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CHAPTER TEN

HIV

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1 Introduction

Since the 1980s, the human immunodeficiency virus (HIV) has been the cause of one of the most alarming and devastating pandemics in history. In addition to being a considerable health problem, it threatens the economic and social fabric of many communities.

In the past, humanitarian programmes paid relatively little attention to HIV prevention, treatment and care because HIV was not perceived as an immediate threat to life and therefore not a relief issue. However, the characteristics that define a complex emergency, such as conflict, social instability, poverty, environmental destruction and powerlessness, can increase affected populations' vulnerability and risk to HIV by:

- reducing access to HIV prevention services; breaking down health infrastructure;
- disrupting social support networks; increasing exposure to sexual violence (rape) and sexual abuse (demanding sex in return for food or shelter);
- population movement to an area of higher HIV prevalence.*

Studies have shown that the factors that affect HIV transmission in humanitarian settings are complex, and depend on many dynamic and interacting factors, including the HIV prevalence in the region of origin and that of the host population, the level of interaction between displaced and surrounding populations, the duration of displacement and the location and level of isolation of the displaced population (e.g. urban versus camp-based

* UNAIDS and UNHCR. *Strategies to support the HIV related needs of refugees and host populations*. Geneva, 2005. http://data.unaids.org/publications/IRC-pub06/jc1157-refugees_en.pdf.

HIV

refugees).

When planning HIV programming in humanitarian settings, RH officers and programme managers must consider:

- the combined impact of humanitarian emergencies and HIV, including factors that may increase vulnerability to HIV;
- existing policy and practice in humanitarian response that aim to prevent the spread of HIV and mitigate its impact;
- the availability and accessibility of prevention, care and treatment services for people living with HIV (PLHIV), including interruption, restarting or continuation of antiretroviral treatment;
- stigma and discrimination against people infected and affected by HIV.

2 Objective

The objective of this chapter is to assist RH officers, programme managers and service providers to plan for and implement comprehensive HIV prevention, care and treatment services as part of the humanitarian response.

3 Programming

Priority HIV interventions in a humanitarian response deal with the prevention of HIV transmission, and are included in the MISP (see Chapter 2: MISP). These are:

- Facilitate and enforce respect for standard precautions.
- Make postexposure prophylaxis to prevent HIV transmission (PEP) available (as part of clinical care for rape survivors and occupational exposure).

- Ensure safe blood transfusion practice.
- Make free condoms available.

Also ensure that antiretrovirals (ARVs) are available to continue treatment for people already on ARVs prior to the crisis, including for the prevention of mother-to-child-transmission (PMTCT) (See page 192,ART).

When planning for comprehensive HIV prevention, care and treatment services, address the following programme components:

- Needs assessment
- HIV awareness
- HIV prevention
- HIV counselling and testing
- Prevention of mother-to-child transmission (PMTCT)
- The use of antiretroviral (ARV) for prevention and treatment purposes
- Care for PLHIV
- Care for children living with HIV
- Management of opportunistic infections, STIs and tuberculosis.

3.1 Needs assessment

RH officers and programme managers must collect or estimate the following information for the setting they work in, in coordination with other health sector/cluster actors:

Population characteristics

- HIV prevalence (for both displaced and host populations). This can be found on the UNAIDS website, with the local Joint UN Team on AIDS, as well as with the National AIDS Control Programme.
- Number of PLHIV from the affected

population whose HIV treatment services were disrupted (e.g. PMTCT and antiretroviral therapy (ART) programmes) and who are in need of continuation of ARV regimens.

- Behavioural and environmental factors that might place vulnerable subgroups at increased risk of HIV transmission.

Health services characteristics

- Health facility staff with experience in HIV prevention, treatment and care and training needs of staff.
- National ARV protocols for prevention (PEP, PMTCT) and treatment (ART) and available ARVs.
- Availability of laboratory services.
- Existence of a reliable supply chain that can support sustainable access to HIV commodities.

National legislation and policies

Reproductive health programme managers and service providers must also be familiar with national legislation and policies related to HIV, assess how refugees and IDPs are included and if there are any gender, age or other status-based restrictions. Examples include.

- Laws and/or policies on HIV testing, including pre- and post-test counselling. Are there mandatory testing laws?
- Laws and/or policies related to condom distribution, injecting drug users (IDUs) and harm reduction in the context of injecting drug use.
- Laws and/or policies regarding HIV transmission.
- Laws and/or policies regarding health-care provider disclosure of HIV status.
- Laws and/or policies governing provision of and access to ART.

HIV epidemic characteristics

To have an impact on HIV prevalence, programme efforts must be targeted appropriately. As a useful programming guide, WHO and UN-

AIDS have categorized HIV epidemics in different countries broadly as: low level, concentrated level and generalized epidemics (see Table 24).

