TB control or PMTCT programs
- Support for inpatient hospital/clinic feeding programs with nutrition training and the establishment of a hospital/clinic demonstration garden for vegetables, fruit and medicinal herbs
- Support for nutrition education training and other capacity-building activities for formal and traditional/community-based HBC providers
- Incorporation of food and nutrition resources to support the establishment or continuation of community HIV-related activities, including peer education and treatment supporters
- Support for training in topics such as nutrition, treatment literacy, PL, SGBV, stigma reduction, gender, substance abuse, etc.

## Connecting the Displaced to HIV Services

UNAIDS and UNHCR recommend that refugee programming include culturally and linguistically relevant community-based prevention interventions (UNHCR 2005). In Uganda, where more than 220,000 refugees share health services with 135,000 people from surrounding communities, UNHCR works with the government to provide refugees with access to VCT, screening and treatment for STIs, and PMTCT services.

# Annex I: Additional Resources on Food Assistance and HIV in Emergency Settings


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