

GUIDELINES

for HIV/AIDS interventions in emergency settings



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Acknowledgements

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The Inter-Agency Standing Committee (IASC) was established in 1992 in response to General Assembly Resolution 46/182 that called for strengthened coordination of humanitarian assistance. The resolution set up the IASC as the primary mechanism for facilitating inter-agency decision-making in response to complex emergencies and natural disasters. The IASC is formed by the representatives of a broad range of UN and non UN humanitarian partners, including UN agencies, NGOs, and international organizations such as World Bank and the Red Cross Movement.¹

These *Guidelines* are to be field tested. Users will be invited to provide comments to the Task Force.

Preface

The Inter-Agency Standing Committee (IASC) is issuing *Guidelines for HIV/AIDS interventions in Emergency Settings* to help individuals and organizations in their efforts to address the special needs of HIV-infected and HIV-affected people living in emergency situations. The *Guidelines* are based on the experiences of organizations of the UN system and their NGO partners, and reflect the shared vision that success can be achieved when resources are pooled and when all concerned work together.

It is difficult to grasp the scale of devastation that HIV/AIDS engenders in stable societies. It is even harder to gauge the impact of the pandemic on people whose lives have been uprooted by conflict and disaster. In January 2003, the IASC issued a statement in which it committed itself to “redoubling our individual and joint agency responses to promote a comprehensive, multi-faceted approach to this unprecedented crisis” as it faced the impact of HIV/AIDS on food security and human survival, as evidenced in southern Africa.

Over the ensuing months, the IASC undertook to develop a practical handbook that could be put to immediate use for the benefit of those who most need our commitment and support. We trust that these *Guidelines* will serve that aim.



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Emergency Relief Coordinator
and Under-Secretary-General for Humanitarian Affairs

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List of acronyms

AIDS	Acquired immunodeficiency syndrome
ARV	Antiretrovirals
BCC	Behaviour change communication
CAP	Consolidated appeal process
CBO	Community based organization
CBR	Crude birth rate
CHAP	Common humanitarian action plan
CSO	Country support offices
EPI	Expanded programme on immunization
HIV	Human immunodeficiency virus
HH	Household(s)
IDP	Internally displaced persons
IDU	Intravenous drug users
IEC	Information, education and communication
MCH	Mother and child health
MISP	Minimum initial service package
MOH	Ministry of health
NGO	Nongovernmental organizations
PEP	Post exposure prophylaxis
PTA	Parent/teacher associations
PLWHA	People living with HIV/AIDS
RH	Reproductive health
SGBV	Sexual and gender based violence
STI	Sexually transmitted infections
TB	Tuberculosis
VCT	Voluntary counselling and testing

Chapter 1: Introduction

Over the last two decades, complex emergencies resulting from conflict and natural disasters have occurred with increasing frequency throughout the world. At the end of 2001, over 70 different countries experienced an emergency situation, resulting in over 50 million affected persons worldwide. Sadly, the very conditions that define a complex emergency - conflict, social instability, poverty and powerlessness - are also the conditions that favour the rapid spread of HIV/AIDS and other sexually transmitted infections.

The rationale for a specific HIV/AIDS intervention in crises

At the end of 2002, there were 42 million people worldwide living with HIV/AIDS. The long-term consequences of HIV/AIDS are often more devastating than the conflicts themselves: mortality from HIV/AIDS each year invariably exceeds mortality from conflicts. Most people are already living in precarious conditions and do not have sufficient access to basic health and social services.

During a crisis, the effects of poverty, powerlessness and social instability are intensified, increasing people's vulnerability to HIV/AIDS. As the emergency and the epidemic simultaneously progress, fragmentation of families and communities occurs, threatening stable relationships. The social norms regulating behaviour are often weakened. In such circumstances, women and children are at increased risk of violence, and can be forced into having sex to gain access to basic needs such as food, water or even security. Displacement may bring populations, each with different HIV/

AIDS prevalence levels, into contact. This is especially true in the case of populations migrating to urban areas to escape conflict or disaster in the rural areas.

As a consequence, the health infrastructure may be greatly stressed; inadequate supplies may hamper HIV/AIDS prevention efforts. During the acute phase of an emergency, this absence or inadequacy of services facilitates HIV/AIDS transmission through lack of universal precautions and unavailability of condoms. In war situations, there is evidence of increased risk of transmission of HIV/AIDS through transfusion of contaminated blood.

The presence of military forces, peacekeepers, or other armed groups is another factor contributing to increased transmission of HIV/AIDS. These groups need to be integrated in all HIV prevention activities.

Recent humanitarian crises reveal a complex interaction between the HIV/AIDS epidemic, food insecurity and weakened governance. The interplay of these forces must be borne in mind when responding to emergencies.

There is an urgent need to incorporate the HIV/AIDS response into the overall emergency response. If not addressed, the impacts of HIV/AIDS will persist and expand beyond the crisis event itself, influencing the outcome of the response and shaping future prospects for rehabilitation and recovery. Increasingly, it is certain that, unless the HIV/AIDS response is part of the wider response, all efforts to address a major humanitarian crisis in high prevalence areas will be insufficient.

Purpose of the guidelines

The purpose of these guidelines is to enable governments and cooperating agencies, including UN Agencies and NGOs, to deliver the *minimum* required multi-sectoral response to HIV/AIDS during the early phase of emergency situations. These guidelines, focusing on the early phase of an emergency, should not prevent organizations from integrating such activities in their preparedness planning. As a general rule, this response should be integrated into existing plans and the use of local resources should be encouraged. A close and positive relationship with local authorities is fundamental to the success of the response and will allow strengthening of the local capacity for the future.

Target audience

These guidelines were designed for use by authorities, personnel and organizations operating in emergency settings at international, national and local levels. The guidelines are applicable in any emergency setting, regardless of whether the prevalence of HIV/AIDS is high or low. For example, even in low prevalence settings, a breakdown in the health infrastructure can cause increased transmission of HIV/AIDS if health care workers do not follow universal precautions against blood-borne diseases. Certainly the guidelines should be applied in emergency settings with high HIV/AIDS prevalence, where an integrated response is urgently needed in order to prevent the epidemic from having an even greater and more devastating impact.

Although HIV/AIDS is not given as high a priority in low prevalence settings, this

does not mean that emergency response personnel in low-prevalence settings can be complacent. Even in low prevalence settings, advocacy is needed to raise awareness of the importance of integrating emergency responses and HIV/AIDS prevention and care programming. At the very least, key actors in any emergency response situation, along with the relevant authorities and existing response teams, should establish coordination mechanisms to decide the appropriate minimum response for their geographic area based on these *Guidelines* and the existing response to the disease.

Description of chapters, sectors and the Matrix

This document consists of four chapters, the last being the *Guidelines* themselves. Chapters 1 through 3 provide background and orientation information. Chapter 4, recognizing that any response to a disaster will be multi-sectoral, describes specific interventions on a sector-by-sector basis.

The sectors are:

1. Coordination
2. Assessment and monitoring
3. Protection
4. Water and sanitation
5. Food security and nutrition
6. Shelter and site planning
7. Health
8. Education
9. Behaviour change communication (BCC)
10. HIV/AIDS in the workplace

A Matrix, incorporating these sectors, provides a quick-but-detailed overview of the various responses. The Action sheets, one for each sector, provide more in-depth information.