3.2 HIV awareness

Incorporate efforts to prevent HIV in humanitarian settings into communication campaigns relevant to the population and the situation.

Communication efforts in the early humanitarian response focus on informing people where they can access basic services. As soon as possible, take into account the characteristics of the population to tailor communications concerning HIV. For example:

- What level of HIV knowledge and common misconceptions of HIV do the people have?
- What common practices put people at risk of HIV transmission?
- What elements of the new situation create risk for HIV transmission?
- What are the common attitudes and beliefs regarding people infected with HIV?

Tailor communication campaigns to create generalized awareness about HIV and acquired immunodeficiency syndrome (AIDS). In addition, design specific communications campaigns to:

- target people who may be vulnerable to practices that increase the risk of HIV transmission. Displaced people face risks because protective community systems are interrupted, sexual networks change and youth often initiate onset of sexual activity earlier;
- reduce discriminatory behaviour and assure care and support of PLHIV.

Community groups, such as health clubs at schools, post-test clubs (including anyone who has been tested for HIV, regardless of serostatus) and Stop-AIDS associations in the police and military, can be effective in motivating their members to practise safer sexual behaviours. Associations of PLHIV can be powerful catalysts

Table 24: HIV Epidemic Scenarios		
	Epidemic scenario	Know your epidemic
Low level	(HIV prevalence < 1%: HIV prevalence has not reached significant levels in any sub-population (this suggests either that networks of risk are diffuse or that the virus has been introduced recently)	Knowledge of risk behaviours, networks and other factors indicating the potential for HIV spread — such as rates of other sexually transmitted infections — is essential for prevention planning
Concentrated	HIV prevalence is high enough (5% or more) in one or more sub-population, such as men having sex with men, injecting drug users or sex workers and their clients, to maintain the epidemic in that sub-population. However, the virus is not circulating in the general population, where the prevalence remains < 1%	The future course of this type of epidemic will be determined by <ul style="list-style-type: none"> • the size of the vulnerable sub-population(s) and • the frequency and nature of interactions between them and the general population
Generalized	HIV prevalence is between 1% and 15% in pregnant women attending antenatal clinics, indicating that HIV prevalence is present among the general population at sufficient levels to enable sexual networking to drive the epidemic. In a population with more than 5% prevalence, every sexually active person has potentially a high risk of infection and no sub-populations are considered “low-risk”	Social norms that lead to multiple sexual partner relations and/or norms and policies that prevent people from protecting themselves (e.g. norms that decrease girls’ access to education and information) are directly implicated in the epidemic dynamics and need to be addressed
<p>An exceptional situation exists in the southern African region, where large numbers of people — over half of them girls and women — are living with HIV. In this hyperendemic scenario, HIV prevalence exceeds 15% in the adult population. These situations require exceptional effort and resources to mobilize entire communities to change sexual behaviours.</p>		

for change of individual and community-wide attitudes.

Essential messages include:

- HIV, the virus that causes AIDS, spreads

through: unprotected sexual intercourse (intercourse without a condom) with someone who is infected with HIV; transfusions of HIV-infected blood; reusing needles and syringes contaminated with HIV; and from an HIV-infected woman to her child during

pregnancy, childbirth or breastfeeding.

- Everyone must know about HIV and AIDS and how to prevent it because AIDS is not curable, only preventable.
- There is an effective treatment for HIV and AIDS that, although it is not a cure, can prolong life if taken lifelong.
- Having a sexually transmitted infection (STI) (e.g. gonorrhoea or syphilis) increases one's risk of transmitting or acquiring HIV.
- The risk of infection through sexual intercourse can be reduced by: using condoms correctly every time; maintaining a mutually monogamous relationship with an uninfected partner; or abstaining from sexual intercourse.
- Everyone who may have been exposed to HIV should consult a qualified health worker for voluntary information, counselling and testing to protect their health.
- Pregnant women should access HIV voluntary counselling and testing (VCT). If infected, they will be offered appropriate medication to reduce the risk of transmitting the infection at delivery or through breastfeeding to their infants.
- Stigma, discrimination, wrong information and negative attitudes towards PLHIV increase the potential for suffering and for the HIV epidemic to spread. Discrimination against PLHIV is a human rights violation.

For more information on communication campaigns, see Chapter 1: Fundamental Principles.

3.3 HIV prevention

It is essential that RH officers and programme managers understand the characteristics of the settings they work in and the population's knowledge and behaviours in order to match HIV programming to those factors. In humanitarian settings, people may engage in behaviours that place them at higher risk of exposure to HIV, even if they do not identify themselves as belonging to an at-risk group.

