Draft

Using IMAI and IMCI

in the immediate response to emergencies

August 2008

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Abbreviations

AIDS	acquired immunodeficiency syndrome
ARV	antiretroviral
ART	antiretroviral therapy
HIV	human immunodeficiency virus
IMAI	Integrated Management of Adolescent and Adult Illness
IMCI	Integrated Management of Childhood Illness
MSF	Médecins Sans Frontières
PMTCT	prevention of mother to child transmission
STI	sexually transmitted infection
TB	Tuberculosis
UNAIDS	Joint United Nations Programme on HIV and AIDS
UNFPA	United Nations Population Fund
UNHCR	United Nations High Commission for Refugees
WHO	World Health Organization

Introduction

The global HIV epidemic requires the integration of attention to HIV prevention, treatment, care and support into emergency responses. Conflict and displacement can amplify the risk of contracting HIV through the use of unsafe blood, poor implementation of universal precautions in health care facilities, absence of treatment for sexually transmitted infections, which facilitates HIV transmission, behavioural changes including risk-taking behaviour and survival sex, scarcity of condoms, and sexual violence[1].

The humanitarian response to HIV in emergency settings has evolved substantially in the last two decades. Were as previously the focus was largely confined to HIV awareness and prevention, expanded access to antiretroviral therapies globally, combined with simplified regimes for long-term therapy, emergency prophylaxis and prevention of mother-to-child transmission have seen a growing acceptance of the possibility of increased levels of HIV treatment, care and support within emergency settings, including in the acute phase. This has both revolutionized responding to HIV in emergency settings as well as creating new challenges. While this is welcome, it requires accurate information and guidance on which services to provide services and how to provide them in the often chaotic and insecure circumstances of the acute phase of an emergency.

The Inter-Agency Standing Committee[2]

The Inter-Agency Standing Committee (IASC), an inter-agency forum for coordination, policy development and decision-making involving the key UN and non-UN humanitarian partners, developed *Guidelines for HIV/AIDS interventions in emergency settings*[3], which contained the following Principles:

- HIV/AIDS activities should seek to build on and not duplicate or replace existing work.
- Interventions for HIV/AIDS in humanitarian crises must be multisectoral responses.
- Establish coordination and leadership mechanisms prior to an emergency, and leverage each organization's differential strengths, so that each can lead in its area of expertise.
- Local and national governments, institutions and target populations should be involved in planning, implementation and allocating human and financial resources.
- Where non-state entities have control or where the government no longer has the capacity to act, activities may be undertaken in the absence of national policies or programmes.
- HIV/AIDS activities for displaced populations should also service host populations to the maximum extent possible.

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[1] Khaw AJ, Salama P, Burkholder B, Dondero TJ. HIV risk and prevention in emergency-affected populations: a review. *Disasters* 2000; 24: 181–97.

[2] IASC's primary objectives include to:

- develop and agree on system-wide humanitarian policies
- allocate responsibilities among agencies in humanitarian programmes
- develop and agree on a common ethical framework for all humanitarian activities
- advocate for common humanitarian principles to parties outside the IASC
- identify areas where gaps in mandates or lack of operational capacity exist
- resolve disputes or disagreement about and between humanitarian agencies on system-wide humanitarian issues.

http://www.humanitarianinfo.org/iasc/content/about/default.asp

[3] Inter-Agency Standing Committee (2005). Guidelines for HIV/AIDS interventions in emergency settings.

- When planning an intervention, cultural sensitivities of the beneficiaries should be considered. Inappropriate services are more likely to cause negative reaction from the community rather than achieve the desired impact.

The Guidelines also recognized that any response to an emergency needs to be multisectoral, providing specific interventions in the following areas: coordination, assessment and monitoring, protection, water and sanitation, food security and nutrition, shelter and site planning, health, education, behaviour change communication (BCC) and HIV in the workplace.

This resource guide aims to expand on the health sector-related aspects of these guidelines, offering practical advice on some crucial issues concerning HIV prevention, treatment, care and support in the acute phase of an emergency.

What is an emergency?

Emergencies are situations that threaten the lives and well-being of large numbers of people, requiring extraordinary action to ensure their survival, care and protection. Emergencies include natural disasters such as hurricanes, droughts, earthquakes and floods, as well as internal and international armed conflict which result in internally displaced people, refugees or other persons of concern. Furthermore, complex emergencies are humanitarian crises in which a significant breakdown of authority has resulted from internal or external conflict. Such emergencies have a devastating effect on great numbers of children and women, and call for a complex range of responses. There are three phases in the cycle of displacement:

- the acute phase, associated with the onset of conflict or some other emergency and flight of those affected;
- the post-acute (post-emergency) phase, marked by greater stability; and
- the rehabilitation phase, when durable solutions are secured such as reconstruction after natural disasters or refugees return home, are resettled in a third country, or are permanently integrated within the host country.

Why is HIV of concern during emergencies?

Humanitarian emergencies caused by conflict or natural disasters, are frequently characterized by the displacement of large numbers of people, with severe disruption of basic infrastructure, resulting in overcrowding, increased exposure to disease vectors, food insecurity, and lack of access to safe water, sanitation, and basic health services.[4] In populations affected by humanitarian emergencies, the risk of communicable diseases is greatly increased, with particularly high morbidity and mortality from communicable diseases in acute conflict situations. Diarrhoeal diseases, measles, malaria (in endemic areas), and acute respiratory infections are usually the most important causes of morbidity and mortality in displaced populations, particularly in the presence of high rates of malnutrition.

Additionally, public health programmes such as those for tuberculosis, malaria and HIV are at risk of being disrupted during an acute humanitarian emergency. The factors that affect HIV transmission vary by context and arise during different phases of the cycle of displacement. Rapid reconnection of people living with HIV with treatment services is essential to ensure continuity of care, to reduce the possibility of drug resistance and to reduce preventable

[4] WHO (2005). Communicable disease control in emergencies: A field manual. Edited by M.A. Connolly. http://whqlibdoc.who.int/publications/2005/9241546166_eng.pdf

morbidity and mortality. It is also crucial to reduce the risk of development and spread of multidrug-resistant tuberculosis (MDR-TB) and extensively drug-resistant tuberculosis (XDRTB).

WHO provides guidance for the development of HIV prevention and care models, services and health worker capacity through the Integrated Management of Adult Illness (IMAI) and Integrated Management of Childhood Illness (IMCI) programs. These are health care strategies that address the overall health of the person by supporting a shift from an acute care to a chronic care model that includes providing HIV prevention and antiretroviral therapy. In order to achieve this IMAI/IMCI includes generic training tools for patient monitoring, referral and back-referral to district hospitals, clinical team building, clinical mentoring and district planning, in order to strengthen health systems.

In the context of an acute humanitarian emergency, particularly in settings with high HIV prevalence, IMAI/IMCI-based training modules, which are practical "how to" tools, can be used as the building blocks to re-establish primary health care at the community level, and in doing so HIV prevention, treatment, care and support will automatically be integrated into the humanitarian response.

How the document is organized and how it should be used

This guide focuses specifically on the health sector response, particularly the role of frontline health workers, during the acute phase of an emergency with some over lap with food security and nutrition and HIV in the workplace.

Section 1 sets out a process for situation assessment both in terms of emergency preparedness and in the initial response to an emergency. **Section 2** looks at how IMAI/IMCI can be used to assist in rebuilding primary health care capacity and thereby integrate HIV prevention, treatment, care and support into the acute phase of an emergency response. **Section 3** examines a number of key issues that need to be addressed during the acute phase, namely:

1. HIV treatment, care and support
2. Prevention of mother-to-child transmission
3. Food support
4. Palliative care
5. Responding to sexual violence and exploitation
6. Prevention of HIV infection:
    a. sexual (condom supply and usage)
    b. injecting drug use (sterile injecting equipment)
    c. safe blood supply
    d. universal precautions and post exposure prophylaxis
7. Management of sexually transmitted infections
8. TB co-infection

This resource guide is in keeping with the IASC Principles and provides practical guidance to health care workers on responding to HIV prevention, treatment, care and support in the acute phase of an emergency based on WHO (and UNAIDS Cosponsor) guidelines. Each sub-section in Section 2 consists of:

1. Statement of the issue.
2. Priority actions.
3. Primary resources (WHO and UNAIDS Cosponsors' publications).
4. Secondary resources.

Section 1: HIV-related data and information

Timely access to accurate information about HIV prevalence and incidence in the displaced and host populations, the context of HIV risk and vulnerability and availability of antiretroviral therapy and other forms of HIV treatment, care and support are critical for planning an emergency response. As there is often little warning of an emergency, this information needs to be collated prior to an emergency - hence the need for emergency preparedness[5].

Emergency Preparedness

Emergency preparedness focuses on addressing the causes of emergencies with a view to avoiding recurrences or mitigating its impact and strengthening resilience, especially on vulnerable households and communities, and building local capacity to address the crisis (including pre-positioning of relief items to shorten the time of the response). These efforts are often linked to early warning systems, especially in natural disaster prone areas.

For the health sector response, a number of actions are required for emergency preparedness, including:

- Map current services and practices
- Plan and stock medical and reproductive health supplies
- Adapt/develop protocols
- Train health personnel
- Plan quality assurance mechanisms
- Train staff on the issue of sexual and gender-based violence and the link with HIV
- Determine prevalence of injecting drug use[6]
- Develop instruction leaflets on cleaning injecting materials
- Map and support prevention and care initiatives
- Train staff and peer educators
- Train health staff on reproductive health issues linked with emergencies and the use of reproductive health kits
- Assess current practices in the application of universal precautions

The extent to which these actions have been addressed prior to an emergency will significantly impact upon the quality and breadth of services that can be provided in the acute phase of an emergency.

HIV baseline assessment

In order to coordinate and cooperate with other organizations and authorities, it is essential to collect standardized data, which will facilitate a common understanding of the need for, and the extent and priorities of the HIV response in an emergency. Factors influencing this include:

- the existing seroprevalence rates in the displaced populations and surrounding communities;
- the prevalence and types of sexually transmitted infections;

[5] Inter-Agency Standing Committee (200X). Guidelines for HIV/AIDS interventions in emergency settings. Action sheet 2.1: Assess baseline data.
http://www.who.int/hac/network/interagency/IASC_Guidlines_HIV_AIDS_in_Emergency_Settings.pdf

[6] WHO and UNHCR (2008). Rapid Assessment of Alcohol and Other Substance Use in Conflict-affected and Displaced Populations: A Field Guide, 2008
http://www.who.int/mental_health/emergencies/unhcr_alc_rapid_assessment.pdf

- the context of risk and vulnerability – who becomes HIV infected and why;
- the level and quality of available health services (including antiretroviral therapy); and
- background information on demographic and education levels.

