CAFOD and ART

CAFOD's position on supporting anti-retroviral therapy (ART) for people with HIV and AIDS

Guidance for CAFOD staff accompanying partners in the response to HIV and AIDS

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Introduction

This paper is intended primarily as guidance for CAFOD staff providing HIV-related technical support and accompaniment to programme partners and to those staff involved in decisions regarding financing programmes. The resource is provided to such staff both for their own use and for sharing and discussion with partner programmes as appropriate. It is also offered as information to other staff within CAFOD whose work would engage them with programme responses to HIV eg staff working in media, communications, campaigns and public policy, communities, supporters and fundraising.

The document also offers a statement on CAFOD's understanding of how and whether it supports antiretroviral therapy (ART) within its programmatic response to HIV. Thus it can be a useful resource in discussions with other NGOs; with the UK government (DFID) and other institutional donors; with other members of Caritas and CIDSE agencies; and with Church officials acting as gatekeepers of programme development or diocesan or wider Church strategies.

Rationale for this paper

A number of events in recent years have made ART an increasingly accessible option in countries worst affected by HIV and AIDS. These include dramatic reductions in the prices of brand-name versions of antiretroviral drugs (ARVs), brought about by systematic advocacy work by activists and NGOs based mainly in the South, and by a move by pharmaceutical companies towards a more collaborative approach with other sectors responding to HIV. High quality generic versions of a number of these drugs have also become widely available at a fraction of the cost of the brand-name products and some of these have been approved by WHO for inclusion in its essential medicines list.

Recent events also include an intensified commitment by (or elicited from) countries of the North and by international agencies; through initiatives such as the Global Fund for AIDS, TB and Malaria (GFATM), the

WHO 3x5 initiative and its sequel, the UK government's commitment to universal access to antiretrovirals by 2010 which has since been adopted by G8 members at the Gleneagles summit in July 2005 and by UN members at the UNGASS review meeting in June 2006. The US President's Emergency Plan For AIDS Relief (PEPFAR) has likewise made access to ART a high priority for programmes it supports.

In the light of these events, CAFOD's earlier decision not to fund ART programmes needed to be reconsidered. Given the unequalled access to large populations enjoyed by Catholic health care establishments in many countries worst affected by HIV, and the high quality of care and stable infrastructure that typifies these, Catholic health providers have become an increasingly prominent and effective channel for implementation of WHO, GFATM and PEPFAR initiatives. A number of existing CAFOD partner programmes in Africa, Asia, Eastern Europe and parts of Latin America are either providing ART through funding received from other donors, or are providing one or other of the wider services required for implementation of ART provision programmes. This made it even more incumbent upon CAFOD to reassess its role within this increasingly complex yet potentially beneficial scenario.

Process of reflection and consultation

As part of the discernment informing this paper, the topic was discussed at CAFOD's HIV Advisory Group (HAG) in 2005 with contributions based on programme experience from:

- Octavio Valente Jr from CAFOD programme partner: Grupo pela Vida, Brazil
- Sue Lucas, HAG member with experience from Salvation Army Human Capacity Development programmes
- Alice Welbourn, HAG member who contributed from the perspective of International Community of Women living with HIV (ICW)
- Geertje Van Mensvoort, HIV Policy Analyst, CORDAID
- Jackie Reeve, CAFOD programme officer for South Africa, drawing on the extensive experience of programme partners in that country who are providing ART
- Open forum with CAFOD staff attending the meeting

The topic was also discussed at the HIV team meeting in Harare, July 2005, with contributions from two programmes in Zimbabwe: Mashambanzouo and The Centre, both operating in Harare and the surrounding areas. Feedback on earlier drafts of this document was obtained from HAG and from impromptu consultations with partner programmes coordinated by Medical Missionaries of Mary (MMM) personnel, long-time CAFOD partners and collaborators in Ethiopia, Zambia and Tanzania.