This section discusses three specific vulnerable groups: injecting drug users (IDUs), men who have sex with men (MSM) and sex workers. Each of these groups has unique characteristics and is discussed separately, although the following elements are consistent for all programmes targeting vulnerable groups:

- Involve vulnerable groups from the start in programme design, implementation and monitoring.
- Locate programme activities in places frequented by the group of interest (clubs, neighbourhoods, etc.).
- Create safe virtual (telephone hotlines) or physical (drop-in centres) spaces tailored to each group where people can comfortably seek information and referrals for care and support.
- Promote consistent and correct use of male and female condoms and ensure their availability, affordability and reliable supply.
- Train health and social workers to provide high-quality, client-friendly, HIV-related services to PLHIV and their partners and families, including STI treatment, VCT, PMTCT, family planning and treatment for tuberculosis (TB) and AIDS.
- Address structural barriers, including policies, legislation and customary practices, that discriminate against the group and prevent access and utilization of appropriate HIV prevention, treatment and care services.

Injecting drug users

While sharing syringes and other equipment for drug injection is a well-known route of HIV transmission, injecting drug use also contributes to the epidemic's spread beyond the circle of those who inject. Sexual partners of an IDU are at risk through sexual transmission. Children born to mothers who contracted HIV through sharing needles or having sexual intercourse with an IDU may become infected as well.

HIV can spread explosively through sharing of contaminated needles among IDUs (prevalence

can expand from 5% to 50% in one year). IDUs may have additional HIV transmission risks such as sex work and imprisonment. The criminalization of injecting drug use can lead to social marginalization and limit access to services. All this can further fuel the epidemic

Harm-reduction measures, such as access to sterile injection equipment, drug dependence treatment, community-based outreach and provision of HIV-prevention information, are among the most effective measures to prevent the spread of HIV. Programmes aiming to reduce IDU-related HIV transmission must provide adequate coverage of sterile injection equipment (including in prisons), good-quality, noncoercive treatment for drug dependence, user-friendly RH and PMTCT services for women IDUs and for sexual partners of IDUs and training for service providers on HIV-related services for IDUs.

Peer-led public health outreach prevention programmes have been shown to work. Key messages may include:

- If you inject drugs, you are at high risk for HIV. Consider getting help from trained professionals to reduce your risk. A drug-addiction treatment programme and counselling are the first steps towards HIV prevention, care and treatment
- If you are on HIV medication, getting “high” increases your chance of forgetting to take the medication. Get a drug buddy/friend to help you remember to take your HIV drugs on schedule.

Men having sex with men (MSM)

MSM refers to all men who have sex with other men, regardless of how they identify themselves (gay, bisexual or heterosexual). MSM practices vary around the world. In order to design appropriate programmes for MSM among displaced populations, it is necessary to understand local social networks and common practices. It is estimated that fewer than one in 20 MSM worldwide have access to HIV prevention, treatment and

care services. Stigmatization, criminalization and discrimination, along with lack of understanding about behaviours and attitudes, are significant barriers to implementing effective programmes.

Where social, cultural and religious attitudes stigmatize MSM, programmes to meet their needs can result in criticism from community leaders and members. However, with funding and support, RH officers and programme managers can design programmes to reverse the spread of HIV among MSM. For example:

- Determine the size and characteristics of the community of MSM among the affected population and involve them in designing and implementing targeted activities.
- Offer specific information on prevention and risk-reduction strategies in communication campaigns, such as consistent and correct use of condoms. Ensure reliable access to condoms and water-based lubricants.
- Offer access to medical and legal assistance for boys and men who experience sexual coercion or violence. Clinical care for both male and female rape survivors is part of the MISP (see Chapter 2: MISP).
- Promote the integration of alternative sexual communities in public awareness campaigns to decrease homophobia.

Sex workers

The exchange of sex for money or goods is present in all communities, including in displaced communities. This includes children and women who do not consider themselves sex workers but who struggle to survive. Therefore, it is of utmost importance to ensure safety, protection and access to food and support for vulnerable people, such as orphans and women as single heads of families.

Protecting sex workers from HIV infection benefits them and the general population. Successful programmes situate their activities in the locations where sex workers can be reached. Programming considerations are:

- Ensure the consistent availability of quality male and female condoms. To see an effective reduction of HIV transmission through sex work requires >90% compliance of correct use of condoms among sex workers and their nonregular sex partners.
- Integrate violence reduction strategies in sex work settings. Programmes should work with law enforcement to ensure the sex workers' ability to protect themselves and to ensure safer sex practices by their clients.
- Engage communities and sex workers in enforcing child protection policies and regulations.
- Link sex workers and their families to support mechanisms, including the provision of assistance and incentives for women to leave sex work through a range of legal, economic and social services.
- Address the "demand" side of sex work — work to change the behaviour of sex workers' clients. Humanitarian staff, peacekeepers, civil police and members of the general population are clients of sex workers in humanitarian settings.