Different HIV epidemics scenarios

For the purpose of epidemiological surveillance UNAIDS and WHO have categorized the HIV epidemics taking place in different countries broadly as low level, concentrated or generalized. For HIV programme planning purposes, there is an additional scenario, hyperendemic epidemic.

In **low-level epidemic scenarios**, HIV has not spread to significant levels in any sub-population i.e. less than 1%.

In **concentrated epidemic scenarios**, HIV prevalence is high enough in one or more sub-populations such as men who have sex with men, injecting drug users or sex workers and their clients to maintain the epidemic in that sub-population, but the virus is not circulating widely in the general population.

Generalized epidemic scenarios: A number of countries now consistently report an HIV prevalence of between 1–5% in pregnant women attending antenatal clinics, indicating that the presence of HIV among the general population is sufficient for sexual networking to drive the epidemic.

Hyperendemic epidemic scenarios: describes the exceptional epidemiological situation in the southern African Region, where over 15% in the adult population — over half of them women and girls—are living with HIV. These epidemics are driven by extensive heterosexual, multiple concurrent partner, sexual relations with low and inconsistent condom use. In such epidemics, all sexually active persons have an elevated risk of HIV infection.

The assessment should consider both interventions targeting emergency affected populations and those available to the host population. Furthermore, the assessment should include particular attention to the needs of women, children and adolescents, single-headed households, certain ethnic and religious groups (if there is a history of marginalization of particular groups), persons with disabilities, sexual minorities and drug users.

Useful sources of data on HIV risk, vulnerability and impact may include:

- voluntary blood donor testing data;
- trends derived from AIDS case surveillance reporting;
- notification of new TB cases;
- incidence of sexually transmitted infections (new cases/1,000 persons/month) and trends disaggregated by syndrome (male urethral discharge, genital ulcer disease, syphilis at antenatal clinics, etc.);
- percent and trends of hospital bed occupancy of persons between 15 and 49 years of age;
- HIV-related information from the areas/countries of origin of the displaced population (for example, HIV prevalence and incidence data disaggregated by age, sex and risk behaviour(s), if available; STI incidence and trends data; and percentage of HIV-positive people with access to antiretroviral therapy, who require it);
- data from HIV treatment centres – number of people currently on antiretroviral therapy;
- HIV sentinel surveillance of pregnant women (proxy indicator for the general population);

- HIV sentinel surveillance of most-at-risk groups (people with sexually transmitted infections, injecting drug users, men who have sex with men, and sex workers);
- data derived from voluntary testing and counselling services;
- prevention of mother-to-child transmission data; and
- behavioural surveillance surveys.

The main task at this stage is to use the above information, and any other information gleaned from people with local knowledge, to develop an accurate picture of the HIV prevention, treatment, care and support needs of the communities affected by the emergency.

Other key baseline data that might assist include:

- trends in condom availability and usage;
- incidence and trends of gender-based violence;
- acute and chronic nutrition status of population using population-based surveys among different groups (children 6-59 months of age, pregnant women, adults);
- if food aid is distributed, amount (kcal/person/day) and quality (food basket);
- amount (litres/person/day) and quality of water available; and
- information on coping strategies of food insecure people.

This baseline data provides a quick assessment of the types of issues to be faced in an emergency and an indication of the extent to which HIV-related issues need to be built into the emergency response and provide a guide for targeting HIV initiatives to the people who need them most.

Section 2: IMAI/IMCI

What is IMAI/IMCI?

Integrated Management of Adult and Adolescent Illness (IMAI) and Integrated Management of Childhood Illness (IMCI) are health strategies that address the overall health of the patient. One of their most distinctive elements is the focus on the management of chronic disease and prevention rather than just the treatment of acute illness. This supports the shift from an exclusively acute care model of health service delivery to a chronic care model. IMAI/IMCI also integrates important but neglected areas into the overall care model for HIV such as prevention and mental health. The strategy streamlines existing services so that, even where resources are scarce, the health system can function more efficiently by simplifying and standardizing health care delivery.

Key features

- An integrated service delivery approach—a coherent and consistent package.
- Balances attention to acute and chronic care.
- Integrated clinical management of TB and HIV.
- Integrated patient monitoring with care and treatment.
- Links prevention interventions with acute care and chronic HIV care.
- Helps alleviate human resource limitations through task shifting.
- Involves people living with HIV to train health workers and in the clinical team.
- Increases the efficiency of training.

How can it be used?

IMAI is an integrated, flexible set of interventions in several compatible formats. The IMAI guidelines are based on key clinical symptoms for a "syndromic" approach to care. They need little laboratory support, can be used where resources are scarce, and are designed for adaptation to different conditions. Adaptation involves the choice of interventions to address the priority needs of the country and modification of the guideline content to take account of culture difference, local disease conditions, the health system, the essential drug use, etc.

Primary care IMAI/IMCI modules include:

- Acute care (including opportunistic infections, when to suspect and test for HIV, prevention)
- IMAI/IMCI Chronic HIV Care with ARV Therapy and Prevention
- General principles of good chronic care
- Palliative care: symptom management and end-of-life care
- IMCI chart booklet for High HIV Settings
- TB Care with TB-HIV Co-Management

These can all be downloaded at http://www.who.int/hiv/capacity/modules/en/index.html

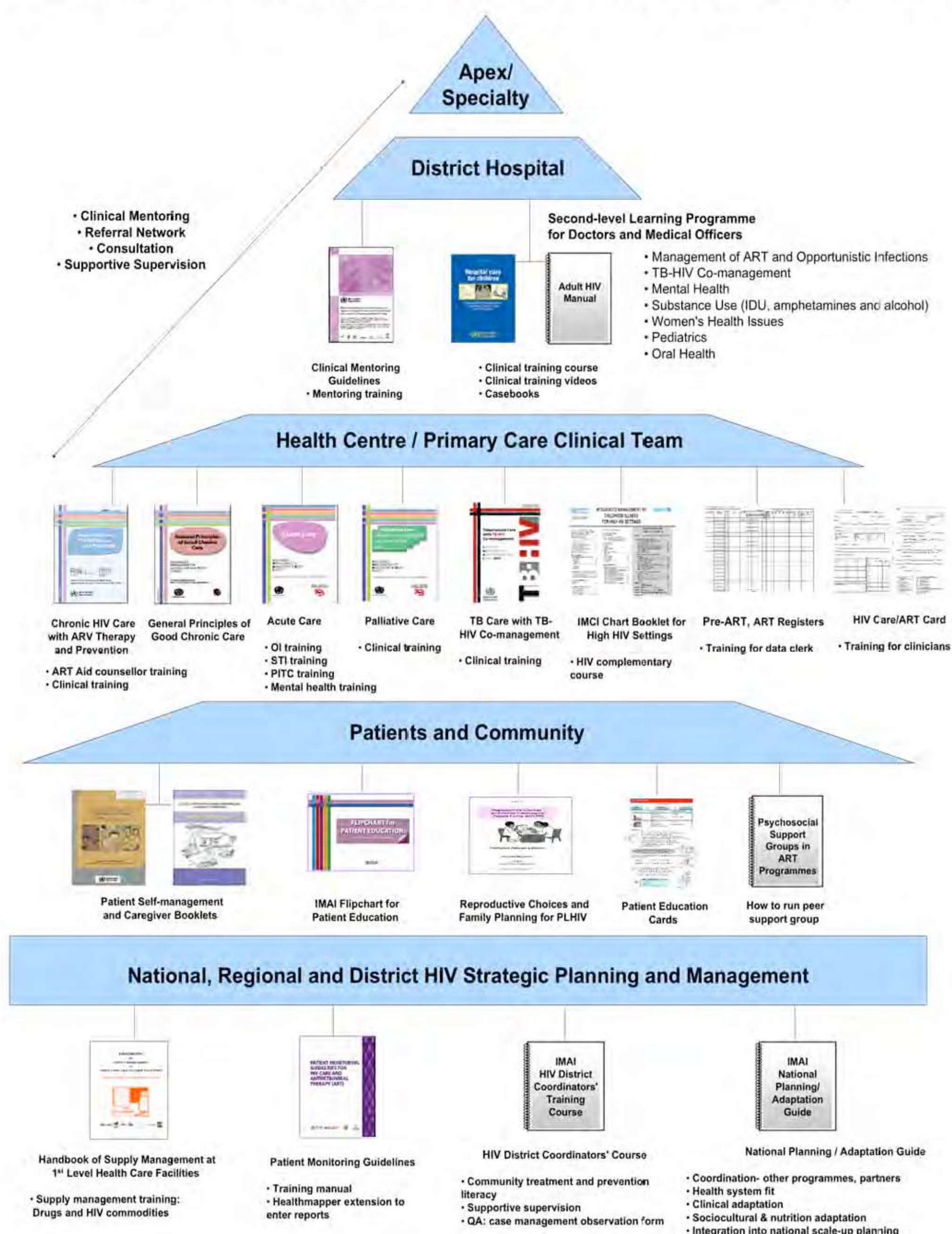
Patient and community IMAI/IMCI modules include:

- Patient Self-Management Booklet
- Caregiver Booklet
- Flipchart for Patient Education
- Patient treatment cards
- Reproductive choices and family planning for people living with HIV - Counselling tool

These can all be downloaded at
http://www.who.int/hiv/pub/imai/PatientCommune/en/index.html

Note that there are a number of new materials in draft that provide more detailed information:

- Three interlinked patient monitoring systems for HIV care/ART, MCH/PMTCT (including malaria prevention during pregnancy), and TB/HIV http://www.who.int/hiv/pub/imai/patient_guidelines_july2008/en/index.html
- Operations Manual for Delivery of HIV Prevention, Care and Treatment at Primary Health Care Centres in High-Prevalence Resource-Constrained Settings.



Training materials

Training materials on the above modules have been developed targeting the groups listed below. Please note there are two options for accessing the training materials.

1. IMAI Sharepoint http://www.who.int/hiv/capacity/IMAIsharepoint/en/index.html
   Please note that you are required to register to use this site
2. The links to the WHO internet provided below.