The guidelines drawn up by the AIDS Funding Network Group[1] also served as reference for these reflections and the recommendations set out in these pages.

Recommendations: criteria and possibilities for CAFOD

The following are proposed by CAFOD's HIV team and endorsed by its International Leadership Team (ILT). They are very much work in progress, to be informed by programme experience and reviewed two years from the date of this document. The points set out below apply as appropriate whether ART is provided as treatment to people with HIV or as a preventive measure eg where there is risk of mother-to-child transmission (MTCT) of the virus. Some of the principles also apply to Post-Exposure Prophylaxis (PEP). It is beyond the remit of this paper to set out clinical or associated technical guidelines and standards for the use of ART as treatment, prevention of MTCT (PMTCT) or PEP and practitioners should refer to relevant WHO or national guidelines for such details.

Essential criteria

Any decision by CAFOD to support ART, in whatever manner, must ensure that the following criteria have been addressed and are being met:

1. ART initiatives should be located within a wider spectrum of health care

A holistic approach, within which ART is presented as one option within a broad spectrum of health care, is essential. This spectrum encompasses attention to the nutritional, psychological, spiritual and social wellbeing of individuals, and attention to their basic health care needs. ART should normally be considered as a later rather than a first option within this spectrum. Even where clinical signs or CD4 counts[2] suggest a person qualifies for ART, partner programmes emphasise the importance of first ensuring that other options to improve the person's immune status have been explored. Preliminary options could include improved nutrition with a more balanced diet from available food supplies, supplementary vitamins, varying what vegetables and herbs are grown and the like, and effective treatment of opportunistic infections. Treatment of helminthic[3] infections can also improve the immune system. WHO has called on member states to pursue a policy of integrating nutrition, as a priority, into comprehensive responses to HIV and AIDS[4].

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[1] Begun as a network of Catholic development and relief agencies funding HIV projects in the South, this is a forum for sharing experiences, developing guidelines, understandings and good working principles. AFNG guidelines on ART were first produced in 2001 and revised in April 2004.
[2] The number of CD4 lymphocytes in the blood of HIV-infected persons is a measure of the strength of the immune system.
[3] Parasitic worms infections.
[4] WHA57.14, May 2004

Programme experience suggests that attention both to nutritional aspects and to treatment of opportunistic infections can delay the point at which an individual may need to start ART and/or will improve that person's general health and therefore their capacity to get maximum benefit from ART. In contrast, pressure from funders to meet quotas can seek to make ART the first line of treatment. Programmes need CAFOD's support to argue for a more holistic approach within which ART is available at the appropriate stage and when a person's immune system has already been strengthened as far as possible by other means. Key to this criterion is ensuring a balanced approach to match the situation of the individual.

In this more holistic approach to care, prevention also assumes a wider meaning: prevention of infection, prevention of progression and prevention of death through restoring good health and thereby improved access to education and/or work opportunities and consequent poverty alleviation. Thus the care and prevention connection is reinforced.

This approach also requires institutional donors to commit funds for broad-based health care and not just ART provision, and for strengthening local/national health systems and infrastructures, as appropriate to the scale of funding provided.

2. Programmes and agencies need to avoid the "re-medicalisation of AIDS" that can be a consequence of ART availability

CAFOD's assertion since 1986 that HIV and AIDS are development as well as health concerns has been echoed increasingly over the last decade by UNAIDS and other UN agencies as well as NGOs, community-based organisations and governments North and South. This understanding establishes health care as a component within wider care and mitigation efforts, and also establishes an inextricable link between care/mitigation and prevention. It further calls for a transformation, through international efforts, of social, political and economic factors that are fuelling the HIV pandemic and that in their turn are negatively affected by this pandemic.