3.4 Voluntary counselling and testing

HIV voluntary counselling and testing (VCT) is not a priority intervention at the onset of a humanitarian response because it is not an immediately life-saving intervention. As soon as the situation is stabilized however, it is important to offer VCT for people who want to know their serostatus. VCT services are standard practice to improve

the health and well-being of individuals and as an entry point to appropriate care and treatment services. Provide counselling to prepare clients for their test result and to encourage behaviour change, whatever the test outcome.

Provider-initiated HIV testing and counselling

In generalized epidemics where an enabling environment is in place and adequate resources are available (including recommended standards for HIV prevention, care and treatment), HIV testing and counselling should be offered by health-care providers as part of standard clinical care. If there are resource and capacity constraints, a phased implementation of this provider-initiated testing and counselling will be needed. The following is a priority list for phased implementation:

1. TB clinics
2. STI services
3. Antenatal, childbirth and postpartum health services
4. Medical inpatient and outpatient facilities

In **low-level and concentrated epidemics**, health-care providers *should not initiate* VCT with every patient attending a health facility, since most people will be at low risk. VCT facilities should be made available in stabilized humanitarian settings, either through established services or mobile clinics.

Some behaviours that put people at a higher risk of exposure to HIV, such as sex work or injecting drug use, also make people more susceptible to coercion, discrimination, violence, abandonment, incarceration or other negative consequences upon disclosure of an HIV-positive test. Health-care providers require special training and supervision to uphold standards of informed consent and confidentiality for these populations. HIV VCT for these groups should be accompanied by the implementation of a supportive social, policy and legal framework.

Quality VCT services

Whether client- or provider initiated, the follow-

Mandatory HIV testing should
NEVER be supported.

*This comprises a violation
of a person's rights.*

ing programme components ensure quality VCT services:

- *Consent, privacy and confidentiality* are essential. HIV testing must only be done on a voluntary basis. Always obtain informed consent before someone undergoes testing. VCT must never be imposed on anyone under any circumstance.
- Make services available free of charge.
- Ensure pre- and post-test counselling is part of all VCT services.
- Post-test support services must be available, including referral networks and access to additional testing (such as a CD4 count) to assess suitability for entry into care and treatment programmes.
- VCT should only be carried out when adequate testing standards are available. Follow the nationally validated testing algorithm for HIV testing, while paying due consideration to specific human rights issues that may arise for the affected population.
- Use testing technologies that are appropriate for the setting, such as rapid tests utilizing finger-stick whole-blood specimens. Obtaining a test result with rapid HIV tests takes less than 30 minutes and is associated with higher rates of successful post-test counselling and follow-up. This supports the decentralization of VCT. Consider local storage conditions and order rapid tests that do not require refrigeration where appropriate.

3.5 ARV and ART interventions

It is important to plan the provision of essential antiretroviral drugs (ARV) and antiretroviral therapy (ART) programmes. Providing HIV-related services to populations in humanitarian settings is a difficult yet critical undertaking, which is firmly rooted in international human rights laws. As with all HIV and AIDS policies and programmes, ART must be linked to prevention, care and support programmes. It should not be implemented as a parallel intervention but rather as an integrated programme linked to other services (e.g. health,

nutrition, education, social services and water and sanitation).

Where ART is available it is important that counselling covers the risks and benefits of ART and the importance of adhering to the treatment schedule.

The essential interventions that use ARVs are:

- Postexposure prophylaxis (PEP)
- Prevention of mother-to-child transmission (PMTCT)
- ART

PEP

RH programme managers must ensure that the prompt administration of PEP (within 72 hours) to reduce the likelihood of HIV transmission is included in protocols for the following two situations:

- **Services for rape survivors:** In order to prevent and manage possible health consequences of rape, survivors must have access to clinical care, including supportive counselling. This care includes the provision of PEP.
- **Occupational exposure:** Despite standard precautions put in place and adhered to in health-care settings, occupational exposure to blood and body fluids potentially infected with HIV may occur, for example through a needle stick injury. Ensure PEP is available in these settings as part of a comprehensive standard precautions package that reduces the likelihood of HIV transmission after such an exposure.

The recommended PEP regimen is a 28-day combination therapy with two nucleoside-analogue reverse-transcriptase inhibitors (NRTIs), often zidovudine and lamivudine. For more detailed information on PEP, please refer to Chapter 2: MISP, p. 32.

WHO promotes a comprehensive strategic approach to the prevention of HIV infection in infants and young children, which consists of:

- primary prevention of HIV infection (see Chapter 9: Sexually Transmitted Infections, section 3.3, STI prevention);
- prevention of unintended pregnancies among women living with HIV (see Chapter 5: Family Planning, section 3.11, FP for people living with HIV);
- prevention of HIV transmission from mothers living with HIV to their infants;
- care, treatment and support for mothers living with HIV, their children and families.