The Matrix, shown on pages 16 - 19, is divided into columns according to specific phases of the emergency: emergency preparedness, minimum response and comprehensive response. These *Guidelines* give emphasis to the *minimum* required actions needed in order to manage HIV/AIDS in the midst of an emergency. Each of the bullet points in the sectors in the minimum response column corresponds to an Action sheet that provides information on the minimum activities that should be undertaken to consider HIV/AIDS in the overall response to the crisis. It also shows the interaction between the different sectors.

Use of the companion CD-ROM

A companion CD-ROM disk is attached to the back inside cover of this book. It contains many of the articles, documents, and training materials mentioned here in the printed text. Additionally, the entire text is reproduced in other formats: Adobe Acrobat™, HTML (for users who wish to display the text within a web browser), and Microsoft Word. For PC users, the CD-ROM, upon insertion into a CD-ROM player, will automatically launch itself in a browser such as Internet Explorer or Netscape. From the top page, users can navigate to materials cited in the text, footnotes and reference sections of the text. There are also links to organizations and other resources. The CD-ROM will be updated every year, with new materials added as they become available.

Chapter 2: The context: Addressing HIV/AIDS in emergency settings

While the impact of HIV/AIDS is generally well documented and understood, considerably less attention has been given to the spread of HIV/AIDS in emergency settings.

In the past three years, however, spurred by Security Council Resolution 1308 on HIV/AIDS and Peacekeepers (2000), and the Graça Machel's study on the Impact of Conflict on Children (2000), there have been increased efforts to describe how HIV spreads in emergency settings. In addition, a number of humanitarian organizations have made efforts to prevent new transmission and provide support for those already affected even in the midst of an emergency. Little by little, data is being collected, lessons are being learned and practices shared.

From the information available to date, the thinking on HIV transmission in emergency settings is that:

- The risk of HIV transmission appears to be low in places with low HIV prevalence rates at the beginning of an emergency, and where populations remain isolated. This appears to remain true even when there are high levels of risk behaviours such as rape. Sierra Leone and Angola during the conflict years typify this scenario.
- War can accelerate the transmission of HIV in places where rape and sexual exploitation are superimposed on high levels of HIV before the beginning of an emergency. Causality, however, is difficult to determine, as it is almost impossible to know if survivors

of rape became infected because of the rape, or were already infected. Examples of this situation can be found during the genocide in Rwanda and in Eastern Democratic Republic of Congo today.

- In areas affected by natural disaster, the impact of HIV depends on existing HIV prevalence rates and the capacity of the government, international agencies, donors and civil society to respond. In 2002-2003, when Southern Africa went through a food shortage, it is believed that people with HIV, already poorer because of lost household income and greater medical expenses incurred by the person living with AIDS, suffered disproportionately when faced with lack of food caused by the regional shortage.

It is important to remember, however, that significant work remains to be done in accurately assessing prevalence rates and information related to risk behaviours for HIV in emergency settings.

Risk of transmission in emergency contexts

Although arriving at definitive conclusions is based on the scant HIV prevalence data available in emergency settings, we do know that many of the conditions that facilitate the spread of HIV are common in these settings.

Such conditions include but are not limited to:

- Rape and sexual violence, including rape used as a weapon of war by fighting forces against civilians. This is most often exacerbated by impunity for crimes of sexual violence and exploitation
- Severe impoverishment that often leads

women and girls with few alternatives but to exchange sex for survival

- Mass displacement which leads to break up of families and relocation into crowded refugee and internally displaced camps where security is rarely guaranteed
- Broken down school, health and communication systems usually used to programme against HIV transmission.
- Limited access to condoms and treatment for sexually transmitted infections.

droughts, earthquakes, and floods, as well as situations of armed conflict. A complex emergency is a humanitarian crisis where a significant breakdown of authority has resulted from internal or external conflict, requiring an international response that extends beyond the mandate of one single agency. Such emergencies have a devastating effect on great numbers of children and women, and call for a complex range of responses.

People already living with HIV/AIDS in emergencies

In general, people already infected with HIV are at greater risk of physically deteriorating during an emergency because:

- People living with HIV/AIDS are more prone to suffer from disease and death as a consequence of limited access to food, clean water, and good hygiene than are people with functioning immune systems.
- Caretakers may be killed or injured during an emergency leaving behind children already made vulnerable by infection with HIV/AIDS or loss of parents to AIDS.
- Health care systems break down (attacks on health centres, inability to provide supplies, flight of health care staff), and populations have limited access to health facilities because roads are blocked or mined, and financial resources are even more limited than usual.

What should be done for HIV/AIDS in emergencies?

For years, humanitarian organizations have ignored HIV in emergencies, focusing their attention on life-saving measures such as health, water, shelter and food. HIV was not seen as a direct threat to life. Recently, however, a number of humanitarian organizations have realized the importance of preventing HIV transmission early on in an emergency.

The WHO, UNAIDS, UNHCR 1996 *Guidelines on HIV/AIDS in Emergencies*, followed by the Minimum Initial Service Package (MISP) on reproductive health, provided the first guidance on how to prevent HIV transmission during an emergency. However, little implementation of these guidelines occurred, often due to competing priorities, lack of funds, poor coordination by humanitarian organizations, and a lack of importance given to the issue. In addition, these guides provided a medicalized approach to the problem and did not sufficiently call for a multi-sectoral response to HIV in emergencies.

What is meant by an emergency?

An emergency is a situation that threatens the lives and well-being of large numbers of a population, extraordinary action being required to ensure the survival, care and protection of those affected. Emergencies include natural crises such as hurricanes,

Since 2000, there has been a greater acceptance of HIV as an emergency concern in the humanitarian field accompanied by

the realization that HIV/AIDS must be dealt with through a multi-sectoral response.

These *Guidelines* present such a multi-sectoral approach to preparing for and responding to HIV in emergencies. They provide guidance for humanitarian coordinators on what to do, and detail for implementing organizations on how to do it. They are based on the understanding that all humanitarian actors involved have a degree of responsibility within their mandate to prevent and mitigate HIV and AIDS. Effective implementation will rely on strong collaboration between international agencies, local authorities and local groups and NGOs who are instrumental in reaching vulnerable populations.

Emergency preparedness and response

Emergency preparedness focuses on addressing the causes of the emergency with a view to avoiding its recurrence or mitigating its impact and strengthening resilience, especially on vulnerable households and communities, and building up 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.

Disaster preparedness includes the continuous collection and analysis of relevant information and activities in order to prepare for and reduce the effects of disasters such as:

- predicting hazards by identifying and mapping key threats;
- assessing the geographical distribution of areas vulnerable to seasonal threats;

- defining which groups and communities are more at risk;
- assessing strengths and coping mechanisms of vulnerable groups and their capacity to respond to a threat; and
- identifying gaps in government preparedness plans and advocating with policymakers to ensure that plans are developed that aim to reduce the disaster's impact on vulnerable populations.

Emergency preparedness plans are developed in order to minimize the adverse effects of a disaster, and to ensure that the organization and delivery of the emergency response is timely, appropriate and sufficient. Such preparedness plans should be part of a long-term development strategy and not introduced as a last-minute response to the unfolding emergency. In the case of HIV/AIDS, such preparedness means that all relief workers would have received a basic training, before the emergency, in HIV/AIDS, as well as sexual violence, gender issues, and non-discrimination towards HIV/AIDS patients and their caregivers. It also implies that adequate and appropriate supplies specific to HIV are pre-positioned. These are crosscutting issues which are relevant to all sectors.