The availability of ART has, in some instances, resulted in a narrow re-focusing by practitioners on clinical conditions requiring medical responses, to the exclusion of a more holistic approach. In similar vein, funders and the public at large have tended to ignore wider mitigation and prevention considerations as well as the psychological and social support still needed by people affected by HIV and to concentrate solely on provision of and access to ART treatment. As well as the implications for sustainability of such an approach, this re-medicalisation of AIDS reverses the broader understanding and consequent strategies developed over

the last decade. It also jeopardises the effectiveness of these strategies which, in the longer term are the only viable means of reducing and even eliminating the pandemic that is HIV and AIDS.

Linked to this consideration is the recognition that ART restores people to good health who have been chronically sick. These people are then entitled to and able to resume work, education and wider social activities

Programmes that have up to now concentrated on providing support to sick and dying adults and children, and to bereaved families, may now need to diversify their services (eg to include back to work/education support schemes, etc) with the consequent implications for programmes' skills base and capacity.

Creative initiatives to help children catch up on (often considerable) lost schooling are called for as part of this changed focus.

3. "ART literacy" should be provided prior to commencement of treatments

People with HIV, their families and wider communities where ART is to be provided need to understand what the therapy is and what it is not, what the potential benefits and side effects might be, how and why voluntary counselling and HIV testing (VCT) features within ART, and what other tests or monitoring will be required, where and when. Issues of adherence and wider health care should also be explained. It is also important to dispel or clarify the increasing misconceptions circulating in many communities regarding ART (eg that the side effects are unbearable, the tablets are difficult to take etc).

Staff and volunteers involved in ART provision and linked services such as VCT need the information, understanding and skills to ensure they are competent and confident in taking forward these programmes. CAFOD staff's own literacy must likewise be addressed. While staff are not expected to be conversant with the details of different drug regimes and optimum treatments, they do need to have a general understanding of this subject matter and also be informed as to any government guidelines or policies, along with strategies supported by eg GFATM or PEPFAR that are operative in the countries in which they work.

UNAIDS and WHO publications offer further details on aspects to be covered in community and programme staff preparation, along with simplified materials for use in community contexts (see Further Resources at the end of this document). Partner programmes may be aware of similar resources produced at national level or developed by themselves or other NGOs locally.

4. Initiatives to break down stigma and discrimination need to be part of early preparatory work with communities and programme staff

Such initiatives need to break down any tendency to an "us and them" mentality. ART programmes need to gain the support first and foremost of community gatekeepers. Secondly they should work to ensure that women and children are included and that the stigma often attached especially to women known to have HIV is tackled. Similarly, traditional values that might make women or children a lower priority for treatment will need to be addressed. Involvement of people with HIV as key implementers of ART programmes can also be powerful in tackling stigma, provided these are appropriately supported, endorsed and protected in their turn.

5. Pre-and post-test counselling must always be provided when HIV testing is carried out

As well as the general points for such counselling, in the context of ART they should also include information to ensure accurate understanding of this treatment and how it would apply to individuals who test positive. Even where the pressures of back-donor funding, enrolment quotas and the like are at play, this preparatory and post-test counselling cannot be dispensed with or short-circuited. Ongoing counselling (eg on living positively with HIV, on prevention concerns, on wider concerns for themselves or their families etc) should also be provided to individuals who come forward but do not go on to access ART.

Photo: Caroline Irby

Those providing voluntary counselling and testing (VCT) need skills, understanding and support, including supervisory support in dealing with increasingly complex issues appropriately. This is essential both to ensure appropriate standards and also to avoid burnout of VCT counsellors.

6. **Programmes should ensure the involvement of local communities in the design and implementation of ART initiatives**

This requirement also recognises that, in some instances, communities may make it difficult for people who have been ostracised locally to come forward for treatment. Thus programmes must also strive to ensure that people marginalised by their communities have equity of access to ART as required.

7. **Programmes should ensure the meaningful involvement of people with HIV…**

…in the design and implementation of ART programmes. Within this broad criterion it is important to ensure in particular that women with HIV and young people with HIV are meaningfully involved at all stages of planning and decisions regarding implementation. As well as contributing the expertise that comes from their lived experience, such involvement can help remove the stigma attached to HIV infection and can establish people with HIV as valued and active members of their communities.