For clinicians

- Basic HIV Care ART Clinical Training Course
  http://www.who.int/3by5/capacity/chronic/en/index.html
- Acute Care Training Course
  http://www.who.int/3by5/capacity/acure/en/index.html
- TBHIV and TB IC
- Palliative Care Training Course
  http://www.who.int/3by5/capacity/palliative/en/index.html
- PMTCT Training
- IMCI HIV Complementary Training
- Reproductive Choices and Family Planning Training Course
- Adolescent training material
- Supply Management Training Course

For people living with HIV and lay providers

- Basic ART Aid Training Course to prepare and others to be an integral part of the chronic HIV care team at the health facility and to be responsible for patient education, psychosocial support and ART preparation, initiation, monitoring and support. http://www.who.int/3by5/capacity/basicART/en/index.html
- Expert Patient-Trainers http://www.who.int/3by5/capacity/expert/en/index.html
- Expert Trainer Training Course

How can IMAI/IMCI assist in the acute phase of emergency settings?

As has previously been suggested, IMAI/IMCI can assist in re-establishing primary health care at the community level, and integrating HIV prevention, treatment, care and support in the process. As such, IMAI/IMCI can assist in building the capacity and improving the quality of health care in an emergency setting. As a first step, in identifying which modules of IMAI/IMCI will be useful, a number of basic questions need to be answered such as:

- Has the country adapted IMAI/IMCI modules? If so, which ones?
- If not, what systems does the country have in place for providing HIV prevention, treatment, care and support?
- If there are no systems are in place, which IMAI/IMCI modules are necessary in the current situation?
- What physical resources are available i.e. clinics, laboratory equipment, etc.?
- What human resources (clinical and lay persons) are available?
- Have they been trained in IMAI/IMCI modalities?
- What are the gaps in their training? What are their training needs?

The following sample planning guide schematically outlines the process involved. To identify existing resources both physical and human, and immediate training needs as well as identifying gaps in supplies.

Sample Planning Guide: Re-establishing Primary Care

Health System	Intervention	IMAI/IMCI Modules (M) & Training (T)
Care Systems	Has the country adapted IMAI/IMCI modules? If so, which ones? If not, what systems does the country have in place for providing HIV prevention, treatment, care and support? If none, which IMAI/IMCI modules (or parts thereof) can be used in the current situation?	Acute care, Chronic HIV, General principles, Palliative care, TB Care (all M)
Physical Resources	What buildings/structures are available? Do these need to be reorganized for primary health care services? What medications are available? What medical and surgical supplies are available? What laboratory facilities are available? Is access to safe blood (with HIV screening of donated blood) available?	Operations Manual for Delivery of HIV of PTC (M)
	Systems: drugs and supplies management, human resources management Laboratory and diagnostic services	Supply Management(T)
Human Resources	• What human resources (**clinical**) are available? • Have they been trained in IMAI/IMCI modalities? • What are the gaps in their training? • If yes, what are their immediate training needs?	Basic HIV Care ART, Acute Care, TBHIV, Palliative Care, PMTCT, IMCI HIV, RP&FP, Adolescent (all T)
	• What human resources (**lay persons**) are available? • Have they been trained in IMAI/IMCI modalities? • What are the gaps in their training? • If yes, what are their immediate training needs?	Basic ART Aid, Expert Patient-Trainers, Expert Trainer (all T)

Acute **Post acute** **Transition**

Section 3: Areas Requiring Priority Action

1. HIV treatment, care and support

Providing ongoing treatment, care and support for HIV-positive people is essential in an emergency as:

- People living with HIV can be more prone than people with fully-functioning immune systems to disease and death as a consequence of limited access to food, clean water and good hygiene.
- In most national antiretroviral therapy programmes, people living with HIV are generally only provided with up to a one month supply of antiretroviral drugs. Interruptions in access to antiretroviral therapy for people with HIV on treatment may result in the development of drug resistance, causing preventable morbidity and mortality.
- Antiretroviral therapy has both HIV prevention and care aspects. People receiving antiretroviral therapy with undetectable viral loads are largely non-infectious. As such, maintaining people on antiretroviral therapy will be beneficial for HIV prevention efforts in the emergency context.
- Opportunistic infections can be life threatening in the absence of access to diagnosis, prophylaxis and treatment services.
- The absence of prevention of mother-to-child (PMTCT) services increases the risks of maternal transmission of HIV to children[7].

Access to basic care
Even in the absence of antiretroviral therapy, there are still treatment, care and support initiatives that can be put in place that prolong life, reduce morbidity and increase the quality of life of people living with HIV. These are the **absolute minimum standard** and should be available in all settings:

- improvements in access to nutritious food, good shelter and clean water;
- primary health care that is able to prevent or detect and treat common opportunistic infections and TB co-infection (See **sub-section 8: Tuberculosis**);
- home-based care to relieve symptoms and provide support (See **sub-section 4: Palliative care**); and
- counselling and psychological support.

Diagnosis, treatment and prophylaxis for opportunistic infections
While access to antiretroviral therapies has increased in many developing countries; access is often still limited. The result is that many HIV-positive people still become ill from and some die from preventable or treatable opportunistic infections. Even when people are taking antiretroviral therapy, opportunistic still occur, though this may be less frequent. Diagnosis and treatment guidance for the following common opportunistic infections are covered in the primary resources listed below:

- Oral and oesophageal candida (thrush)
- Pneumonia
- Fever
- Persistent diarrhoea
- Skin problems or bumps

[7] Inter-Agency Standing Committee (2005). Guidelines for HIV/AIDS interventions in emergency settings.

Primary Resource(s)
WHO (2005). Acute Care for adolescents and adults. Integrated Management of Adolescent and Adult Illness. http://www.who.int/hiv/pub/imai/en/acutecarerev2_e.pdf

WHO and UNICEF (2006). Integrated Management of Childhood Illness for High HIV Settings. Chart: http://whqlibdoc.who.int/publications/2006/9789241594370.cb_eng.pdf

Access to antiretroviral therapies
In recent years, the number of people in developing countries with access to antiretroviral therapies has steadily grown with present coverage estimated at 3 million from 6 million in need. The result is that increasing numbers of people who are already on antiretroviral therapies will be caught up in natural and man-made emergencies.

The 2005 IASC *Guidelines for HIV/AIDS Interventions in Emergency Settings* underline that the provision of antiretroviral therapy (ART) should be form part of a comprehensive response during the stabilization phase. However, it is increasingly apparent that with expanded access to ART, an increasing number of people on ART will be caught up in emergency situations. In 2006, WHO, UNHCR, UNAIDS, UNICEF and MSF agreed that the presence of an emergency should not affect a person's access to HIV services and that provision of such services (including access to ART) is not only feasible but an inalienable human right and should be included in national strategic plans[8]. This reality has been recognized by UNHCR, which expressly stated in 2007 that:

> Continuity of ART is a priority in order to ensure treatment effectiveness and avoid the possibility of developing resistance. UNHCR and its partners should attempt to ensure as a priority that ART continues to be provided to persons who were previously taking ART before conflict and/or displacement[9].

In circumstances where the displaced person is either currently on ART, or has a history of previously being on ART, the following is recommended:

- Establish that the person is HIV positive – either by a repeat HIV rapid test to confirm infection, or if HIV testing is not yet available, by some means of verifying that the person has previously been on ART (e.g. a patient card)
- If the individual is currently on ART, continue their current treatment regime with no interruption.
- If there has been a treatment interruption, try to restart treatment as soon as possible, after careful assessment of the reasons for the interruption.
- Provide each person with at least a one month supply of antiretroviral drugs if it is likely to be difficult for them to return to the drug distribution site.
- Adherence counselling and support should be undertaken in light of the new circumstances[10].

Displaced persons can be affected by unforeseen events, causing them to move unexpectedly. To minimize the impact of this, all patients should carry a copy of their own clinical HIV

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[8] Consensus Statement: Delivering Antiretroviral Drugs in Emergencies: Neglected but Feasible. http://www.who.int/hac/techguidance/pht/HIV_AIDS_101106_arvemergencies.pdf

[9] UNHCR (2007). Antiretroviral Medication Policy for Refugees. Key principles governing the provision and use of ARVs in UNHCR's operations, No 2 at 6.

[10] Currently, the only guidance on this issue is offered by The Southern African HIV Clinicians Society in collaboration with UNHCR (2007). Clinical Guidelines for antiretroviral therapy management for displaced populations Southern Africa. http://www.sahivsoc.org/invoices_temp/sahivsoc_guideline_18_july_2007.pdf

summary, such as a treatment card, which includes their drug regimens, prior toxicity, illness history and laboratory results. All people living with HIV should also be aware of their basic medical history and be able to relate it verbally to health workers as they move around. It should be understood that stopping antiretroviral therapy suddenly is rarely associated with drug resistance; poor dosing, poor drug quality and poor adherence are far more common causes.

Ensuring that the patient is fully informed of the importance of continuous therapy and issues around side effects are integral to successful treatment. To assist this, drug regime specific treatment education support cards should be used.

Issue	Action
HIV prevalence	• What is the HIV prevalence in the host and displaced populations[11]? • What is the estimated number of displaced, HIV-positive people, who are already undergoing antiretroviral therapy?
Drug regimes	• What are the first and second line antiretroviral drug regimes in use in the host and country of origin[12]? • Are they compatible[13]? • Do ART regimes of displaced people need to be changed to accommodate drug regimes available in the host country?
Drug supply (Identify which drugs will be needed and how they will be supplied)	• Are these first and second line antiretroviral drug regimes available in the emergency setting? • By whom (i.e. Government or NGOs or other stakeholders) and how are drugs being supplied? • If there are supply interruptions, how can these be minimized? • Is strategic substitution necessary[14]?
Health worker capacity and quality of care (Identify which staff members will prescribe and counsel)	• Are staff sufficiently skilled and confident to provide antiretroviral drugs? • What training can be made available to improve their level of knowledge and skill? • What quality assurance measures can be put in place?
Access to services	• How will patient's privacy be maintained? • Can community members/volunteers or people living with HIV be used to spread the word about the availability of stop-gap antiretroviral drugs?

[11] Use relevant Ministry of Health data (see Section 2: Data sources for emergency preparedness. Otherwise for estimates see
http://www.who.int/globalatlas/DataQuery/default.asp
[12] Use relevant Ministry of Health data. Otherwise check the relevant country's Global Fund grant
http://www.theglobalfund.org/programs/search.aspx?lang=en&component=HIV/AIDS
[13] For further guidance, see: WHO (2006). Antiretroviral therapy for HIV infection in adults and adolescents
http://www.who.int/hiv/pub/guidelines/artadultguidelines.pdf
Addendum: http://www.who.int/hiv/art/ARTadultsaddendum.pdf
WHO (2006). Antiretroviral Therapy Guidelines for HIV Infection in Infants and Children: Towards Universal Access. www.who.int/hiv/pub/guidelines/art/en/index.html
[14] i.e. with another combination of drugs.