A disaster preparedness plan should put in place certain elements in order to bring about a successful response:

- a solid needs assessments that will allow relief agencies to jointly determine who does what and where, under the umbrella of a comprehensive humanitarian action plan;
- staff properly trained and emergency response tools available on time;
- common tools for natural disasters and complex emergencies;

- funding mechanisms that ensure money is readily available, and
- information management network available to key decision-makers.

Linking with a comprehensive response

The rehabilitation and recovery phases of an emergency cycle permit a more comprehensive response, built upon the initial minimum response and enhancing coverage and sustainability.

In the Matrix, presented below, the comprehensive response specifies the activities to be undertaken following the initial phase. The rehabilitation phase can last until the situation causing the emergency has returned to normal. During the comprehensive phase, it is important to coordinate activities with the local authorities and among the various actors providing services to the population.

Since the present *Guidelines* concentrate on addressing the minimum required actions to address HIV/AIDS issues in an emergency, emphasis is given herein to necessary and feasible interventions. However, emergency responses clearly should not be limited to the minimum required actions; more comprehensive actions need to occur as soon as possible to ensure appropriate rehabilitation and recovery. In at-risk areas ("chronic vulnerable areas," drought-prone areas) where crises are known to be recurrent or of slow onset, prevention and emergency preparedness should be a priority.

Groups at risk: women

In emergencies, women are highly vulnerable to HIV/AIDS. In times of civil strife, war and displacement, women and children are at increased risk of sexual violence and abuse. In acute emergency situations where there is severe food insecurity and hunger, women and girls may find themselves coerced to engage in casual or commercial sex as a survival strategy to gain access to food and other fundamental needs. In addition, the disruption of communities and families, particularly when people flee from their land, involves the break-up of stable relationships and the dissolution of social and familiar cohesion, thus facilitating a context of new relationships with high-risk behaviour.

Groups at risk: children

Emergencies also aggravate the vulnerable condition of children affected by the HIV/AIDS epidemic, including orphans, HIV infected children, and child-headed households. Displaced people and refugee children confront completely new social and livelihood scenarios with notable vulnerability, a circumstance that facilitates HIV transmission and aggravates AIDS impact on well being. Emergency situations also deprive children of education opportunities, including the opportunity to learn about HIV/AIDS and basic health. Children in situations of armed conflicts, and displaced, migrant and refugee children are particularly vulnerable to all forms of sexual exploitation.

Groups at risk: mobile populations

Emergencies often result in the movement or displacement of people. Displaced persons, refugees, returnees and demobilised military personnel including children soldiers are among society's most vulnerable. Most are separated from their families, spouses or partners. They are exposed to unique pressures, working constraints, and living conditions. They are often seen as a threat to the cultural integrity or to job security of the hosting population, a misperception that often gives rise to xenophobia. They feel anonymous and tend to cluster on the margins of cities, or are housed in camps that were intended to be temporary, or to have no homes at all. Vulnerability to HIV infection is greatest when people live and work in conditions of poverty, social exclusion, loneliness and anonymity. These factors may provoke risk-taking behaviours that would not have been exhibited prior to displacement.

sources and disrupting their agricultural and livelihood systems. Civil strife and war further exacerbate both their poverty and their vulnerability, leading to acute emergencies where poor people endure starvation, fear for their survival, and may be forced to flee from their homes and land. Forced migration of the rural poor towards cities increases the risk of contracting HIV/AIDS, as sero-prevalence in urban areas is higher. Rural populations are also less aware of the means of prevention and might lack access to them.

Groups at risk: the rural poor

People in the developing world, particularly the rural poor, are highly vulnerable to disasters. In fact, most emergencies involve poor people living in rural areas. Poor communities and households have fewer means to protect themselves from, and to cope with, the consequences of natural disasters. Due to their poverty they also are often forced to live in areas that are prone to natural disasters such as landslides or floods. Access to basic health services is often minimal or non-existent.

Climatic and agricultural disasters, such as drought and large-scale pest infestations, hit rural people hardest, devastating their food

Chapter 3: The Matrix

The Matrix (shown on pages 16 - 19, and also as a separate sheet intended for posting to a wall) provides guidance on key actions for responding to HIV/AIDS in emergencies. The Matrix is divided into three parts: Emergency preparedness, Minimum response, and Comprehensive response.

Each programmatic sector on the chart provides guidance on responding appropriately to HIV/AIDS in emergency situations. Only the minimum response phase is presented in the Action sheets. The country's or region's situation and capacity assessment will help determine which additional HIV/AIDS responses should be undertaken. Detailed action points for each of the bullets of the Matrix are provided in the Action sheets on the subsequent pages.

- 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.
- 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.

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 multi-sectoral 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.

Sectoral response	Emergency preparedness
<p>1. Coordination</p>	<ul style="list-style-type: none"> • Determine coordination structures • Identify and list partners • Establish network of resource persons • Raise funds • Prepare contingency plans • Include HIV/AIDS in humanitarian action plans and train accordingly relief workers
<p>2. Assessment and monitoring</p>	<ul style="list-style-type: none"> • Conduct capacity and situation analysis • Develop indicators and tools • Involve local institutions and beneficiaries
<p>3. Protection</p>	<ul style="list-style-type: none"> • Review existing protection laws and policies • Promote human rights and best practices • Ensure that humanitarian activities minimize the risk of sexual violence, and exploitation, and HIV-related discrimination • Train uniformed forces and humanitarian workers on HIV/AIDS and sexual violence • Train staff on HIV/AIDS, gender and non-discrimination
<p>4. Water and sanitation</p>	<ul style="list-style-type: none"> • Train staff on HIV/AIDS, sexual violence, gender, and non-discrimination
<p>5. Food security and nutrition</p>	<ul style="list-style-type: none"> • Contingency planning/preposition supplies • Train staff on special needs of HIV/AIDS affected populations • Include information about nutritional care and support of PLWHA in community nutrition education programmes • Support food security of HIV/AIDS-affected households
<p>6. Shelter and site planning</p>	<ul style="list-style-type: none"> • Ensure safety of potential sites

Minimum response (to be conducted even in the midst of emergency)	Comprehensive response (Stabilized phase)
1.1 Establish coordination mechanism	<ul style="list-style-type: none"> • Continue fundraising • Strengthen networks • Enhance information sharing • Build human capacity • Link HIV emergency activities with development activities • Work with authorities • Assist government and non-state entities to promote and protect human rights
2.1 Assess baseline data 2.2 Set up and manage a shared database 2.3 Monitor activities	<ul style="list-style-type: none"> • Maintain database • Monitor and evaluate all programmes • Assess data on prevalence, knowledge attitudes and practice, and impact of HIV/AIDS • Draw lessons from evaluations
3.1 Prevent and respond to sexual violence and exploitation 3.2 Protect orphans and separated children 3.3 Ensure access to condoms for peacekeepers, military and humanitarian staff	<ul style="list-style-type: none"> • Involve authorities to reduce HIV-related discrimination • Expand prevention and response to sexual violence and exploitation • Strengthen protection for orphans, separated children and young people • Institutionalize training for uniformed forces on HIV/AIDS, sexual violence and exploitation, and non-discrimination • Put in place HIV-related services for demobilized personnel • Strengthen IDP/refugee response
4.1 Include HIV considerations in water/sanitation planning	<ul style="list-style-type: none"> • Establish water/sanitation management committees • Organize awareness campaigns on hygiene and sanitation, targeting people affected by HIV
5.1 Target food aid to affected and at-risk households and communities 5.2 Plan nutrition and food needs for population with high HIV prevalence 5.3 Promote appropriate care and feeding practices for PLWHA 5.4 Support and protect food security of HIV/AIDS affected & at risk households and communities 5.5 Distribute food aid to affected households and communities	<ul style="list-style-type: none"> • Develop strategy to protect long-term food security of HIV affected people • Develop strategies and target vulnerable groups for agricultural extension programmes • Collaborate with community and home based care programmes in providing nutritional support • Assist the government in fulfilling its obligation to respect the human right to food
6.1 Establish safely designed sites	<ul style="list-style-type: none"> • Plan orderly movement of displaced