8. **The specific needs of children and their rights to equal access to ART should be addressed in programme planning**

This will include the need for paediatric formulations of drugs, as well as child-focused education, support and counselling services. It requires programmes to ensure that children are included in health services, with particular emphasis on ensuring inclusion of child-only households, often overlooked in broader service provision. This point also includes the rights of children restored to health, or those relieved of care duties, to resume schooling.

Photo: Caroline Irby

Programme partners have highlighted the need to harmonise treatment services for children and those for their mothers. If mothers and children are treated at separate clinics or on different days, then if there is a conflict, or if the mother cannot afford transport for both, she will sacrifice her treatment for that of the child.

9. Gender-specific considerations must be taken into account

Women and men will have different opportunities and encounter different hindrances in accessing ART. For men, work-related mobility or cultural taboos or peer pressures may deter them from accessing health services more generally and VCT/ART programmes in particular.

For women, loss of privacy, lack of family or community support, lack of peer advice and support, reduced access to oral or written information, and judgmental attitudes from staff may hinder their access. Costs of transport to treatment sites, child care, blood tests, treatments for opportunistic infections, improved nutrition, along with the time lost to income earning opportunities, may also deter. In many instances women need to seek permission from spouses or in-laws in order to do anything outside the home, another potential obstacle to accessing ART. Many of these constraints will be even more acute in rural settings. The uneven burden of care that falls to women when family members are sick, along with a heightened sense of guilt, may make them put their own health needs last.

Where women are given ART during pregnancy and after giving birth as a protective measure for their baby, their own longer-term ART needs should also be attended to wherever possible. This is a strategy to benefit the mother and new-born child as well as other dependant family members, in the immediate and longer term. Decisions on breast-feeding will be part of the health advice to pregnant women who have HIV. Where abrupt weaning at eg four months is a chosen strategy, or where formula feed is an acceptable alternative (as per WHO guidelines), mothers need ongoing support to implement these successfully and sustainably.

The hindrances mentioned above are not attributable exclusively to men or women. For example, women can also be hindered by peer pressure and men by transport cost etc. While recognising this these criteria also ask programmes to include a gender perspective in situation analysis and programme design and implementation.

10. Initiatives to promote treatment adherence should be in place

Programme experiences suggest that community-based support mechanisms are effective, modelled on, for example, the use of volunteers for community-based DOTS[5] programmes. Much can be learnt from such community-based TB programmes and their experience of using people with HIV also treated for TB as volunteers. Children have also proven effective monitors of their parents' treatment adherence, provided they too are supported in this.

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[5] Directly Observed Treatment Short Course: combines diagnosis and registration of TB patients with multi-drug treatment, high quality anti-TB drugs, individual patient outcome evaluation and cohort evaluation.

11. Long term sustainability should be assured as far as possible

Continuity of treatment, once begun, is critical for personal and public health, in order to minimise the dangers of developing resistant strains of HIV and render treatments ineffective. Making this an absolute pre-requisite may be counterproductive in some instances, knowing that immediate-term access means prompt improvement in the health of sick family members and prolongation of life and opportunities. Nonetheless, programmes should have some assurances of continuity of supplies of drugs, of laboratory supplies and equipment and of the funding to finance these. UNICEF guidelines recommend a minimum funding time frame of five years [6] [7]. AFNG guidelines (footnote 1) recommend a commitment of at least 3-5 years. UNHCR's antiretroviral medication policy for refugees recommends a minimum period of 1 year.[8]

12. Initiatives need to ensure they are complementing rather than unnecessarily duplicating existing services

ART provision requires a range of services, concerned with more than the direct dispensing of drugs. It requires programmes to work in a multi-sectoral rather than isolated fashion, and to identify their particular niche within a broader, coordinated strategy. To this end, they should undertake preparatory baseline assessments, identify gaps, use snapshot surveys and learn from other experiences. This can be particularly challenging to those faith-based organisations more accustomed to working independently of other actors.