In comprehensive RH programmes, all four components must be implemented in order to reach the overall goal of improving maternal and child health (MCH) in the context of HIV.

PMTCT

This should be read in conjunction with Chapter 6: Maternal and Newborn Health.

In the absence of prophylaxis, the probability that an infant born to an HIV-positive mother will become infected ranges from 20% to 45% among breastfeeding women. Administration of a single dose antiretroviral drug reduces this figure by approximately two-thirds, while using complex regimens of triple-ARV therapy and/or elective caesarean section and avoidance of breastfeeding reduce the probability to less than 2%.

Where a woman who is known to be living with HIV presents for antenatal, delivery or postpartum care, actively pursue the opportunity to prevent transmission of HIV to her infant. For the

implementation of a mother-to-child transmission programme, the following must be established:

- Antenatal care services
- Maternal and child health care, including safe delivery care
- Provider-initiated HIV testing and counselling, using opt-out approach, that is, individuals must specifically decline the HIV test after receiving pretest information if they do not want the test to be performed
- Counselling on infant feeding
- Availability of ARVs and PMTCT protocols (see Table 25).

Infant feeding*

The risk of infants acquiring HIV through breastfeeding must be balanced against the higher risk of death from other causes, such as malnutrition, diarrhoea and pneumonia among non-breastfed infants. Evidence on HIV transmission has shown that exclusive breastfeeding for up to six months is associated with a three- to four-fold decreased risk of transmission of HIV compared to non-exclusive breastfeeding.

RH officers should discuss within the health sector/cluster and with national health authorities to promote a single infant feeding practice across communities as the standard of care. Women who are HIV positive should be counselled and supported to either:

- Breastfeed and receive ARV interventions
- Or**
- When replacement feeding is **acceptable, feasible, affordable, sustainable and safe**, avoid all breastfeeding, because this will give infants the greatest chance of HIV-free survival.

The provision of ARVs to pregnant and breastfeeding women living with HIV and the infant who is breastfeeding is strongly recommended

* This section is based on: *Infant feeding in the context of HIV. Key Messages*, WHO 2009. www.who.int/hiv/pub/paediatric/advice/en/.

and the health sector/cluster should strive to introduce them (see oral antiretroviral prophylaxis below). However, the absence of ARVs does not change the recommendations regarding breastfeeding:

- Exclusive breastfeeding for the first six months of life is recommended for HIV-infected mothers (whose infants are HIV uninfected or of unknown HIV status) unless replacement feeding is acceptable, feasible, affordable, sustainable and safe. At six months, introduce appropriate complementary foods and continue breastfeeding for the first 12 months of life. All breastfeeding should then only stop once a nutritionally adequate and safe diet without breast milk can be provided.
 - If infants and young children are known to be already HIV infected, mothers are strongly encouraged to exclusively breastfeed for the first six months of life and continue breastfeeding as per the recommendations for the general population, that is, up to two years of age or beyond.
 - Whatever the feeding decision, health services should follow up all HIV-exposed infants, and continue to offer infant feeding counselling and support, particularly at key points when feeding decisions may be re-considered, such as the time of early infant diagnosis and at six months of age.
- At minimum, the mother should receive a single dose of Neviraprine (Sd-NVP) 200 mg at the onset of labour and the infant should receive Sd-NVP 2 mg per kg of body weight orally as soon as possible, but no later than 72 hours following birth. While not considered the optimal preventive regimen, the simplicity of this method makes it suitable for humanitarian settings. Programmes using Sd-NVP are a short-term interim measure and steps must be taken to enable more effective regimens to be delivered as soon as possible.
 - If the woman is seen in antenatal care and she is not in need of ART for her own health or if triple ARV drugs are not available, ARV prophylaxis should begin at 14 weeks gestation or as soon as possible thereafter, continuing through delivery and breastfeeding, and after delivery for the infant.

Table 25 provides recommended prophylactic ARV options recommended for HIV-infected women who do not need treatment for their own health.

Follow up children born to mothers living with HIV: initially for post-partum prophylaxis and later to assess their HIV status and offer antiretroviral therapy if needed.

Involve partners in programmes for PMTCT. This is key to ensure support within families.

Where feasible, ensure mothers living with HIV have access to ART (see below). When a pregnant woman meets the criteria,^{FN} start ART as soon as possible. If antiretroviral therapy cannot be started when the mother has developed AIDS, Sd-NVP should NOT be provided to the mother for PMTCT to prevent development of viral resistance to NVP.

If the supply of ARV drugs is insufficient to

For more information on breastfeeding see Chapter 6: Maternal and Newborn Health.