Sectoral response	Emergency preparedness
<p>7. Health</p>	<ul style="list-style-type: none"> • Map current services and practices • Plan and stock medical and RH supplies • Adapt/develop protocols • Train health personnel • Plan quality assurance mechanisms • Train staff on the issue of SGBV and the link with HIV/AIDS • Determine prevalence of injecting drug use • Develop instruction leaflets on cleaning injecting materials • Map and support prevention and care initiatives • Train staff and peer educators • Train health staff on RH issues linked with emergencies and the use of RH kits • Assess current practices in the application of universal precautions
<p>8. Education</p>	<ul style="list-style-type: none"> • Determine emergency education options for boys and girls • Train teachers on HIV/AIDS and sexual violence and exploitation
<p>9. Behaviour change communication and information education communication</p>	<ul style="list-style-type: none"> • Prepare culturally appropriate messages in local languages • Prepare a basic BCC/IEC strategy • Involve key beneficiaries • Conduct awareness campaigns • Store key documents outside potential emergency areas
<p>10. HIV/AIDS in the workplace</p>	<ul style="list-style-type: none"> • Review personnel policies regarding the management of PLWHA who work in humanitarian operations • Develop policies when there are none, aimed at minimising the potential for discrimination • Stock materials for post-exposure prophylaxis (PEP)

Minimum response (to be conducted even in the midst of emergency)	Comprehensive response (Stabilized phase)
<p>7.1 Ensure access to basic health care for the most vulnerable</p> <p>7.2 Provide condoms and establish condom supplies</p> <p>7.3 Establish syndromic STI treatment</p> <p>7.4 Ensure IDU appropriate care</p> <p>7.5 Manage the consequences of SV</p> <p>7.6 Ensure safe deliveries</p> <p>7.7 Ensure safe blood transfusion services</p>	<ul style="list-style-type: none"> • Forecast longer-term needs; secure regular supplies; ensure appropriate training of the staff • Palliative care and home based care • Treatment of opportunistic infections and TB control programmes • Provision of ARV treatment • Ensure regular supplies, include condoms with other RH activities • Reassess condoms based on demand • Management of STI, including condoms • Comprehensive sexual violence programmes • Control drug trafficking in camp settings • Use peer educators to provide counselling and education on risk reduction strategies • Voluntary counselling and testing • Reproductive health services for young people • Prevention of mother to child transmission
<p>8.1 Ensure children's access to education</p>	<ul style="list-style-type: none"> • Educate girls and boys (formal and non-formal) • Provide lifeskills-based HIV/AIDS education • Monitor and respond to sexual violence and exploitation in educational settings
<p>9.1 Provide information on HIV/AIDS prevention and care</p>	<ul style="list-style-type: none"> • Scale up BCC/IEC • Monitor and evaluate activities
<p>10.1 Prevent discrimination by HIV status in staff management</p> <p>10.2 Provide post-exposure prophylaxis (PEP) available for humanitarian staff</p>	<ul style="list-style-type: none"> • Build capacity of supporting groups for PLWHA and their families • Establish workplace policies to eliminate discrimination against PLWHA • Post-exposure prophylaxis for all humanitarian workers available on regular basis

Chapter 4: The Guidelines

Sector 1: Coordination

Phase: Minimum response

Action sheet 1.1:

Establish coordination mechanisms

► Background

The main goal of all humanitarian coordination efforts is to meet the needs of the affected populations in an effective and coherent manner. The presence of HIV/AIDS adds a further dimension to both the crisis and its aftermath. The interplay between the epidemic and emergency settings results in:

- people affected by the crisis being at greater risk of contracting HIV/AIDS;
- households affected by HIV/AIDS having to face the additional burden of the crisis and who may not be able to benefit from emergency relief interventions;
- disruption of existing HIV/AIDS programmes and activities; and
- individuals and organizations external to the area (including humanitarian and military personnel) being more vulnerable to HIV/AIDS and STI, and thereby contributing further to the spread of the epidemic.

It is therefore essential to:

- identify the different actors, and to ensure appropriate coordination;
- raise the awareness and motivation of decision-makers to improve projects, programmes and policies;

- strengthen the capacity of institutions working in affected areas;
- ensure the dissemination of relevant information and facilitate provision of technical assistance to users.

Existing HIV/AIDS coordination mechanisms (including National AIDS programmes, UN theme groups on HIV/AIDS) should ensure that ongoing national policies and plans do not exclude emergency-affected areas, and that the special risks and vulnerabilities of internally displaced persons, refugees and other affected groups are given proper consideration. Coordination is needed at the local, regional, national and international levels.

Coordination works best when relevant organizations and stakeholders are involved in the definition of a common set of ethical and operational standards. This allows for true complementarity with due mutual respect for each other's mandates and roles.

► Key actions

▼ Set up and strengthen coordination mechanisms

- Identify and ensure collaboration of existing regional, national and local coordination bodies (for HIV/AIDS and for emergencies). This includes the Humanitarian coordinator and the Office for the coordination of humanitarian affairs (OCHA) and UNAIDS. Define and map the mandate and strengths of each stakeholder to avoid duplication and identify gaps.
- Identify an office or some central point as the focal point for the coordination effort, and appoint staff as needed. Put in place record-keeping

mechanisms and procedures to ensure all stakeholders are informed.

- Promote the incorporation of HIV/AIDS prevention, care and mitigation into situation assessments, emergency preparedness plans and the overall humanitarian response.
- Review existing information and carry out local needs assessments to identify populations most at risk and priority areas for interventions.
- Incorporate HIV/AIDS considerations into donor appeals (including CAP and CHAP) and assist in the development of specific HIV/AIDS related appeals.
- Maintain a constant dialogue with donors on the overall funding, including monitoring and evaluation of activities funded.
- Identify and report shortfalls in funding to the international community.
- Institute ongoing review of the operating environment to ensure that effective contingency plans are elaborated for any possible change.

▼ Raise awareness of decision makers and programme managers

- Organize information and advocacy seminars at central level.
- Promote the incorporation of HIV/AIDS in emergencies on agendas of relevant coordination mechanisms at national level.
- Promote the review of HIV/AIDS national strategic plans to adjust to the evolving imperatives of responding to HIV/AIDS in emergencies.
- Collaborate with media organizations to explain to donors and partners the links between HIV/AIDS and the emergency.