Programmes need to include ancillary services often overlooked but which, if not provided, can significantly reduce the uptake and success of ART initiatives. For example, people may need transport or child care facilities to be provided. Timing, location and means of administration of programmes may need to be adapted to suit workplace or education timetables, domestic duties, farming demands and the like.

13. Initiatives to provide ART should be operating within national policy and strategies and/or WHO guidelines…

…whichever is applicable. Where programmes funded by different donors (eg GFATM and PEPFAR) are operating in a given geographic region, participating CAFOD partners should seek to ensure that, as far as possible, different regimes are not applying within a single family, as this can cause confusion and mistakes

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[6] HIV AIDS CARE AND SUPPORT Procurement of Anti-Retrovirals for ART and PMTCT www.supply.unicef.dk/Catalogue/ART_Supplies_Product_information_SummaryJune2004.pdf

[7] Antiretroviral drugs for treating pregnant women and preventing HIV infection in infants in resource-limited settings: towards universal access. Recommendations for a public health approach. 2006. http://www.who.int/hiv/pub/guidelines/pmtct/en/index.html

[8] Antiretroviral Medication Policy for Refugees, UNHCR, January 2007 http://www.unhcr.org/publ/PUBL/45b479642.pdf

regarding treatment adherence. It is likewise desirable to have mechanisms in place between various ART programmes to prevent duplication of client enrolment and treatments.

14. The impact of ART initiatives and programme partners' capacity to absorb these should be assessed

The effect on existing programmes of massive and rapid increases in funding and perhaps accelerated expansion of operating areas, staffing etc can place unmanageable strain on programmes. Similarly, the increased and often complex and bureaucratic administration requirements, the extra work in community mobilisation and adherence training place unmanageable burdens on already over-stretched staff. Pressures to meet funders' quotas can cause short-cutting in already pressurised services. Increased resources for ART can divert skilled medical and other health care staff away from other areas of health care.

15. Programmes supporting access to ART must ensure that sound ethical guidelines are in place and operating

A number of ethical questions present, including issues of informed consent; confidentiality; equity of access for all within a programme area who qualify, regardless of gender, age, social status, ethnicity, means of HIV infection. Ethical questions also arise in relation to monopolies by brand-name drugs over generics; conditional ties of funders; unbridled ability power of funders to "call the tune" regardless of local experience or wider considerations of good practice standards, etc. Little exists by way of overall guidelines on ethical issues, even though some of the points named here are mentioned in UNAIDS and WHO resources listed in this document. Some are also considered in the AFNG guidelines referred to earlier. Programmes need to ensure that they have given due consideration to ethical issues presenting in their context.

Possibilities for CAFOD support for ART programmes

If all of the above criteria are met, a number of options present. CAFOD can support, through funding, and the provision or commissioning of technical support and wider programme capacity development, one or more aspects of ART initiatives as listed below.

The options listed are grouped by type of responses. Options 1-17 are regarded as the most likely types of response normally considered for funding by CAFOD. They comprise initiatives to support implementation of ART programmes and are not directly concerned with the actual procurement or provision of ARV drugs

themselves. Options 18 and 19 acknowledge a possibility, in exceptional circumstances only, that CAFOD might fund the actual provision of ARV drugs, provided that the criteria specified above are in place.

Awareness and skills development

Photo: Lorna Fielding

1. Community preparation work: personal, family and community literacy projects prior to the implementation of ART provision.
2. Ongoing community support and education initiatives once an ART programme has begun.
3. Staff and volunteer education - "ART literacy" work - with this group before implementation of an ART programme and throughout the duration of the programme.
4. Support for "skills diversification" initiatives and re-training for programmes needing to broaden their services beyond caring for sick people.
5. Supporting "back to work/school" and similar initiatives to support those benefiting from ART who wish to be more active in work, education and social spheres.