Primary Resource(s)
The Southern African HIV Clinicians Society in collaboration with UNHCR (2007). Clinical Guidelines for antiretroviral therapy management for displaced populations Southern Africa.
http://www.sahivsoc.org/invoices_temp/sahivsoc_guideline_18_july_2007.pdf
See 1.2 Patient presents on ART or with history of previously taking ART and 1.3 Contingency planning

Patient treatment cards
http://www.who.int/hiv/pub/imai/patient_education_cards.pdf

Secondary Resource(s)
WHO (2006). Antiretroviral therapy for HIV infection in adults and adolescents
http://www.who.int/hiv/pub/guidelines/artadultguidelines.pdf
Addendum: http://www.who.int/hiv/art/ARTadultsaddendum.pdf

WHO (2006). Antiretroviral Therapy Guidelines for HIV Infection in Infants and Children: Towards Universal Access. www.who.int/hiv/pub/guidelines/art/en/index.html

UNHCR (2007). Antiretroviral Medication Policy for Refugees.
http://www.unhcr.org/publ/PUBL/45b479642.pdf

Culbert. H, Tu. D, O'Brien. D, Ellman. T, Mills. C, Ford. N, Amisi. N, Chan. K, Venis. S and Médecins Sans Frontières (2007). HIV Treatment in a Conflict Setting: Outcomes and Experiences from Bukavu, Democratic Republic of the Congo. *PLOS Medicine,* May 2007, Vol 4, 5, e129. www.ete-online.com/search/citedby/pmc/15679919

2. Prevention of mother-to-child transmission

HIV transmission from a HIV-positive mother can occur during pregnancy, labour and delivery, or afterwards through breastfeeding. In the absence of any intervention, an estimated 15–30% of HIV-positive mothers will transmit HIV to their child during pregnancy or delivery. Breastfeeding increases the risk of HIV transmission by 10–20%, depending on clinical factors and the pattern and duration of breastfeeding.

There are a number of measures which can be taken to limit HIV transmission in this context. Comprehensive prevention of mother-to-child transmission (PMTCT) of HIV includes:

- the primary prevention of HIV among women, especially young women;
- avoiding unintended pregnancies among HIV-positive women and promoting family planning methods, particularly in women who are HIV-positive;
- preventing HIV transmission from HIV-positive pregnant women to their infants by:
    - using an antiretroviral prophylaxis regimen,
    - avoiding unnecessary invasive obstetrical procedures, such as artificial rupture of membranes or episiotomy,
    - modifying infant feeding practices (replacement feeding given with a cup when acceptable, feasible, affordable, sustainable and safe, otherwise exclusive breastfeeding for the first months of life is recommended).

However, before comprehensive prevention of mother-to-child transmission programmes can be considered during the acute phase of an emergency, basic interventions to prevent excess neonatal and maternal morbidity and mortality must be put in place which involves providing clean delivery and midwife delivery kits, establishing a referral system to manage obstetric emergencies and organizing comprehensive services for antenatal, delivery and postpartum care[15].

Nevertheless, the population affected by an emergency will include women who are in the later stages of pregnancy, and who will therefore deliver within the first days, weeks or months of the emergency recovery period. While it may not be possible to implement comprehensive PMTCT services during the acute phase of an emergency, there are a number of scenarios that can and should be addressed, namely:

- HIV-positive pregnant women, who know they are HIV-positive, and about to give birth; and
- Feeding of infants born to women who know that they are HIV-positive.

An overarching principle is that pregnant women living with HIV need to have sufficient information, based on local realities, to make informed decisions about antiretroviral therapy, antiretroviral prophylaxis and infant feeding options.

Expectant HIV-positive pregnant women

HIV-positive pregnant women, who know they are HIV-positive, and about to give birth may face similar obstacles to those HIV-positive people who are already taking antiretroviral therapy and are faced with disruptions in their supply of drugs due to the emergency. Some pregnant HIV-positive women will already be taking antiretroviral therapy while others for whom treatment is not yet medically indicated will have been advised to take antiretroviral prophylaxis during labour. The dilemma faced by both groups of women is the same i.e.

[15] Inter-Agency Standing Committee (200X). Guidelines for HIV/AIDS interventions in emergency settings. http://www.who.int/hac/network/interagency/IASC_Guidlines_HIV_AIDS_in_Emergency_Settings.pdf

women facing an imminent birth without the means to prevent the possibility of HIV transmission to their child during labour.

Early in an emergency, most births will take place outside of health facilities without the assistance of trained health care providers. So what can be done realistically in these situations?

1. For pregnant HIV-positive women, who are already taking antiretroviral therapy, their access to ongoing antiretroviral therapy needs to be secured (see **sub-section 1: Treatment, care and support**)
2. For those women who have at least one-off access to trained health care workers, **WHO has recommended that a single dose of nevirapine for both mother and child is the absolute minimum**[16], and should be considered as a temporary measure while concrete steps are taken to identify and address the specific obstacles to provision of more effective regimens. The aim during the acute phase of an emergency is to provide coverage for those pregnant women whop know that they are HIV-positive.
3. Where pregnant HIV-positive women do not have access to antiretroviral therapy or treatment is not medically indicated, WHO recommends the following the antiretroviral prophylactic regimen for PMTCT[17].

Mother	Pregnancy Labour Postpartum	Azidothymidine (AZT) from 28 weeks of pregnancy or as soon as possible thereafter AZT and lamivudine (3TC) plus a single dose of nevirapine (200mg) AZT and 3TC x 7 days
Infant		Single dose nevirapine (NVP) and AZT x 7 day. **Note**: If the mother received less than 4 weeks of AZT during pregnancy, give AZT to the newborn for 4 weeks.

WHO has provided the following guidance for self-administered antiretroviral prophylaxis for PMTCT [18]. Such guidance with an adequate supply of drugs is essential during the acute phase of an emergency when medical support may be extremely limited.

Prepare for ARV drugs during labour and to the newborn:
If woman cannot give birth at the facility, provide the woman with ARV drugs for herself and the newborn, and provide careful instructions about how to take them.

- Provide ART or ARV prophylaxis for the woman to take at home—for herself and her newborn
- Provide AZT and NVP syrup in small bottles and instruct carefully on how to give to the newborn

[16] Single dose nevirapine carries a risk of drug resistance for the mother. See WHO (2006). Antiretroviral Drugs for Treating Pregnant Women and Preventing HIV Infection in Infants: Towards Universal Access: Recommendations for a public health approach, at 52. http://www.who.int/hiv/pub/guidelines/pmtctguidelines3.pdf

[17] WHO (2006). Antiretroviral Drugs for Treating Pregnant Women and Preventing HIV Infection in Infants: Towards Universal Access: Recommendations for a public health approach. http://www.who.int/hiv/pub/guidelines/pmtctguidelines3.pdf

[18] WHO (2005). Chronic HIV Care with ARV Therapy. Integrated Management of Adolescent and Adult Illness. http://www.who.int/hiv/pub/imai/Chronic_HIV_Care7.05.07.pdf

- Reinforce the advice on later visits to clinic
- Arrange for treatment supporter, traditional birth attendant or community health workers to help with ART or ARV prophylaxis in the home

Infant Feeding

If a woman knows that she is HIV-positive[19]

Inform her about the following options for feeding, and their advantages and risks:

- If acceptable, feasible, safe and sustainable (affordable), she might choose replacement feeding with home-prepared formula or commercial formula.
- Exclusive breastfeeding, stopping as soon as replacement feeding is possible. If replacement feeding is introduced early, she must stop breastfeeding.
- Exclusive breastfeeding for 6 months, then continued breastfeeding plus complementary feeding after 6 months of age, as recommended for HIV-negative women and women who do not know their status.

Up to 20% of infants born to HIV-positive mothers may acquire HIV through breastfeeding[20]. However, breastfeeding is vital to the health of children, reducing the impact of many infectious diseases and preventing chronic diseases, particularly in the context of emergency settings where hygiene is likely to have broken down and a clean water supply is doubtful. Exclusive breast feeding for up to six months has been shown to decrease the risk of HIV transmission three to four fold compared with non-exclusive breast feeding. It is recommended that infants should be exclusively breastfed for the first six months of life[21].

Exclusive formula feeding has also proved an effective way to prevent postnatal MTCT; however, this is unlikely to be a viable option in emergency settings due to the inability to guarantee a continuous supply of formula, fuel and clean water.

Issue	Action
Drug regimes	• What is the antiretroviral drug regime used in the host country for prevention of PMTCT?[22] • What is the current antiretroviral prophylactic regimen for PMTCT in use in the host community?
Drug supply	• By whom (i.e. Government or NGOs or other stakeholders) and how are drugs being supplied? • Are they available in the emergency setting? • Is strategic substitution necessary and/or possible?
Health worker capacity and quality of care	• Are staff/birth attendants/traditional healers skilled and confident to provide antiretroviral drugs? • Are staff/birth attendants/traditional healers skilled and confident to provide counselling on infant feeding? • What training can be made available to improve their level

[19] WHO (2006). Updated second edition: Pregnancy, childbirth, postpartum and newborn care. http://www.who.int/making_pregnancy_safer/publications/PCPNC_2006_03b.pdf

[20] WHO; UNICEF; UNFPA and UNAIDS (2007). HIV and infant feeding: Update. http://whqlibdoc.who.int/publications/2007/9789241595964_eng.pdf

[21] No food or liquids including water. The only exception is drops and syrups consisting of vitamins, mineral supplements and medicines. It should be noted that mixed feeding increases the risk of diarrhoea and may increase the risk of HIV transmission. WHO; UNICEF; UNFPA and UNAIDS (2007). HIV and infant feeding: Update. http://whqlibdoc.who.int/publications/2007/9789241595964_eng.pdf

[22] Use relevant Ministry of Health data. Otherwise check the relevant country's Global Fund grant http://www.theglobalfund.org/programs/search.aspx?lang=en&component=HIV/AIDS

	of knowledge and skill?
Access to services	• Is it possible to provide presenting HIV-positive pregnant women with a supply of drugs and instructions on how and when to take them during labour and after birth? • Can community members/volunteers or people living with HIV be used to spread the word about the availability of antiretroviral drugs for PMTCT? • Can community health workers be used to assist women during labour and to support infant feeding?