▼ Raise awareness and/or train local institutions in areas affected by HIV/AIDS

- Joint field visits by representatives of relevant national coordinating bodies³ to relevant administrative areas with the aim of:
 - exchanging information by contacting local authorities and key humanitarian actors, and
 - organizing training and awareness raising workshop for local institutions. (Duration: approximately 2 days, which can be adjusted according to time constraints);
- Activities should ensure that:
 - HIV/AIDS in emergencies is included on the agenda of relevant local coordination mechanisms;
 - Simple reporting and information-sharing systems are set up at local level;
 - Complementary local needs assessments are carried out to identify populations most at risk and priority areas for interventions;
 - Periodic support missions are undertaken by representatives of relevant coordinating bodies at country level and/or national centre of expertise.

▼ Provide information and technical assistance

- Ensure that appropriate support is provided to all stakeholders for strategic planning, assessment, monitoring and analysis in relation to HIV/AIDS in emergency-affected areas.
- Review, share, and discuss the existing information with relevant stakeholders, and inform populations of the risks posed by HIV/AIDS.
- Ensure that regular and consistent

reports are made available to all stakeholders on how HIV/AIDS is being addressed throughout the humanitarian response. The focal point/coordination body is responsible for maintaining a network of communication between all stakeholders.

- Ensure that information, reference material and tools are made available;
- Ensure that national reference systems and networks are set up to facilitate exchange of information and advice;
- Develop central web page to store and facilitate access to display relevant information and resources, if appropriate.

► Key resources

Guidelines on how to integrate HIV/AIDS in the Consolidated Appeals Process.

The impact of HIV/AIDS on food security.
www.fao.org/docrep/meeting/003/Y0310E.htm

Food security and HIV/AIDS: an update.
www.fao.org/DOCREP/MEETING/006/Y9066e/Y9066e00.HTM

The silent emergency: HIV/AIDS in conflicts and disasters, CAFOD.

Sowing Seeds of Hunger: a Video Documentary. (copies can be obtained from FAO upon request)
<http://www.fao.org/english/newsroom/focus/2003/aids.htm>

Websites:

www.unaids.org

www.reliefweb.int

www.fao.org/hiv/AIDS/

Action sheet 2.1: Assess baseline data

► Background

In order to coordinate and cooperate with other organizations and authorities, it is essential to set up a standardized database. It will allow common understanding and follow up of the epidemiological situation. A variety of factors influence the transmission of HIV in emergency settings, including:

- the existing sero-prevalence rates in displaced populations and surrounding communities,
- the prevalence and types of sexually transmitted infections (STI),
- the level and types of sexual interactions and sexually related behaviour, and
- the level and quality of available health services, and
- the background information on demographic and education levels.

In emergency situations, it is often difficult to obtain epidemiological data (in particular in conflict situations) or reliable data (governments may be reluctant to agree on releasing figures). Hospital data most likely do not reflect the situation in rural areas. In addition, culturally-related factors pertaining to the setting must be considered, as well as the maturity of the epidemic in both host and displaced populations. There are many

challenges in assessing baseline data in emergencies primarily due to limited data; often proxy indicators must be used.

As with any emergency, the assessment should consider both interventions targeting emergency affected populations and those available to local populations. In order for an intervention to work (for example, in a camp-based population), it will be necessary to become involved with the surrounding population.

All groups at risk for HIV transmission must be included in the assessment. The identification of such groups is often context specific; however, groups generally include (although are not limited to) the following:

- women,
- children and adolescents,
- single headed households,
- certain ethnic and religious groups (often minorities who are discriminated against),
- persons with disabilities, and
- drug addicts.

People living with HIV/AIDS are frequently stigmatized and discriminated against. An assessment should include persons who are considered core transmitters, such as commercial sex workers and armed military or paramilitary personnel. Finally, interaction between displaced and local populations and the local communities needs to be evaluated for the possibility of HIV/AIDS transmission.

Older persons, while not necessarily at risk for HIV/AIDS, are vulnerable to increased demands placed upon them, as they often have to take care of young children who have been orphaned.

► Key actions

▼ Perform HIV/AIDS rapid risk and vulnerability assessment.

Assess level of existing risks and specific factors that make the risk groups listed above more vulnerable to HIV transmission. This information guides programme design and policy implementation. This information can be obtained qualitatively through key informant interviews and focus group discussions that include health and community workers, community and religious leaders (displaced and host populations), women and youth groups, government, UN and NGO workers, as well as by observation of the emergency setting and its environs.

▼ Undertake HIV/AIDS surveillance.

Existing baseline data may include:

- voluntary blood donor testing;
- trends of AIDS case surveillance reporting;
- new TB cases;
- STI incidence (new cases/1,000 persons/month) and trends disaggregated by syndrome (male urethral discharge, genital ulcer disease, syphilis at antenatal clinics);
- percent and trends of hospital bed occupancy of persons between 15-49 years of age;
- HIV/AIDS information from the areas of origin of the displaced population;
- sentinel surveillance of pregnant women (proxy for general population);
- sentinel surveillance of high-risk subgroups (STI patients, intravenous drug users, and commercial sex workers);
- voluntary testing and counselling;
- prevention of mother to child

transmission; and

- behavioural surveillance surveys.

Challenges to surveillance reporting include:

- difficult interpretation when antiretroviral (ARV) therapy has been instituted;
- inconsistent mortality registration; and
- poor syndromic diagnosis and reporting of STI.

▼ Other key baseline data

- Trends in condom 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
- Information on coping strategies of food insecure people

▼ Feedback

- participating organizations and governments;
- sector workers;
- affected populations

▼ See also: Monitoring activities (Action sheet 2.3) and shared database (Action sheet 2.2).

► **Key resources**

UNHCR/WHO/UNFPA. Inter-agency field manual. Reproductive health in refugee situations. Geneva, 1999. Chapter 9.
www.unhcr.ch/cgi

WHO. Guidelines for sexually transmitted infections surveillance: WHO, 1999.
www.who.int/emc-documents/STIs/whocdscsredc993c.html

UNAIDS/WHO. Guidelines for second generation HIV surveillance. Geneva: UNAIDS/WHO, 2000: 1-48.

Demographic and Health Surveys at:
www.measuredhs.com

Measuring impacts of HIV/AIDS on rural livelihoods and food security, FAO HIV/AIDS programme
http://www.fao.org/sd/2003/PE0102_en.htm

UNAIDS. Epidemiological fact sheets on HIV/AIDS and sexually transmitted infections.
www.unaids.org/hivaidsinfo/statistics/fact_sheets/index_en.htm

Action sheet 2.2:

Set-up and manage a shared database

► Background

One component of coordination is the setting up of a shared and standardized database of information. Each sector needs to have a lead agency whose responsibility is to coordinate and communicate with other organizations and governments involved in the emergency response. A database facilitates comparisons between various locations as well as the aggregation and interpretation of information from the lowest level (clinics and camps) to the highest level (country or regional level). Ideally, a database should be developed during the preparedness phase. However, if this has not occurred before the emergency, it should become a priority of the emergency response.

► Key actions

- ▼ Make inventory of existing data collection forms and systems to examine possible linkage with HIV/AIDS information system. The forms can be sourced either in the countries or neighboring countries.
- ▼ Develop standardized forms. The types of forms may vary according to available programmes, but include the following:
 - health information system, including confidential clinical AIDS case

reporting, STI by syndrome, gender-based violence, and death reporting components;

- blood screening (HIV and syphilis);
- orphan programmes; and
- protection cases.