Supplementary or complementary services/initiatives

6. Support for transport costs and/or child-care provision for potential beneficiaries.
7. Support for VCT, either as "stand-alone" services or as optional components of other services such as TB treatment, antenatal services, community health services, STI treatment services, and for provision of the necessary technical and counselling skills and supervision this would require. Support for provision of additional trained VCT counsellors to meet increased demands of ART and for strengthening the ART literacy of all VCT staff.
8. Support for community-based accompaniment or buddying schemes similar to DOTS models for treating TB or for any form of adherence monitoring initiatives.
9. Follow-up support/education with individuals and families qualifying for ART.

10. Psycho-social support for staff and volunteers involved in ART programmes.

11. Funding nutrition and food security initiatives eg food supplements, vegetable and herb gardens, training in improved kitchen garden techniques, irrigation methods, nutritional education initiatives, labour-saving techniques etc.

Photo: Annie Bungeroth

12. Provision of formula feed (in line with WHO guidelines) as an alternative to breast-feeding.
13. Funding medications and alternative treatments proven to be effective for opportunistic infections or as prophylactic measures and that form part of the holistic spectrum of health care advocated in this document.

Initiatives to improve infrastructure of potential programmes

14. Examples of this include: provision of transport systems for programme staff and volunteers, laboratory and diagnostic facilities for initial assessment and ongoing monitoring, funding for referrals and contracting with complementary partnerships to provide these services. They might also include funding to strengthen general health care infrastructure where this complies with other CAFOD funding criteria.
15. Funding for laboratory tests to monitor ART as established by national government guidelines.

Support for wide-ranging advocacy initiatives related to ARVs

16. Examples include initiatives seeking equal access to treatments, reform of international trade laws and pricing systems of pharmaceutical companies, support for WHO-approved generic versions of ARVs, lobbying on anti-discrimination laws, support for gender-specific advocacy issues or issues affecting children specifically etc. The success of campaigns, often led by networks of people living with HIV and AIDS, for drug price reductions, approval of generic drugs, and modification of some TRIPS conditions is widely acknowledged. Support for such advocacy initiatives is crucial and consistent with CAFOD's wider commitment to strengthening its own and partners' advocacy work.
17. Strengthening the capacity of partner programmes to access in-country funding for ART provision, through initiatives funded by GFATM, World Bank, bilateral donations to their governments, PEPFAR.

Purchase and administration of ARVs

Options 18 and 19 are both considered as "last resort" options or as options that might be considered only in very exceptional circumstances.

18. Where alternative options are not available, CAFOD might on occasion fund the purchase and administration by partner programmes of ARVs, in accordance with national policies and in compliance with WHO protocols, guidelines and lists of approved drugs. If entered into, this would require a minimum commitment of 3-5 years for development programmes and 1 year for humanitarian response initiatives. It also requires the partner, not CAFOD, to undertake all work of procurement, all decisions regarding treatment protocols, and all distribution. Such funding may be:
    a. small scale, where a programme targets its existing catchment population and provides ART to the proportion of this population who qualify. Experience of other agencies suggests this may be a few hundred people at most and that the additional costs to CAFOD might be met from within existing CAFOD funds. Pilot projects, with defined time frame (5 year minimum as recommended by UNICEF) and limited scale, would be advisable initially;
    b. larger scale, or scaled up initiatives, involving several thousand beneficiaries. In such instances CAFOD would need to raise new monies from back donors
19. CAFOD will not, under normal circumstances, engage directly in procurement, distribution or management of ART provision programmes. Exceptionally, most likely in humanitarian responses such as Darfur where CAFOD staff are more directly operational and providing health care, CAFOD may allocate some funding to provision of ARVs, provided this complies with national policies, meets the criteria listed above and provided that CAFOD staff engaged to provide the health care also have sufficient expertise to manage the administration and clinical decisions required. Sustainability for a minimum of 1 year should be assured. Decisions regarding procurement, treatment protocols or any other clinical aspects should not fall to wider CAFOD staff. Managers of such programmes are responsible for ensuring that the criteria set out in this paper are met, before endorsing this option.