Oral antiretroviral prophylaxis

Mothers known to be HIV-infected should be provided either with life-long ART or antiretroviral (ARV) prophylaxis through pregnancy and breastfeeding.

Prophylactic ARV regimens should start from as early as 14 weeks gestation or as soon as possible when women present late in pregnancy, in labour or at delivery.

^{FN} Start lifelong ART for all pregnant HIV positive women with severe or advanced clinical disease (WHO clinical stage 3 or 4), or with a CD4 count at or below 350 cells/mm³, irrespective of gestational age.

Table 25: ARV Prophylaxis Options Recommended for Pregnant Women Who Do Not Need Treatment for Their Own Health *

Option A: Maternal AZT	Option B: Maternal triple ARV prophylaxis
Mother	Mother
<ul style="list-style-type: none"> • Antepartum daily AZT (>14 weeks gestation) • sd-NVP at onset of labour* • AZT + 3TC during labour and delivery* • AZT + 3TC for 7 days postpartum* <p>*sd-NVP and AZT+3TC intra- and post-partum can be omitted if the mother receives more than 4 weeks of AZT during pregnancy</p>	<p>Triple ARV drugs starting > 14 weeks gestation until one week after breastfeeding has completely stopped. Recommended regimens include:</p> <ul style="list-style-type: none"> • AZT + 3TC + LPV/r • AZT + 3TC + ABC • AZT + 3TC + EFV • TDF + (3TC or FTC) + EFV
Infant	Infant
<p>Breastfeeding infant NVP daily from birth until one week after all exposure to breast milk has ended</p> <p>Non-breastfeeding infant AZT or NVP daily from birth to 6 weeks</p>	<p>Breastfeeding infant NVP daily from birth to 6 weeks</p> <p>Non-breastfeeding infant AZT or NVP daily from birth to 6 weeks</p>
<p>AZT: Azidothymidine, zidovudine; 3T: Lamivudine; Sd-NVP: Single-dose nevirapine; LPV/r: Lopinavir/ritonavir; ABC: Abacavir, EFV: Efavirenz.</p> <p>All regimens are administered by mouth. Paediatric formulations exist for AZT, 3TC and NVP.</p> <p>* From <i>Rapid advice: use of antiretroviral drugs for treating pregnant women and preventing HIV infection in infants</i>. WHO. 2009. www.who.int/hiv/pub/mtct/advice/en/index.html.</p>	

commence antiretroviral therapy for the mother, prophylaxis for the baby may still be offered.

ART

From the beginning of the humanitarian response, ensure continuation of ARV drugs for people who were already enrolled in an ART programme before the onset of a crisis. For patients who are on ART or who were on ART but who no longer have access to the medication, ARV continuity is a priority in order to ensure treatment effectiveness and to avoid

developing viral resistance. The following are recommended:

- An HIV test — or a document — to confirm HIV status and a patient card showing the ART regimen that is/was followed.
- If the individual is currently on ART, continue the treatment without interruption. If there has been treatment interruption, assess the reasons for the interruption and restart the regimen as soon as possible.
- If the same ARV drugs as in the previously followed first-line regimen are not available

and if there is no history of treatment failure or serious adverse reaction to proposed alternative ARVs, substitute another first-line regimen immediately, based on national protocols.

- Patients who were previously taking protease inhibitors that are not available in the changed setting can be prescribed a first-line regimen until second-line regimens become available. However, people who were on protease inhibitors due to an adverse reaction to a first-line regimen must be closely monitored if they are restarted on a first-line regimen. If toxicity recurs and second-line regimens are not available, ART should be discontinued. Continue prevention of opportunistic infections (see 3.6).
- Provide adherence counselling and support in light of the new circumstances.

When refugees and returnees who are on ARV treatment are repatriated to their region or country of origin, ensure that they can continue their treatment without interruption. Link with health authorities in the country or region of origin to coordinate this.

Plan for comprehensive HIV testing and counselling and ART programmes as soon as possible. Before initiating ART services it is important to consider the following questions:

- What is the minimum provision of ARVs that can be made available?
- For how long is funding available? A minimum funding of one year should be guaranteed.
- Can the affected population be enrolled in national ART programmes?
- What are potential procurement and drug management constraints?
- What is the mobility of the population? What are the security situation and future likelihood of displacement that could lead to treatment interruption?
- What is the laboratory capacity (at the health centre and/or the referral level)?