Depending upon the situation and programme, there may be systems in place for:

- sentinel surveillance (antenatal and high risk).
 - Surveys: behavioural surveillance, nutrition, others.
 - Voluntary counselling and testing .
 - Prevention of mother to child transmission.
 - Supplemental and therapeutic feeding programmes.
- ▼ Develop standardized case definitions, as above.
 - ▼ Achieve consensus with partners and actors on the items above, together with the harmonizing of existing government forms, if applicable.
 - ▼ Provide housing of shared database with open access to users.
 - ▼ Provide training:
 - various sector workers involved in reporting, collecting and analysing data; and
 - designated “data specialist” to manage hardware and software with computer aspects of data.
 - ▼ Feedback at all levels:
 - participating organizations, governments;
 - sector workers;

- affected population.

▼ **See also:** Assess baseline data (Action sheet 2.1) and Monitoring activities (Action sheet 2.3).

► **Key resources**

UNHCR/WHO/UNFPA. Inter-agency field manual. Reproductive health in refugee situations. Geneva, 1999. Chapter 9.

www.unhcr.ch/cgi-bin/texis/vtx/home/opedoc.pdf

WHO. Guidelines for sexually transmitted infections surveillance: WHO, 1999.

UNAIDS/WHO. Guidelines for second generation HIV surveillance. Geneva: UNAIDS/WHO, 2000: 1-48.

Websites

www.unaids.org

Action sheet 2.3: Monitor activities

► Background

During the acute phase of an emergency, the core programmes described in the Matrix should be implemented. Beyond these basic activities, other HIV/AIDS programmes may be continued from pre-emergency programmes, depending upon the member state's level of development, the stage of the epidemic, and the phase of the emergency. Monitoring must be conducted with short-term, mid-term, and long-term goals in mind. By tracking process, output, biological and behavioural indicators from the outset, HIV/AIDS in emergency settings can be managed more effectively.

► Key actions

▼ Develop basic indicators for minimum response.

Every programme needs a core set of standardized indicators to denote progress and outcome. Basic indicators for many of these programmes already exist. (See **Key resources**.) Organizations need to agree upon a limited number of important and standardized indicators, all measured in the same way. Additionally, benchmarks and trends must be established to interpret the indicators, and thereby the success of the programme.

For example, male condom supply and utilization:

- Short-term process indicators:

Calculation for sufficient supply of male condoms in stock for 3 months:

Sexually active males* x 1.2 (wastage) x 12 condoms/
month =

Y condoms x 3 months

* 15 years and above; if unknown, use estimate of 20% of population.

Distribution of condoms:

No. of condoms distributed in 1 month /number of
sexually active males in population =

Number of condoms/sexually active male/month

Benchmark: minimum: 12 condoms/sexually active male/month⁴

- Midterm outcome indicators:

STI incidence by syndrome over time:

No. new cases of male urethral discharge syndrome/1,000
adult males*

*15 years and above; if unknown, estimate 20% of population/
month.

No. new cases of syphilis among 1st time visits by women
at antenatal clinics/1,000 women of child bearing age
(15-49 years)/month

No. new cases of genital ulcer disease (male and female)/
1,000 adults in population/month

Possible benchmark: reduction in cases by 25% over 6 months.

▼ **Consensus on above indicators with harmonization of existing government indicators, if applicable.**

▼ **Training**

- various sector workers involved in collecting, reporting and analysing data;
- designated “data specialist” to manage hardware and software computer aspects of data.

▼ **Feedback**

- participating organizations, governments;
- sector workers;
- affected population.

▼ **See also:** Assess baseline data (Action sheet 2.1) and Set-up and manage a shared database (Action sheet 2.2).

► **Key resources**

National AIDS Programmes: a guide to monitoring and evaluation. Geneva: UNAIDS, 2000.

UNHCR. Prevention and response to sexual and gender-based violence in refugee situations. Inter-agency lessons learned 2001, Geneva.

UNHCR/WHO/UNFPA. Inter-agency field manual. Reproductive health in refugee situations. Geneva, 1999. Chapter 9.
www.unhcr.ch/cgi

WHO. Guidelines for the management of sexually transmitted infections. 2001.

Handbook of indicators for HIV/STI programs, USAID, first edition March 2000, app. II

Websites

www.dec.org/default.cfm

Action sheet 3.1: Prevent and respond to sexual violence and exploitation

► Background

Sexual and gender-based violence (SGBV) is violence committed against females and males because of the way a society assigns roles and expectations based on gender. This form of violence includes specific acts against women, such as sexual harassment, rape, female genital mutilation, wife beating, forced marriage, forced prostitution (also referred to as sexual exploitation) and/or discrimination and abuse for not conforming to social standards. Attacks on the masculinity of males, such as male rape or mutilation of genitals, are also forms of gender-based violence.

Sexual and gender based violence infringes upon the fundamental human rights of adults and children, affecting individual and community development. SGBV intensifies in conflict and post-conflict situations, adding to the risks faced by refugees, returnees, internally displaced persons and other persons affected by emergency situations. In response, humanitarian workers have begun to actively direct the attention of the international community to strengthening and enhancing the protection of women and children in situations of humanitarian crisis.

SGBV increases the possibilities and the likelihood of spreading sexually transmitted infections and HIV/AIDS. In emergency situations, rape and exchange of sex for survival are the most visible manifestations of sexual violence.

► Key actions

▼ Advocate against violence and exploitation.

Advocate with fighting forces and peacekeepers, when relevant, for cessation of sexual violence and exploitation of women and children.

A training for peacekeepers has been developed on the protection of children and includes a section on sexual violence and exploitation (Save the Children-Sweden, The Office for the Special Representative of the Secretary General on Children in Armed Conflict, UNICEF.)

UNAIDS HIV/AIDS awareness card for Peacekeeping Operations includes the relevant code of conduct to be respected by peacekeeping personnel.

▼ Provide training in codes of conduct.

Train humanitarian workers, food distributors, and international, national and local partner organizations on the Inter-Agency Standing Committee **Core Elements of a Code of Conduct on Sexual Violence and Exploitation and sanction violations.**

The **Core Elements** include:

- Sexual exploitation and abuse by humanitarian workers constitute acts of gross misconduct and are therefore grounds for termination of employment.
- Sexual activity with children (persons

under the age of 18) is prohibited regardless of the age of majority or age of consent locally. Mistaken belief in the age of a child is not a defence.

- Exchange of money, employment, goods, or services for sex, including sexual favours or other forms of humiliating, degrading or exploitative behaviour is prohibited. This includes exchange of assistance that is due to beneficiaries.
- Sexual relationships between humanitarian workers and beneficiaries are strongly discouraged since they are based on inherently unequal power dynamics. Such relationships undermine the credibility and integrity of humanitarian aid work.
- Where a humanitarian worker develops concerns or suspicions regarding sexual abuse or exploitation by a fellow worker, whether in the same agency or not, s/he must report such concerns via established agency reporting mechanisms.
- Humanitarian workers are obliged to create and maintain an environment which prevents sexual exploitation and abuse and promotes the implementation of their code of conduct. Managers at all levels have particular responsibilities to support and develop systems which maintain this environment.

▼ Establish co-ordination mechanisms.

Coordination is essential to develop common monitoring and evaluation tools and to agree on common systems for referrals for health care, counselling, security and legal needs.