Primary Resource(s)

WHO (2006). Pregnancy, childbirth, postpartum and newborn care. Updated second edition http://www.who.int/making_pregnancy_safer/publications/PCPNC_2006_03b.pdf

WHO (2006). Antiretroviral Drugs for Treating Pregnant Women and Preventing HIV Infection in Infants: Towards Universal Access: Recommendations for a public health approach. http://www.who.int/hiv/pub/guidelines/pmtctguidelines3.pdf

WHO; UNICEF; UNFPA and UNAIDS (2007). HIV and infant feeding: Update. http://whqlibdoc.who.int/publications/2007/9789241595964_eng.pdf

Secondary Resource(s)

WHO (2005). Chronic HIV Care with ARV Therapy. Integrated Management of Adolescent and Adult Illness. http://www.who.int/hiv/pub/imai/Chronic_HIV_Care7.05.07.pdf

WHO and UNFPA (2006). Sexual and reproductive health of women living with HIV/AIDS. Guidelines on care, treatment and support for women living with HIV/AIDS and their children in resource-constrained settings.
https://www.who.int/reproductive-health/docs/srhwomen_hivaids/text.pdf

WHO Recommended Interventions for Improving Maternal and Newborn Health.
http://whqlibdoc.who.int/hq/2007/WHO_MPS_07.05_eng.pdf

UNHCR (2007). Antiretroviral Medication Policy for Refugees.
http://www.unhcr.org/publ/PUBL/45b479642.pdf

WHO and UNAIDS (2007). Guidance on provider-initiated HIV testing and counselling in health facilities. http://whqlibdoc.who.int/publications/2007/9789241595568_eng.pdf

WHO (2004). HIV testing and counselling toolkit. www.who.int/hiv/topics/vct/toolkit/en/

3. Nutritional support

People living with HIV have special dietary and nutritional needs. Adequate intake of energy, protein, and micronutrients is essential for coping with HIV, fighting off opportunistic infections and for the success of antiretroviral therapy:

- A 2003 WHO Expert Consultation on nutrient requirements for HIV-positive people recommended that an increase of 10% in energy requirements is needed to maintain body weight and physical activity in asymptomatic HIV-positive adults. This proportion can rise to 20-30% for symptomatic adults and to as high as 50-100% for children with acute weight loss and infection.
- Food security and nutrition are also fundamental to the success of HIV therapy. There is emerging evidence that patients who begin antiretroviral therapy without adequate nutrition have lower survival rates. Adequate dietary intake and absorption are essential for achieving the full benefits of therapy. Antiretroviral therapy itself may increase appetite and it is possible to reduce some side-effects and promote adherence to the therapy if some of the medicines are taken with food. Given the importance of adherence in delaying viral resistance to first-line drugs, nutritional support becomes even more important in the longer run for sustaining antiretroviral treatment.
- HIV and TB co-infection are common. TB also has implications for nutritional needs as it is an energy-wasting disease. Many people in emergency settings may also be suffering from malnutrition which is exacerbated by TB. TB treatment will normally lead to an increased need for calories, therefore nutritional rehabilitation may be an important component of a TB control programme implemented in the post-acute phase of an emergency (see **sub-section 8: Tuberculosis**).
- There is also evidence that nearly all vitamins and minerals affect the immune system or are affected by infection. Although there is much research yet to be done on the specific roles of micronutrients in HIV infection, studies have shown that certain micronutrients are associated with positive outcomes such as slowing disease progression, reducing mortality due to HIV/opportunistic infections, and reducing the incidence of low birth weight among pregnant women with HIV. The special nutritional needs of people living with HIV should be considered when planning rations in emergency settings.

WHO has developed the following guidelines on nutritional needs for adults living with HIV[23]:

Recommendation	HIV+ asymptomatic	HIV+ symptomatic	On antiretroviral therapy
Nutrition assessment	Yes	Yes	Yes
Dietary recommendations: - Energy intake - Protein intake - Micronutrient intake	 Increase by 10% No change At least 1 RDA or daily supplement	 Increase by 20−30% No change At least 1 RDA or daily supplement	In accordance with symptoms
Food safety counselling	Yes	Yes	Yes
Symptom-based nutritional advice	No	Yes	Yes
Iron supplementation	As per existing WHO guidelines	As per existing WHO guidelines	As per existing WHO guidelines
Vitamin A Supplementation	As per existing WHO guidelines; daily intake	As per existing WHO guidelines; daily intake	As per existing WHO guidelines; daily intake not to

[23] WHO (2004). Nutrition Counselling, Care and Support for HIV-Infected Women: Guidelines on HIV-Related Care, Treatment and Support for HIV-Infected Women and Their Children in Resource-Constrained Settings. http://www.who.int/hiv/pub/prev_care/en/nutri_eng.pdf

	not to exceed 1 RDA.	not to exceed 1 RDA.	exceed 1 RDA.
Management of wasting	No	Screen for causes and treat as needed; counsel on increased food consumption; refer for antiretroviral therapy and family food assistance as needed.	Screen for causes and treat as needed; counsel on increased food consumption; refer for review of antiretroviral therapy as it may indicate treatment failure/need to switch to second line therapy; refer for family food assistance as needed.
Nutritional considerations for persons on ARV treatment	No	No	Provide advice on dietary needs and restrictions; counsel on management of nausea and related side-effects; manage toxicity and treatment failure as per WHO guidelines.

In all emergency situations, an understanding of the local context, including HIV prevalence, is paramount in planning rations that will effectively achieve the main objectives of food aid, namely:

- preventing increases in malnutrition; and
- preventing excess mortality.

Many HIV-positive people do not know their status either due to a lack of testing opportunities or, even when testing is available, they choose not to undergo testing for fear of being stigmatized. This makes targeting nutritional support for HIV-positive people and affected families in emergency settings extremely complex. In the context of the acute phase of an emergency, the likely recipients of increased nutritional support (due to the fact that they have been identified) are the two groups discussed previously, namely

- people living with HIV already taking antiretroviral therapy; and
- HIV-positive pregnant women.

Often, local institutions (particularly health services) have no training or information on nutrition education for people living with HIV and do not know what advice to give to HIV-positive people or members of their families.

Issue	Action
Mapping food insecurity	• Mapping areas where levels of food vulnerability overlap with high rates of HIV prevalence.
Targeting food assistance	• Ensure that food aid, when provided to people living with HIV or HIV affected families, does not increase stigmatization or make non-affected vulnerable families feel excluded. ➢ In the first instance, it is preferable to target all food insecure individuals, regardless of whether their HIV status is known. ➢ In some cases, some HIV-positive people may identify themselves or groups such as community organizations, NGOs, etc. may have identified HIV-positive persons. In these situations it may be possible to directly provide additional food assistance to support these HIV-positive people as long as stigma does not become an issue.
Health worker capacity	• Do staff understand the links between nutrition and HIV? • What training can be made available to improve their level of knowledge and skill?

Community involvement	• Depending on the context, work can be undertaken with functioning community-based organizations that are already involved with HIV-positive individuals and affected families to provide food assistance.

Primary Resource(s)

WHO (2004). Nutrition Counselling, Care and Support for HIV-Infected Women: Guidelines on HIV-Related Care, Treatment and Support for HIV-Infected Women and Their Children in Resource-Constrained Settings. http://www.who.int/hiv/pub/prev_care/en/nutri_eng.pdf

Secondary Resource(s)

Consultation on Nutrition and HIV/AIDS in Africa. Evidence, lessons, and recommendations for action. ICC, Durban, South Africa, 10-13 April 2005. See Executive Summary and Participants' Statement (covers macro- and micronutrients, pregnancy and lactation, growth, infant and young child feeding, and interaction between nutrition and antiretroviral treatment). http://www.who.int/nutrition/topics/consultation_nutrition_and_hivaids/en/index.html

Food and Nutrition Technical Assistance Project, Academy for Educational Development (2001). HIV/AIDS: A Guide for Nutrition, Care and Support. http://www.who.int/hac/techguidance/pht/8518.pdf

FAO (2002). Living well with HIV/AIDS: A manual on nutritional care and support for people living with HIV/AIDS. ftp://ftp.fao.org/docrep/fao/005/y4168E/y4168E00.pdf

UNAIDS (2006). The development of programme strategies for integration of HIV, food and nutrition activities in refugee settings. http://www.who.int/hac/techguidance/pht/UNAIDS_BP_HIV_Nut_in_Refs2006.pdf

4. Palliative care

WHO defines palliative care as "an approach that improves the quality of life of patients and their families facing the problems associated with life threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual"[24]. However, palliative care in general is a neglected need and is something that should be provided in the context of continuum of care and not only at the end of life. In countries with high HIV prevalence, there is a close correlation between the proportion of the population needing palliative care and the proportion of people living with HIV.

There is an urgent need to extend the benefits of disease-specific therapy to people living with HIV in developing countries. This includes antiretroviral therapy and prophylaxis and treatment of opportunistic infections. Increased availability of these therapies should not only have a positive impact on survival; such treatment should also promote the key palliative care goals of pain and symptom management and improved quality of life.

However, only some 3 million people, 31% of those estimated to be in need of antiretroviral therapy in low- and middle-income countries were receiving it in 2007. This means as efforts to provide HIV-specific therapies to resource-poor countries continue, there remains a critical need to provide palliative care for the large numbers of HIV-positive people in these countries who may or may not have access to antiretroviral and other therapies. In the context of the acute phase of an emergency, there will be people who are ill and dying from HIV-related causes, who require palliative care

Palliative care is also part of home-based care and includes the management of both acute and chronic symptoms and terminal care. Important elements are: pain control, other symptom management such as oral hygiene and hydration, terminal care, referral to any community/home-based care, and where feasible, information and education on HIV transmission for caregivers and on AIDS for people living with HIV. Attention to palliative care needs is something that can and should be integrated into the provision of health care services once the acute phase of an emergency has passed.