Initiating a minimum package of ART services requires preparation. Ensure that the following are in place:

- Policies, standard operating procedures and standard treatment protocols. When available, national protocols should be followed. In the absence of a national protocol, WHO guidelines should be followed.
- Trained clinic and community workers with competence in treatment protocols, patient counselling and community mobilization.
- A six-month start-up supply of medicines, including ARV, co-trimoxazole, TB treatment and treatment for other opportunistic and co-infections (see 3.6); and a procurement system to assure an uninterrupted supply of required medicines.
- Diagnostic supplies and laboratory capacity, including at least HIV diagnostics, haemoglobin or haematocrit determination, CD4 cell counts, tuberculosis (TB) diagnostics, malaria and syphilis testing.
- A patient monitoring system (including patient treatment cards to provide to patients on ART to allow for follow-up and continued care in another health facility) and referral and communication networks.
- Information packages for patient counselling, education and community mobilization.

3.6 Comprehensive care for PLHIV

Comprehensive care for PLHIV is a component of primary health care that must be available in any humanitarian setting. This is especially important in settings with a generalized epidemic. The elements of comprehensive care include:

- Support to PLHIV
- Patient information and education
- TB treatment and prophylaxis for opportunistic infections
- Family planning
- Community-/home-based care
- Palliative care

Support to PLHIV

Develop confidential programmes to provide psychosocial support for PLHIV. This may include individual counselling and support, support groups or friends of PLHIV and families to whom the patient has disclosed his/her HIV status.

Ensure that PLHIV have nondiscriminatory access to necessary food supplements and nutrition counselling through food assistance programmes. Listing all eligible people without divulging reasons for their inclusion on the supplementary feeding lists helps avoid discrimination.

In humanitarian settings, PLHIV need to be assured of an adequate supply of safe drinking water as they are more susceptible to infection and less able to recover from bouts of water-borne diseases. For similar reasons, provide PLHIV with a Long Lasting Insecticidal Net (LLIN) to reduce the risk of contracting malaria in endemic areas.

Patient information and education

Standard patient information leaflets can be developed, but it is important to consider the following:

- Specific circumstances, including age-appropriate information, language, literacy and level of education
- Information on living with HIV, as well as prevention measures.

TB treatment and prophylaxis for opportunistic infections

In many parts of the world, TB is the leading cause of HIV-related morbidity and mortality. Collaborate with TB control programmes to ensure access for PLHIV to TB treatment. Isoniazid is an effective, well-tolerated and inexpensive antibiotic for TB preventive therapy and should be provided to all people with HIV once active TB disease has been excluded.

To prevent other opportunistic infections in PLHIV, cotrimoxazole is an effective, well-tolerated and inexpensive antibiotic used to prevent pneumocystis pneumonia (PCP) and toxoplasmosis in adults and children with HIV. It is also effective against other infectious and parasitic diseases and demonstrates significant benefits in regions affected by malaria. Furthermore, all HIV-exposed children born to mothers living with HIV must receive cotrimoxazole prophylaxis, commencing at four to six weeks of age and continued until HIV infection can be excluded. In all cases follow national guidelines.

From the start of the humanitarian response, ensure continuation of prophylaxis and refer patients quickly to services providing this.

Family planning

PLHIV must have access to family planning methods and counselling. Offer quality counselling on issues such as contraceptive methods when living with HIV, dual protection with both condoms and another method, emergency contraception, termination of pregnancies and availability of pregnancy support. For more information, see Chapter 5: Family Planning.

Community-/home-based care

It is important to establish a community- or home-based care system to which people with advanced HIV infection can be referred when discharged from the hospital. This is best initiated as soon as the humanitarian situation stabilizes. Clinical and social support for PLHIV must go hand in hand.

Palliative care

Palliative care should cover the management of both acute and chronic symptoms and terminal care. Important elements are pain control, other symptom management, terminal care, backup to any community-/home-based care provided, information and education.

3.7 Care for children with HIV

The following actions are recommended for the care of children with HIV:

- Base initiation of treatment for children on national guidelines.
- Use WHO guidelines for clinical HIV diagnosis where diagnostic and monitoring facilities are not available.
- When ordering syrup formulations, be prepared to have sufficient refrigerated storage space and a functioning cold chain as they come in large volumes.
- In settings where the diagnosis of HIV in children born to HIV-positive mothers may be delayed due to lack of laboratory testing capacity, start these children on cotrimoxazole at around four to six weeks of age or on first contact with health services.
- Where polymerase chain reaction (PCR) monitoring is not available, and in children under 18 months who are diagnosed clinically, counsel parents to seek confirmatory testing after 18 months of age with conventional antibody tests.
- Unaccompanied minors and orphaned children need specific attention and may need to enter a special legal process or agreed-upon guardian/caregiver arrangements.
- The best interests of the child should drive all decisions.