- Establish and continuously review methods for reporting and referrals among different actors. Referrals should focus on providing prompt and appropriate services to survivors.

- Share written information on incidence data among key actors, bearing confidentiality in mind .

▼ Promote awareness of gender rights among beneficiaries.

- Hold discussions with women's groups, religious groups, youth groups, community based organizations and all other appropriate groups in affected communities on sexual violence and on places where survivors can get assistance
- Engage and actively include the community through all stages of programme design, implementation, monitoring and evaluation
- Establish service provision facilities with active participation of the community
- Convene regular meetings of key actors and stakeholders. Designate a "Lead Agency" to take responsibility for coordination.

▼ Ensure the necessary health care services for survivors of SGBV.

- Health care services must be ready to respond compassionately to people who have been raped, sexually assaulted, or sexually abused.
- Health care providers (doctors, medical assistants, nurses, etc.) should be trained to provide appropriate care and have the necessary equipment and supplies.
- Female health care providers should be trained as a priority, but a lack of trained female health workers should not prevent providing care for survivors of rape. (See Action sheet 7.6.)

- Appropriate treatment should be proposed to the victims and post exposure prophylaxis for HIV/AIDS should be provided in places with more than 1% HIV prevalence.

► **Key resources**

Guidelines for Gender-Based Violence Interventions in Humanitarian Settings, Focusing on Prevention of and Response to Sexual Violence in Emergencies, Field test version. IASC, 2005.

<http://www.humanitarianinfo.org/iasc/publications.asp>

Sexual and Gender-based violence against Refugees, Returnees and Internally Displaced Persons: Guidelines for Prevention and Response. UNHCR, July 2002.

IASC Task Force on Protection from Sexual Exploitation and abuse in Humanitarian Crises. Plan of Action. 2002.

How To Guide: Crisis Intervention Teams: Responding to Sexual Violence in Ngara Tanzania. UNHCR, January 1997.

How to Guide: Monitoring and Evaluation of Sexual Gender Violence Programmes. UNHCR April 2000.

Clinical Management of Rape Survivors. Developing protocols for use with refugees and internally displaced persons, revised edition. WHO/UNHCR, 2005.

<http://www.who.int/reproductive-health/emergencies/index.en.html>

SCF-UK, WFP, UNICEF. Preventing and Responding to Sexual Abuse and Exploitation in Humanitarian Crises. Trainers' Notes and Training Materials. October 2002.

Website

www.unaids.org/en/media/fact+sheets.asp

Action sheet 3.2: Protect orphaned and separated children

► Background

Orphaned and separated children are at higher risk of abuse, exploitation and recruitment into fighting forces. Often they have limited access to education, health care and basic necessities compared to their peers who are with parents or other adults. These risks often make children more vulnerable to HIV infection. Every effort should be made to protect children from abuse and to ensure that their rights are protected.

► Key actions

- ▼ Work to prevent separation of orphaned children through training of humanitarian workers and sensitization of parents. (For example, the risk of separation can be limited by putting name and address on children's clothing).
- ▼ Provide boys and girls who are demobilized from child soldiering with basic HIV education, screening and treatment for sexually transmitted infections.
- ▼ Provide immediate care and attention to separated children with special attention to unaccompanied children.
- ▼ Ensure that safe spaces are provided by

child protection agencies, that children are registered and that food, shelter and support are available.

- ▼ Trace and reunite children with parents or relatives, avoiding adoption at the peak of the emergency.
- ▼ Arrange temporary or permanent fostering if parents or relatives cannot be found.
- ▼ In camp settings, provide extra protection to child and female headed households, for example, by grouping them in the centre rather than the periphery of the camp, or by ensuring that they are placed in a social group that will provide them with appropriate protection.
- ▼ Provide psychosocial support to orphaned and separated children and their caregivers.
- ▼ Provide access to appropriate reproductive health services for orphaned and separated children.
- ▼ Establish child friendly spaces where children can meet, play, access basic health and nutrition needs and learn in school or out of school setting, for example, by setting up schools and playgrounds.
- ▼ Ensure that orphaned and separated children are not discriminated against.
- ▼ Ensure provision of support to elderly persons caring for orphaned or separated children.
- ▼ Make sure that local authorities are aware of the existence and specific needs of these vulnerable children.

► **Key resources**

UNICEF. Actions for Children Affected by Armed Conflict, May 2002.

UNICEF, UNHCR, ICRC, IRC, Save the Children, World Vision. InterAgency Guiding Principles on Unaccompanied and Separated Children. 2003

UNHCR, OHCHR, UNICEF, Save the Children. Action for the rights of children. October 2002.

Working with separated children. Field Guide, Training Manual and Training Exercises. Save the Children, London, Uppard, S., Petty, C. and Tamplin, M. 1998.

www.savechildren.org.uk/onlinepubs/guide/sepchildpubs.html

Action sheet 3.3: Ensure access to condoms for peacekeepers, military and humanitarian staff

► Background

Peacekeepers, humanitarian staff and national uniformed services personnel are highly vulnerable to sexually transmitted infections (STI) due to their work environments, mobility, age and other factors that expose them to higher risk of HIV/AIDS infection. In particular, military personnel constitute a population at special risk of exposure to STI, including HIV/AIDS. In peacetime, STI rates among armed forces personnel are generally 2 to 5 times higher than in civilian populations; in time of conflict the difference can be much greater. This population, owing to its discipline, hierarchy, youth and mobility, provides an important avenue for sharing HIV/AIDS awareness and prevention information with both its membership and the wider community.

Key messages, including basic facts on HIV/AIDS and on **Codes of Conduct**, must be emphasized, including the promotion of condoms and condom usage. Condoms offer effective protection against the sexual transmission of HIV if they are used consistently and correctly. Sustainable condom programming identifies key activities required to ensure successful and effective procurement, promotion, and delivery of condoms. However, in emergency

settings there is an immediate need to make condoms freely available to those at risk.

► Key actions

▼ Needs assessment for condom provision

During emergencies, there is seldom enough time to seek detailed information about sexual behaviour; therefore, the calculation of required condom supplies can be difficult.

The following should be ensured:

- Before assessing the condom needs of uniformed services personnel, it is advisable to contact the medical division (if it exists and is accessible) of the armed forces to determine what if anything is being done about HIV/AIDS prevention. This collaboration will facilitate a more realistic needs assessment.
- Some peacekeeping missions have a medical officer and/or may have a focal point or adviser on HIV/AIDS; therefore contact with these people is essential.
- Try to ascertain the number of uniformed service and/or peacekeeping personnel present in the region.
- There is no international scale of issue for condoms. Five male condoms and two to three female condoms (if available) per person per week is supported by agencies specializing in reproductive health for planning purposes.

▼ Procurement

Given the often-harsh conditions in which they will be distributed, good quality condoms are essential. Good quality also ensures effectiveness in preventing the

spread of STI. Condoms can be gotten from donors, intermediary suppliers, or directly from manufacturers.