Primary Resource(s)

WHO (2005). Palliative Care: Symptom Management and End-of-Life Care. Integrated Management of Adolescent and Adult Illness.
http://www.who.int/3by5/publications/documents/en/genericpalliativecare082004.pdf

WHO (2005). Acute Care for adolescents and adults. Integrated Management of Adolescent and Adult Illness. http://www.who.int/hiv/pub/imai/en/acutecarerev2_e.pdf

Secondary Resource(s)

Help the Hospices and Worldwide Palliative Care Alliance (2008). Palliative Care Toolkit: Improving care from the roots up in resource limited settings. By Vicky Lavy, Charlie Bond and Ruth Wooldridge.
http://www.helpthehospices.org.uk/international/documents/Palliative%20Care%20Toolkit%20-%20Improving%20care%20from%20the%20roots%20up%20in%20resource-limited%20settings%20(full%20toolkit).pdf

[24] http://www.who.int/cancer/palliative/definition/en/

Hospice Africa (2006). Pain and Symptom Control in the Cancer and/or AIDS Patient in Uganda and other African Countries - A book for health professionals. Uganda, Fourth Edition 2006. http://www.hospiceafrica.or.ug/papers/bluebk40506.pdf

5. Responding to gender-based violence

Gender-based violence (GBV), and in particular sexual violence, is a serious, life-threatening protection issue primarily affecting women and children (male and female), though it can also affect men. During a crisis, such as armed conflict or natural disaster, institutions and systems for physical and social protection may be weakened or destroyed. Police, legal, health, education and social services are often disrupted. Many people flee, and those who remain may not have the capacity or the equipment to work. Families and communities are often separated, which results in a further breakdown of community support systems and protection mechanisms.

Gender-based violence is especially problematic in the context of complex emergencies and natural disasters, where civilian women and children are often targeted for abuse, and are the most vulnerable to exploitation, violence, and abuse simply because of their gender, age, and status in society. During the early stages — when communities are first disrupted, populations are moving, and systems for protection are not fully in place — most reported GBV incidents are sexual violence involving female survivors/victims and male perpetrators[25]. Sexual violence is often used as a weapon of war, targeting civilian women and children.

Minimizing the vulnerability of women and girls (particularly) to sexual violence is a key priority in the acute phase of emergency recovery and is a key HIV prevention initiative. This can be achieved by:

- the rapid restoration of law and order;
- careful attention to the placement of personnel hygiene areas, and water and food supply points to ensure physical safety;
- security to protect women and girls as they move outside safe areas to collect firewood, water, etc.;
- minimizing family and community dislocation; and
- managing alcohol and other drug use in camps and relocation settings.

Survivors of GBV are at high risk of severe and long-lasting health problems, including death from injuries or suicide. Health consequences can include unwanted pregnancy, unsafe self-induced abortion, infanticide, and sexually transmitted infections, including HIV. Psychological trauma, as well as social stigma and rejection, is also common. Most societies tend to blame the victim in cases of sexual violence, which increases psychological harm. The exact nature and severity of physical and emotional trauma vary greatly among survivors.

Response to GBV must, however, include a set of available services to reduce the harmful consequences and prevent further injury and harm to the survivor. The essential components of medical care after a rape are:

- documentation of injuries;
- collection of forensic evidence;
- treatment of injuries;
- evaluation for sexually transmitted infections (STIs) and preventive care;
- emergency contraception; and

[25] Inter-Agency Standing Committee (2005). Guidelines on gender-based violence interventions in humanitarian settings. Focusing on prevention of and response to sexual violence in emergencies. http://www.humanitarianinfo.org/iasc/content/subsidi/tf_gender/gbv.asp

- psychosocial support, counselling and follow-up[26].

The WHO and UNHCR *Clinical management of rape survivors: Developing protocols for use with refugees and internally displaced people* provides extensive guidance on these issues.

In terms of HIV, there are a number of issues to be considered, including:
- Treatment or prevention of STIs (see **sub-section 7: Management of sexually transmitted infections**);
- Post-exposure prophylaxis (PEP.

Post-exposure prophylaxis
Post-exposure prophylaxis (PEP) usually consists of 2 or 3 antiretroviral drugs given for 28 days. While there are no conclusive data on the effectiveness of PEP in preventing transmission of HIV after rape; on the basis of experience with prophylaxis after occupational exposure and prevention of mother-to-child transmission; it is believed that starting PEP as soon as possible (and, in any case, within 72 hours after the rape) is beneficial.

PEP should be offered to survivors according to the health care provider's assessment of risk, which should be based on:
- what happened during the attack (i.e. whether there was penetration, the number of attackers, injuries sustained, etc.); and
- HIV prevalence in the region.

Risk of HIV transmission increases in the following cases, if:
- there was more than one assailant;
- the survivor has torn or damaged skin;
- the assault included anal penetration; or
- the perpetrator is known to be HIV-positive or is a member of a population most affected by HIV in that country (refer to baseline information).

Note: that attempting to quantify risk in this case is extremely difficult. Providing the victim with information that assists her to make informed choices is the primary objective.

Practical Issues
- If the HIV status of the assailant(s) is unknown, assume they are HIV-positive, particularly in countries with high prevalence.
- It is not a prerequisite for commencing PEP to know the perpetrator's HIV status.
- It is not necessary to test the survivor for HIV before commencing PEP. The first priority is HIV prevention. Introducing HIV testing at this point may exacerbate victim trauma, particularly if the person has not previously been tested for HIV and the result is positive.
- Obviously, if the victim has already been tested HIV-positive before the assault, PEP is not necessary.
- Have emergency contraception available and counsel the survivor about emergency contraception so that she can make an informed decision.
- There can be problems and issues surrounding the prescription of PEP, including the challenge of counselling the survivor on HIV-related issues during this time.

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[26] WHO and UNHCR (2004). Clinical management of rape survivors: Developing protocols for use with refugees and internally displaced people.
www.who.int/reproductive-health/publications/clinical_mngt_rapesurvivors/

Follow-up
As part of standard one week follow-up visit:

- Evaluate PEP side effects and adherence;
- If not supplied at the first visit, provide three weeks supply of PEP drugs;
- Check that survivor has had the full course of any medication for STIs;
- Evaluate STIs and treat as appropriate; and
- Counsel on baseline HIV testing and re-testing after the window period has passed.

Issue	Action
HIV prevalence	• What is the HIV prevalence in the host and displaced populations?[27]
Drug regimes	• What is the antiretroviral drug regime for PEP used in the host community/country?[28]
Drug supply	• By whom (i.e. Government or NGOs or other stakeholders) and how are drugs being supplied? • Are they available in the emergency setting? • If there are supply interruptions, how can these be minimized? • Is emergency contraception available?
Health worker capacity and quality of care	• Are staff sufficiently skilled and confident to provide PEP? • What training can be made available to improve their level of knowledge and skill? • What quality assurance measures can be put in place?
Access to services	• How will patient's privacy be maintained? • Can community members/volunteers be used to spread the word about the availability of care for survivors of GBV?
Prevention	• What measures (i.e. when collecting water/firewood and for toilet areas[29]) are in place to minimize the risk of sexual violence in the emergency setting? • Restoration of law and order

Primary Resource(s)
WHO and UNHCR (2004). Clinical management of rape survivors: Developing protocols for use with refugees and internally displaced people.
http://who.int/reproductive-health/publications/clinical_mngt_rapesurvivors/clinical_mngt_rapesurvivors.pdf

Inter-Agency Standing Committee (2005). Guidelines on gender-based violence interventions in humanitarian settings. Focusing on prevention of and response to sexual violence in emergencies. http://www.humanitarianinfo.org/iasc/content/subsidi/tf_gender/gbv.asp

Secondary Resource(s)

[27] Use relevant Ministry of Health data (see Section 2: data collection for emergency preparedness). Otherwise for estimates see http://www.who.int/globalatlas/DataQuery/default.asp
[28] Use relevant Ministry of Health data. Otherwise check the relevant country's Global Fund grant http://www.theglobalfund.org/programs/search.aspx?lang=en&component=HIV/AIDS
[29] Refer Inter-Agency Standing Committee (200X). Guidelines for HIV/AIDS interventions in emergency settings. Action Sheet 6.1. Establish safely designed sites.
http://www.who.int/hac/network/interagency/IASC_Guidlines_HIV_AIDS_in_Emergency_Settings.pdf

WHO and ILO (2007). Post-exposure prophylaxis to prevent HIV infection: joint WHO/ILO guidelines on post-exposure prophylaxis (PEP) to prevent HIV infection.
http://whqlibdoc.who.int/publications/2007/9789241596374_eng.pdf

UNHCR (2007). Antiretroviral Medication Policy for Refugees.
http://www.unhcr.org/publ/PUBL/45b479642.pdf

WHO (2003). Guidelines for medico-legal care for victims of sexual violence.
http://www.who.int/violence_injury_prevention/resources/publications/med_leg_guidelines/en

6. Prevention of HIV infection

Sexual transmission

In many countries, unprotected sex is the main route of HIV transmission. Condoms are the surest way to arm populations subjected to emergencies with dual protection against STIs, including HIV, and unwanted pregnancy. However condoms may become unavailable when shops and health facilities are destroyed, supply lines are cut off or people become displaced. Male and female condoms should be considered as essential items in emergency relief supplies.

As many people in a crisis or refugee situation will be destitute, it is essential that condoms are cost-free and readily available to those who need them. Condom provision must be accompanied by culturally sensitive, low level literacy information on their correct use. While undertaking behaviour change communication campaigns will not necessarily be a priority in the acute recovery phase; health and relief staff should know how to counsel people on condom use and be able to supply condoms and low level literacy information leaflets to assist in their proper use.

It is not enough simply to have a supply of condoms available; they need to reach the people who are sexually active. In the context of an acute emergency this presents logistical issues. Questions need to be asked about "who is having sex with whom, where and when" as well as "at what points are people accessing services within the emergency setting?" For example, women and young girls in emergency settings are particularly vulnerable to becoming involved in sex work as the exchange of sex for money, services or goods is often a matter of survival. This may leave them susceptible to infection with STIs, including HIV, and unwanted pregnancy. Devising ways to reach people involved in survival sex as well as other particularly vulnerable groups such as injecting drug users, men who have sex with men, transgendered people in the context of the acute phase of emergencies with basic HIV prevention commodities and information is essential.

Calculations for condom supplies for a population of 10 000 for 3 months[30]

Target population:

Male condoms: Kit contents assume that 20% of the population in a camp is male. (10,000 persons x 20 % = 2,000 males) and 20 % of this group will use condoms (2,000 x 20 % users = 400 users) and that each user will need 12 condoms each month for the three months (400 x 12 x 3 months = 14,400 male condoms).

Female condoms: Assuming that around 25% of the population in the camp are potentially sexually active women. (10,000 persons x 25% = 2,500 women) and that 1% will use female condoms (2,500 x 1% users = 25 users) and that each user would need 6 condoms each month (25 x 6 x 3 months = 450 female condoms).