4 Human rights and legal considerations

Ensuring that human rights are respected and protected is critical both for reducing exposure to HIV and to mitigating its adverse effects on individuals and communities. International human rights law contains a number of points that are of direct relevance to people living with or otherwise affected by HIV. The provision of rights promoting HIV interventions is essential in emergency programmes, where sexual violence and reduced access to HIV prevention, care and

treatment services increase the risk of HIV transmission. Key rights issues are:

- **The right to access HIV and AIDS health care:** The right to the highest attainable standard of mental and physical health includes the right to available, accessible, acceptable and quality health facilities, goods and services. Access to HIV programmes must be at least equivalent to those available to others in the surrounding host community. Furthermore, the right to health can only be realized in conjunction with rights to food, water, housing and freedom from discrimination and violence, among other rights.
- **The right to access HIV information and education:** The right to health includes the right to essential health information and education on HIV, as well as sexual and reproductive health.
- **The right to be free from discrimination:** All persons should enjoy the right to be free from discrimination on the basis of gender, sexuality and HIV status and be ensured access to HIV prevention, treatment and care services.
- **The right to voluntary health interventions:** All persons should have the right to provide informed consent and to be free from mandatory HIV testing. The right to physical integrity ensures that all persons have the means to make voluntary, informed decisions about their health care, including whether to learn their HIV status, as well as the right to provide informant consent and to be free from mandatory HIV testing.
- **The right to privacy and confidentiality in HIV-related care:** Guarantees of privacy and confidentiality of health information are essential to ensuring that all persons, including women regardless of marital status, can seek health services without fear that their HIV status will be disclosed.

States have recognized the importance of gender equality, empowerment and participation of

women and girls in all aspects of HIV prevention and response.* In particular, gender-specific protection must be adequately addressed and special attention must be paid to the health needs of women and girls, including ensuring access to RH care and services and appropriate counselling and treatment in all cases of sexual and gender-based violence.

Children are entitled to special protection under the law, as highlighted by the UN Committee on the Rights of the Child. In particular the Convention on the Rights of the Child should guide the responses in all cases involving children, including: nondiscrimination; best interests of the child; the right to life; survival and development; and participation of the child.

4.1 Challenges and opportunities

RH officers, programme managers and service providers must be familiar with national legislation and policies and guidelines pertaining to HIV prevention, treatment and care in the country. In some instances human rights may be compromised by national law or policies or even social and cultural misconceptions. It is important to discuss potential dilemmas with teams and supervisors and decide on the type of engagement of your organization. Important immediate steps service providers can undertake are to ensure that they inform clients directly on possible negative consequences of the law. Furthermore, it is important to explore referral possibilities for clients to another agency or organization that could provide legal support and assistance. Organizations may decide to advocate on the issue and contribute to joint agency advocacy efforts.

* Declaration of commitment on HIV/AIDS (General Assembly Resolution A/RES/S-26/2 of 2 Aug 2001). Paras 14,37,58-62.

5 Monitoring

The following indicators can be used to monitor comprehensive HIV programmes:

- Quality of blood donation screening: The proportion of donated blood units that were screened for HIV in a quality assured manner
- Condom use rate: The proportion of sexually active people who reported condom use at last intercourse
- VCT post-test counselling and result: The proportion of VCT clients tested for HIV, who received their post-test result and counseling
- PMTCT coverage: The proportion of first ANC visit clients who were pre-test counselled
- Coverage of ARV in PMTCT programmes: The ratio of mother-newborn pairs that swallowed ARV on time

For more information on monitoring and evaluation see Chapter 3.

6 Further reading

Essential reading

Priority interventions: HIV/AIDS prevention, treatment and care in the health sector. World Health Organization (WHO), Geneva, 2008. http://www.who.int/pmnch/topics/hiv_aids/priorityinterventions/en/

Rapid advice documents: *Antiretroviral therapy for adults and adolescents; use of antiretroviral drugs for treating pregnant women and preventing HIV infection in infants, Infant feeding in the context of HIV.* www.who.int/hiv/pub/mtct/advice/en/index.html

Antiretroviral drugs for treating pregnant women and preventing HIV infection in infants: towards universal access: recommendations for a public health approach. WHO, Geneva, 2006. <http://www.who.int/hiv/pub/guidelines/pmtctguide->

lines3.pdf

Engender Health. *HIV Prevention in Maternal Health Services; Programming Guide*. United Nations Population Fund, 2004. <http://www.engenderhealth.org/pubs/hiv-aids-sti/hiv-prevention-in-maternal-health.php>

Clinical Guidelines for antiretroviral therapy management for displaced populations. Southern Africa. Southern African HIV Clinicians Society/ UNHCR, 2007. <http://www.unhcr.org/4683b0522.html>

UNHCR and Infant Feeding in Emergencies. Guidance on infant feeding and HIV in emergencies for refugees and displaced populations. UNHCR, Geneva, 2008. <http://www.enonline.net/ife>

Guidelines for addressing HIV in Humanitarian Settings, Interagency Standing Committee. 2009. http://www.aidsandemergencies.org/cms/documents/IASC_HIV_Guidelines_2009_En.pdf