Endorsed by ILT, January 2007

This resource is also available in French, Spanish and Portuguese

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Futher information and resources

A. From CAFOD

Valuing volunteers: Considerations on involving volunteers in development and humanitarian response programmes supported by CAFOD

Volunteers form the mainstay of many community-based programmes supported by CAFOD. The learning gained from HIV-related initiatives in *Valuing Volunteers* may offer valuable insights.

CAFOD's HIV programming and strategy framework

Available in full and in summary version from CAFOD's HIV team. The annex to the full document offers tools for anyone facilitating in-depth consultation on programme development

B. External sources

WHO Guidelines: Antiretroviral therapy for HIV infection in adults and adolescents in resource-limited settings: towards universal access: *Recommendations for a public health approach, 2006*

Reference tool for countries with limited resources as they develop or revise national guidelines for the use of ART in adults and adolescents. The guidelines are primarily intended for use by national/ regional HIV programme managers, NGOs delivering HIV care services, and other policy-makers involved in scaling up comprehensive HIV care and ART in resource-limited countries.
http://www.who.int/hiv/pub/guidelines/adult/en/

WHO Guidelines: ART for HIV Infection in infants and children: towards universal access. Recommendation for a public health approach

http://www.who.int/hiv/pub/guidelines/paediatric020907.pdf

WHO Guidelines: Antiretroviral drugs for treating pregnant women and preventing HIV infection in infants in resource-limited settings: towards universal access: *Recommendations for a public health approach, 2006*

http://www.who.int/hiv/pub/guidelines/pmtct/en/index.html

WHO HIV drug resistance: http://www.who.int/hiv/drugresistance/en Geneva, 2006.

UNHCR, Antiretroviral medication policy for refugees

Policy and guidelines for use of ART as prophylaxis or treatment in refugee settings, January 2007
http://www.unhcr.org/publ/PUBL/45b479642.pdf

WHO, UNHCR: Clinical management of rape survivors

Geneva, 2005. http://www.unhcr.org/protect/PROTECTION/403a0b7f4.pdf

Expanding access to HIV treatment through community-based organisations

This *UNAIDS Best Practice Collection* publication, produced jointly with WHO, is intended as a resource for civil society, groups of people living with HIV, national programme managers, international and national policy-makers and donors to better appreciate and support the concept of community-based provision of ART in low and middle income countries.

http://data.unaids.org/Publications/IRC-pub06/JC1102-ExpandAccessToHIVTreatm_en.pdf?preview=true

Participant manual for the WHO basic ART clinical training course

Training modules based on simplified WHO guidelines to support the delivery of ARV therapy within a primary health care context, based at first-level health facilities or in outpatient clinics.
www.who.int/hiv/pub/imai/participant_manual_for_the_who_basic_art_clinical_training_course_6_days.pdf

HIV and infant feeding: Guidelines for decision makers
Framework for priority action
HIV and infant feeding: counselling tools

Three resources that form part of a joint publication by UNICEF, WHO & USAID.
www.who.int/child-adolescent-health/NUTRITION/HIV_infant.htm

Nutrition and HIV/AIDS: WHO report and recommendations following a consultation on nutrition and HIV/AIDS in Africa, Durban, April 2005 www.who.int/gb/ebwha/pdf_files/EB116/B116_12-en.pdf

NB National policies and guidelines on ART exist for many countries where CAFOD programme partners are working. These should also be consulted and may be available through a country's National AIDS Commission, or Global Fund Country Coordinating Mechanism (structure to assist local groups applying for grants from the Global Fund).