Contents:

Part A: Male condoms

Male Condoms	14,400
20% wastage	2,880
Total	17,280 (120 gross)
Safe Sex Leaflets	400

Part B: Female condoms

Female Condoms	450
20% wastage	90
Total	540 (3.8 gross)
Female Condom use Leaflets	25

Remark:

Parts A and B can be ordered separately in different quantities.
Depending on the culture of the country where this kit will be used, the pictures in the Safe Sex Leaflets may have to be adapted.

Issue	Action
Targeted interventions	• Are there subpopulations at particular risk? i.e. sex workers, injecting drug users, men who have sex with men, transgendered people[31].
Condom supply	• Are male and female condoms on the national essential drugs list? • Are male and female condoms available in the emergency setting? • Are the numbers sufficient for the population present? • If there are supply interruptions, how can these be minimized? Who else is distributing condoms or has supplies?
Health worker capacity and barriers	• Are staff skilled and confident to distribute condoms and provide HIV counselling and information? • Do vulnerable populations experience barriers to accessing condoms? E.g. fear of discrimination. • What actions are required to ensure health workers provide condoms and information to vulnerable populations?
Access to condoms	• What political, religious and cultural issues need to be addressed in relation to providing condoms? • Can community members (i.e. peer educators or outreach workers) be used to distribute condoms and provide information? • Who else can distribute condoms? i.e. primary health care workers, antenatal clinic workers, community health workers. • Where else can condoms be provided? Meetings, venues, food distribution points.

It must also be noted that the presence of untreated STIs, particularly ulcerative STIs, dramatically increases a person's susceptibility to HIV infection. Diagnosis and treatment of STIs (usually by syndromic management in the acute phase of an emergency) is therefore a key HIV prevention initiative.

Primary Resource(s)

UNFPA and the Inter-agency Working Group on Reproductive Health in Refugee Situations (2006). Reproductive Health Kit for Emergency Situations, (revised edition).
www.rhrc.org/pdf/rhrkit.pdf

Secondary Resources

WHO (2005). Communicable disease control in emergencies: a field manual edited by M. A. Connolly. http://whqlibdoc.who.int/publications/2005/9241546166_eng.pdf

Inter-Agency Standing Committee (200X). Guidelines for HIV/AIDS interventions in emergency settings.
http://www.who.int/hac/network/interagency/IASC_Guidlines_HIV_AIDS_in_Emergency_Settings.pdf

Injecting drug use

The sharing of contaminated injecting equipment and drug preparations by drug users is one of the most efficient ways of transmitting HIV. Once HIV is introduced into drug injecting networks, explosive HIV epidemics can occur, which can be exacerbated by the often close links between sex work and drug use.

Emergencies have the potential to greatly increase the vulnerability of individuals to drug use and associated HIV infection as:

- they may affect the availability of drugs in the community. For example, drug supplies may be interrupted, so drug users may inject other drugs or switch from snorting or smoking drugs to the more efficient modes of injecting;
- risk behaviours may be more prevalent among drug users. For example, sharing of drug injecting equipment may be more common, especially when there is reduced availability of needles and syringes; and
- stress, displacement and interruption to work and community life associated with the emergency may result in increased drug use.

Furthermore, intoxication from drug use (including alcohol) can be associated with increased sexual risk behaviour(s), including increased rates of sexual violence (See **sub-section 6: Condoms**)

In most communities, injecting drug use is illegal and drug injecting populations are stigmatized, marginalized and often remain hidden. Therefore most interventions are controversial, may not be supported by local authorities and the community, and even if implemented face challenges in reaching drug users. Even in emergency settings, special attention needs to be given to public education and advocacy to gain support from the community and authorities.

At an absolute minimum, access to bleach and sterile water is essential. Obviously, this should rapidly be replaced by access to sterile injecting equipment, but this requires consistent supply lines to be in place. Depending on the type of drug use, access to opioid substitution therapy may also be a key strategy, as the sudden interruption in supply of illicit drugs may result in severe withdrawal symptoms for opioid users, resulting in preventable morbidity and mortality.

Issue	**Action**
HIV prevalence	• What is the HIV prevalence in the host and displaced populations?[32]
Targeted interventions	• Undertake rapid informal assessment[33] with a few key informants to confirm that drug injecting is occurring and to identify the key individuals/groups to target with information, needles and syringes. Care should be taken in disseminating information that might be sensitive to the general population. • What is the estimated number of injecting drug users?
Provide risk reduction information	• Drug users should be provided with information covering: ➢ modes of HIV transmission; ➢ risks associated with sharing drug injecting equipment (including needles, syringes, rinsing water, filters, etc.)

	and drug preparations; ➢ strategies for reducing risks associated with injecting (including not sharing equipment, reducing sharing frequency and partners, cleaning of injecting equipment); ➢ how to access sterile needles and syringes and how to safely dispose of used equipment; and ➢ how to reduce risk of sexual transmission (including access to condoms).
Ensure uninterrupted and ready access to sterile needles and syringes for injecting drug users	• The needs of injecting drug users should be considered when planning the supply of injecting equipment for an emergency setting. ➢ On average, heroin injectors may inject two to three times a day. ➢ More frequent injecting occurring among cocaine and amphetamine injectors. • Develop a system for collecting and disposing of used injecting equipment to reduce the circulation time of used equipment in the community to prevent its reuse, accidental transmission or to alleviate community angst.
Access to opioid substitution	• Can opioid substitution therapy be introduced to reduce the physical and psychosocial impact of sudden interruptions in access to opioid-based illicit drugs?
Health worker capacity and barriers	• Health workers, positioned at points where injecting equipment is distributed, need to be educated about the reasons for providing equipment to injecting drug users, with an emphasis placed on the objective of preventing HIV transmission. • Health care workers need to be aware of how to undertake a basic clinical assessment and how to offer basic interventions to assist drug users, including management of overdose, detoxification and common complications (for example management of ulcers at injection sites). • Assess whether injecting drug users experience barriers to accessing sterile injecting equipment or other health services? E.g. fear of discrimination from health care workers.
Community involvement	• Can community members (i.e. peer educators or outreach workers) be used to distribute sterile injecting equipment (secondary distribution), provide information on risk reduction or inform about where to access sterile injecting equipment?

Primary Resource(s)

Inter-Agency Standing Committee (2005). Guidelines for HIV/AIDS interventions in emergency settings. Action Sheet 7.5: Ensure IDU appropriate care.
http://www.who.int/hac/network/interagency/IASC_Guidlines_HIV_AIDS_in_Emergency_Settings.pdf

WHO and UNHCR (2008). Rapid Assessment of Alcohol and Other Substance Use in Conflict-affected and Displaced Populations: A Field Guide, 2008

http://www.who.int/mental_health/emergencies/unhcr_alc_rapid_assessment.pdf

WHO (2007). Guide to starting and managing needle and syringe programmes.
http://www.who.int/hiv/idu/Guide_to_Starting_and_Managing_NSP.pdf

Secondary Resources

WHO (2005). Policy and Programming Guide for HIV/AIDS Prevention and Care among Injecting Drug Users. http://www.who.int/hiv/pub/prev_care/policyprogrammingguide.pdf

Flipchart for Patient Education
http://www.who.int/hiv/pub/imai/flipchart.pdf

Universal precautions and post exposure prophylaxis

People working under pressure are more likely to have work-related accidents and to cut corners in sterilization techniques, infection control measures adopted during crises must be practical to implement and enforce. In an emergency, interruptions in the availability of supplies, the absence of trained staff and disruptions to normal procedures can result in a lack of attention to universal precautions and an increased risk of HIV transmission to both staff and patients.

Universal precautions are a simple, standard set of procedures to be used in the care of all patients at all times in order to minimize the risk of transmission of blood-borne pathogens. The guiding principle is that all blood products should be assumed to be potentially infectious. Adoption and adherence to universal precautions are essential to preventing HIV transmission from patient to patient, from health worker to patient and from patient to health worker.

Key Actions

- Provide clear treatment protocols and guidelines, reducing unnecessary procedures as much as possible. For example:
  - Wherever possible, intravenous and intra-muscular treatments should be replaced by oral medicines.
  - Blood transfusions should be reduced to an absolute minimum; volume replacement solutions are preferable.
- Provide sufficient facilities for frequent hand washing in health care settings. Hands should be washed with soap and water, especially after any contact with body fluids or wounds. Ensure an adequate and consistent supply of sterile injecting equipment, gloves, masks, gowns, disinfectant and cleaning materials and other supplies to promote adherence with universal precautions.
- Promote the availability and use of safe systems for the disposal of sharps. Place used disposable syringes and needles, scalpel blades and other sharp items in puncture-resistant containers for disposal. Puncture-resistant containers must be readily available, close at hand, and out of reach of children. Sharp objects should never be thrown into ordinary waste bins or bags, onto rubbish heaps or into waste pits or latrines.
- Ensure that sterilisers are functioning and that they are used properly. If sterilization is not available, or for instruments that are heat sensitive, the instruments must be cleaned and high-level disinfected (HLD). HIV is inactivated by boiling for 20 minutes or by soaking in chemical solutions, such as a five percent solution of chlorine bleach or a two percent glutaraldehyde solution for 20 minutes.
- Ensure the safe disposal of all human waste. It should be recognized that people (including small children) struggling to survive will scavenge; thus, safe disposal is a vitally important consideration. All waste materials should be burnt and those that still pose a threat, such as sharps, should be buried in a deep pit (at least 30 feet from a water source).

All staff must be supervised to ensure their compliance in the use of universal precautions. Staff and patients also need access to post-exposure prophylaxis (PEP) in case of accidental exposure to HIV in the healthcare setting (See **Section 5: Responding to sexual violence and exploitation**)

Primary Resource(s)

WHO (2007). Prevention of HIV Transmission in Health Care Settings. HIV Technical Brief.

http://www.who.int/hiv/pub/toolkits/HIV%20transmission%20in%20health%20care%20settings.pdf

WHO (2004) . Infection Control. Aide Memoire.
http://www.who.int/injection_safety/en/AM_InfectionControl_Final.pdf

WHO and ILO (2007). Post-exposure prophylaxis to prevent HIV infection: joint WHO/ILO guidelines on post-exposure prophylaxis (PEP) to prevent HIV infection.
http://whqlibdoc.who.int/publications/2007/9789241596374_eng.pdf

Secondary Resource(s)

Inter-Agency Standing Committee (200X). Guidelines for HIV/AIDS interventions in emergency settings. Universal Precautions Action Sheet 7.2 and PEP Action Sheet 10.2
http://www.who.int/hac/network/interagency/IASC_Guidlines_HIV_AIDS_in_Emergency_Settings.pdf

UNHCR (2007). Antiretroviral Medication Policy for Refugees.
http://www.unhcr.org/publ/PUBL/45b479642.pdf

Safe blood supply

Blood transfusion can be a life-saving intervention. However, like all treatments, it may result in acute or delayed complications and carries the risk of transfusion-transmissible infections, including HIV, hepatitis viruses, syphilis, malaria and Chagas disease. The efficacy of HIV transmission through transfusion of infected blood is close to 100%. As a result, finding ways to ensure the safety of blood transfusion in emergency situations is extremely important.

Key actions

Avoid unnecessary use of blood.

- Transfuse only in life-threatening circumstances and when no other alternative is possible[34].
- Use blood substitutes whenever possible: simple crystalloids (physiological saline solutions for intravenous administration) and colloids[35].

Select safe donors.

- Collect blood only from donors identified as being least likely to transmit infectious agents in their blood.

Test all blood donated for transfusion.

- Screening for HIV, Hepatitis B and, if possible, also for hepatitis C and syphilis. Use simple or rapid tests in acute emergency situations.
- Results of the HIV tests must be unlinked to the donor and be treated confidentially.
- If time permits, test for ABO grouping; RhD typing (for all transfusions to females in reproductive age group); and cross-matching to rule out ABO compatibility.
- Use Group O RhD negative blood if grouping and cross matching are unavailable.

In emergency settings, appeals for blood donors should be made through the most appropriate communications channels i.e. radio. The messages should indicate who should and should not come forward to donate blood, and where and to whom they should report.

Primary Resource(s)

Inter-Agency Standing Committee (200X). Guidelines for HIV/AIDS interventions in emergency settings. Ensure safe blood transfusion services Action Sheet 7.8.
http://www.who.int/hac/network/interagency/IASC_Guidlines_HIV_AIDS_in_Emergency_Settings.pdf

Secondary Resource(s)

WHO (2001). The Clinical Use of Blood Handbook.
http://www.who.int/bloodsafety/clinical_use/en/Handbook_EN.pdf

WHO (2007). Prevention of HIV Transmission in Health Care Settings. HIV Technical Brief.
http://www.who.int/hiv/pub/toolkits/HIV%20transmission%20in%20health%20care%20settings.pdf

WHO (2003). Guidelines and Principles for Safe Blood Transfusion Practice, Safe Blood Donation, Screening for HIV.
www.who.int/bookorders/anglais/detart1.jsp?sesslan=1&codlan=1&codcol=15&codcch=490#

WHO (2002). Blood safety: Aide-memoire for national programmes.
www.who.int/bloodsafety/transfusion_services/en/Blood_Safety_Eng.pdf

7. Management of sexually transmitted infections

The management of sexually transmitted infections (STIs) is both a HIV prevention and care initiative. The presence of ulcerative STIs increases physical susceptibility to HIV infection in both males and females. Untreated STIs further weaken the immune system of people with HIV and can cause preventable morbidity and mortality.

The incidence of acute sexually transmitted infections (STIs) is believed to be high in many countries. Failure to diagnose and treat STIs at an early stage may result in serious complications and sequelae, including infertility, foetal wastage, ectopic pregnancy, anogenital cancer and premature death, as well as neonatal and infant infections. There is also a strong correlation between infection with both ulcerative and non-ulcerative STIs and HIV transmission. Furthermore, HIV and concomitant infection with some other STIs such as herpes infection and chancroid may produce atypical symptoms, making diagnosis difficult. There have also been a number of anecdotal reports suggesting that the natural history of syphilis may be altered as a result of HIV co-infection.

Many health care facilities in developing countries lack the equipment and trained personnel required for etiological diagnosis of STIs. To overcome this problem, a syndrome-based approach to STI management has been developed and promoted in a large number of developing countries.

The syndromic management approach is based on a STI syndrome: a group of patient symptoms and clinical signs that we can use to decide the appropriate treatment. The antimicrobial regimens are chosen to cover the major pathogens responsible for the syndromes in the specific geographic area. In order to make this determination, a laboratory analysis of the syndromes is made and the pathogens for each syndrome are identified. Subsequently, the management of individual patients will not depend on laboratory investigation.

The benefits of the syndromic management approach are that patients can be treated on the spot, avoiding loss to follow-up, and that treatment can be provided without laboratory testing, something that is very unlikely to be available during the acute phase of any emergency. Note: For all STIs (except vaginitis) the sexual partner(s) of patients should also be examined and promptly treated for the same condition(s) as the index patient.

Many countries have established and used national standardized treatment protocols for the management of STIs. Such protocols are preferable to generic guidelines as they are based on local evidence concerning STI prevalence and drug resistance profiles. In the event that national protocols are not available, WHO's *Guidelines for the management of sexually transmitted infections*[36] provides a simplified tool (a flowchart or algorithm) to guide health workers in the implementation of syndromic management of STIs, while the *Reproductive Health Kit for Emergency Situations* [37]which provides the types and quantities of antibiotics for treating a population of 10 000 people for 3 months.

Issue	Action
STI incidence[38]	• Which STIs are prevalent in the host and displaced populations? • Are STI incidence rates available for the host population and for the area from which the displaced people originate?
Protocols	• Are there national algorithms available?[39]

(Syndromic management algorithms)	• Are these available in primary health clinics? • Which syndromes will be covered?
Drug supply (Identify which drugs will be needed and how they will be supplied)	• Are these drugs on the national essential drugs list? • Are they available in the emergency setting? • If there are supply interruptions, how can these be minimized? • Is strategic substitution necessary?
Health worker capacity and quality of care (Identify which staff members will diagnose, prescribe and counsel)	• Are staff sufficiently skilled and confident to carry out syndromic management? • What training can be made available to improve their level of knowledge and skill? • What quality assurance measures can be put in place?
Access to services	• How will patient's privacy be maintained? • Can other community members (community volunteers) be used to spread the word about the availability and quality of STI management services? • What partner notification strategies are in place?

Primary Resource(s)

UNFPA and the Inter-agency Working Group on Reproductive Health in Refugee Situations (2006). Reproductive Health Kit for Emergency Situations, (revised edition). Page 15. www.rhrc.org/pdf/rhrkit.pdf

WHO (2005). Acute Care for adolescents and adults. Integrated Management of Adolescent and Adult Illness. http://www.who.int/hiv/pub/imai/en/acutecarerev2_e.pdf
Covers diagnosis, treatment and follow-up in men and women.

Secondary Resources

WHO (2007). Training Modules for the Syndromic Management of Sexually Transmitted Infections. http://www.who.int/reproductive-health/stis/training.htm

WHO (2003). Guidelines for the management of sexually transmitted infections. http://www.who.int/hiv/pub/sti/en/STIGuidelines2003.pdf

8. Tuberculosis co-infection

In the acute phase of an emergency, when mortality rates are high owing to acute respiratory infections, malnutrition, diarrhoeal diseases and malaria (where prevalent), Tuberculosis (TB) control is not a priority.

When the basic health services are able to meet the daily needs and care of all acute respiratory infections and acute respiratory symptoms (e.g. pneumonia), for both adults and children, TB services should be developed. The following criteria are essential before a decision to implement a TB control programme is made:

- data indicate that TB is an important health problem;
- the emergency phase is over (death rates < 1 per 10 000 population per day);
- basic needs of water, adequate food, shelter and sanitation are available;
- essential clinical services and basic drugs are available;
- security in, and stability of, the camp envisaged for at least 6 months;
- sufficient funding for at least 12 months; and
- laboratory services for sputum smear microscopy will be available.

The rationale for delaying the development and implementation of TB control programmes is that if there are high rates of treatment defaulters, there is a high risk multidrug-resistant TB developing. The bottom line is: **incomplete treatment is worse than no treatment.**

People with TB whether HIV-positive or HIV-negative, who arrive in an emergency setting, and who have had their TB treatment interrupted due to the emergency should be registered as 'return after treatment interruption' or as 'treatment failure' and their future treatment should follow the course of and be evaluated with the cohort of retreatment cases.

Nevertheless, TB is a particularly important disease in long-term emergencies where refugees or internally displaced persons are in camps or overcrowded communities for long periods. In these conditions, people are at particularly high risk of developing TB owing to overcrowding, malnutrition and high HIV seroprevalence. As such, the development and implementation of TB control programmes in the post-acute phase of an emergency should be a priority in settings with high HIV and/or TB incidence.

TB and HIV co-infection

- In some countries (particularly sub-Saharan Africa), 30-70% of TB patients are infected with HIV.
- TB is the leading cause of death among people living with HIV. Compared with a HIV-negative person, a HIV-positive person is 25 times more likely to progress from infection to active disease. As well as being at greater risk of developing severe disease, HIV-positive people are also at greater risk of developing serious side-effects from TB drugs.
- Since TB is more common in HIV-positive individuals, and because many refugees and displaced persons may come from, or seek refuge in, countries with high HIV prevalence, TB control and HIV programmes should be carefully coordinated. For example, TB clinics are also suitable places for the distribution of condoms.
- The symptoms and signs of TB in patients who are HIV-positive are the same as in non-infected individuals. Spread from the lungs to other parts of the body is common and may result in the severer forms of TB (e.g. meningitis). This is particularly so in children.

- TB patients with concurrent HIV infection respond well to TB treatment but may have more side effects from TB drugs. Some antiretroviral drugs are contraindicated with rifampicin.

Primary Resource(s)

WHO (2005). Communicable disease control in emergencies: a field manual edited by M. A. Connolly. http://whqlibdoc.who.int/publications/2005/9241546166_eng.pdf

Secondary Resource(s)

WHO (2007). Tuberculosis Care with TB-HIV Co-Management. http://www.who.int/hiv/TB_HIVModuleCover23.05.07.pdf

WHO (1997). Tuberculosis control in refugee situations: an inter-agency field manual. http://libdoc.who.int/hq/1997/WHO_TB_97.221.pdf

Conclusion

Whilst the acute response phase of an emergency presents significant challenges, it is important that attention to HIV prevention, treatment, care and support is integrated into the response from the beginning. Obviously each emergency context is different and requires local knowledge and flexibility. The strategies actions outlined in this guide represent the minimum necessary level of integration. As the situation stabilises, a more comprehensive approach to HIV prevention, treatment, care and support can be gradually put in place.

The post acute, and rehabilitation and recovery phases of an emergency permit more comprehensive responses, building upon the initial minimum response and enhancing coverage and sustainability.