Condoms can be accessed through procurement officers or their equivalent, who should ensure that each shipment of condoms they receive have been quality tested. Condoms that satisfy the requirements of the WHO Specification can be gotten from UNFPA, IPPF or WHO.⁵

▼ Distribution of condoms

- Assess the main constraints (and opportunities) pertaining to access to condoms.
- These could include religious or cultural beliefs which restrict or ban the use of condoms.
- Opportunities could include putting condoms into survival kits for armed or peacekeeping forces.
- Contact (if feasible) the medical contingent personnel of both the armed forces and peacekeeping forces to determine whether collaboration on condom distribution is possible. Condoms could be distributed along with other necessary supplies to members of both forces.
- Identify other avenues for distribution, for example, through NGO partners or by targeting establishments frequented by uniformed services (bars and/or brothels).
- Condom packaging should display culturally appropriate instructions (for example, pictorial information) on how to use condoms and how to dispose of them safely. (See: The male condom, technical update.)

▼ Monitoring and evaluation

Monitoring and evaluation, while not the most pertinent high-profile activities in emergency settings, can nevertheless help to establish whether condom supplies are reaching the target audience, if adequate supplies are available, and whether supplementary educational material on correct condom use is required. Minimum response would require close collaboration with dissemination partners and monitoring the dispersal of condoms at targeted outlets.

▼ The UNAIDS Awareness Card strategy

The **Awareness Card** is a plastic-coated sleeve that contains basic facts about HIV/AIDS, a code of conduct for uniformed services, prevention instructions and a pocket for carrying a condom. The Awareness Card is available in 11 languages and is an extremely useful tool in HIV/AIDS awareness raising, especially when combined with condom distribution. To obtain the Awareness cards, contact the UNAIDS Office on AIDS, Security and Humanitarian Response: unaids@unaids.org

► Key resources

See also: Action sheet 10.1: Preventing discrimination by HIV status in staff management.

Manual of reproductive health kits from UNFPA.

Male Condom programming Fact sheets, UNAIDS, WHO, WHO/RHT/FPP/98.15 UNAIDS/98.12.

The Female Condom, A guide for planning and programming, UNAIDS, WHO, WHO/RHR/00.8 UNAIDS/00.12E.

The SHR Awareness Card and peer education kit is available at: shr@unaids.dk

The UNAIDS Guide for Developing and Implementing HIV/AIDS/STI Programming for Uniformed Services. Available from: shr@unaids.dk

Websites

www.unaids.org/en/default.asp

www.unaids.org/html/pub/Topics/Security/FS4peacekeeping_en_doc.htm

Action sheet 4.1: Include HIV considerations in water/sanitation planning

Adapted from International Water and Sanitation Centre (IRC) www.irc.nl

► Background

Hygiene improvement is critical in combating diarrhoeal diseases and intestinal-worm infestations, reducing opportunistic infections and improving maternal and child nutritional status. People with compromised immune systems find it harder to resist and recover from episodes of diarrhoeal disease, intestinal worm infestations, skin rashes and other opportunistic infections. All of these conditions amplify the impact of HIV on health status, in some cases accelerating progression to AIDS. In countries where HIV prevalence is high, good water and sanitation programmes are essential. Bringing safe, reliable water supplies closer to families affected by HIV/AIDS, and to schools and to health care facilities allows for improved personal, domestic, institutional and food hygiene. Ensuring that access to water points and toilets is acceptable and safe for women and girls is also critical to ensuring equity of access and protection from sexual harassment and abuse.

► Key actions

▼ Ensure that vulnerability assessments consider the extreme vulnerability of adults living with HIV to diarrhoeal infections and their sequelae, and adjust programmes and targeting accordingly, especially in high prevalence countries.

▼ Provide hygiene education for family and caregivers, with clear instructions on how to wash and where to dispose of waste when providing care to chronically ill persons.

▼ Consider the appropriate placement of latrines and water points to minimize girls' and women's risk of sexual violence *en route*.

▼ Help dispel myths and misconceptions about contamination of water with HIV, thereby reducing discrimination against people living with or affected by HIV/AIDS. Common misconceptions include the following:

- Sharing a well with people who have HIV will cause contamination of the water point.
- People can become infected with HIV/AIDS due to groundwater pollution near burial sites.

(In fact, HIV is a very fragile virus and cannot be spread through either of these methods.)

Discussion of such beliefs should be encouraged during hygiene promotion activities. Ignoring these beliefs will not diminish their existence and hence will not reduce stigma and discrimination.

- ▼ Facilitate access to water and sanitation for families with chronically ill members; people living with HIV/AIDS may have difficulty obtaining water due to stigmatization and discrimination, limited energy to wait in queues, or insufficient strength to transport heavy water containers.
- ▼ Design water systems to take into account that children and older people frequently fetch water; make sure that pump handles are not too high, that pumping is not too difficult, and that the walls of the well are not too high. This is especially important when the task of fetching water falls increasingly on children and the elderly as a consequence of HIV/AIDS.
- ▼ Facilitate access to extra water for caretakers of people living with HIV/AIDS. They may need greater than usual quantities of water to wash sheets and blankets of chronically ill family members and to bathe the sick more frequently.
- ▼ Include appropriate water and sanitation facilities in health centres and education sites, and provide hygiene education in emergency education programmes.
- ▼ Make extra efforts to ensure that the voices of people living with HIV/AIDS are heard either directly or indirectly by representation; infected people and their families can be inadvertently or intentionally excluded from community-based water decision making.

► Key resources

International Water and Sanitation Centre (IRC). www.irc.nl

International Federation of Red Cross and Red Crescent Societies. Water and Sanitation Kit.

Action sheet 5.1: Target food aid to affected and at-risk households and communities

► Background

Targeting of food aid to HIV/AIDS affected families is particularly complex. In poor countries, testing for HIV status is often not available, and HIV status is not known. Even where voluntary testing is available, many people are afraid to know their HIV status and choose not to get tested; due to the stigma attached to HIV/AIDS, the singling out of HIV-positive persons can be detrimental to both individuals and their families. Vulnerability analysis and other tools have not yet been fully able to incorporate HIV/AIDS into their studies; for the moment, proxy indicators are being used.

► Key actions

▼ Target all food insecure individuals, regardless of whether their HIV status is known.

Note: in some cases, other groups (community organizations, NGOs, etc.) may have identified HIV/AIDS positive persons through voluntary testing. In these situations it may be possible to directly support PLWHA, so long as stigma is not an issue.

▼ Ensure that food aid, when provided to PLWHA and HIV/AIDS affected families, does not increase stigmatization or make

non-affected vulnerable families feel excluded.

- Work should be done with established community-based organizations that are already involved with HIV/AIDS-affected individuals and families.
- Whenever possible, sensitization and prevention awareness activities should be linked to large-scale distribution activities.

▼ In emergencies, certain individuals may be more at risk than others. These are often the same people whose food insecurity is exacerbated by HIV/AIDS, and may include:

- female-, child- and elderly-headed households;
- orphan hosting families;
- families caring for a chronically ill person(s).

▼ Increase the number and types of sites where food is provided. Scale up targeted activities in order to provide additional resources to meet special needs of HIV/AIDS affected households should be considered, such as schools, orphanages, churches, hospitals, MCH clinics and HBC programmes.

▼ Give special attention to those communities that have been particularly affected by the pandemic and whose food security is threatened by HIV/AIDS.

▼ To help identify the most severely affected geographical areas, national data sets, as well as those data sets from other UN agencies, should be analysed. Other indicators additional to prevalence rates can also be used to help locate high prevalence areas.

These proxy indicators include:

- morbidity and mortality rates,
- demographic indicators, and
- health centre data on STI, viral infections, TB rates, and adolescent pregnancies.

Vulnerability assessments, conducted on a regular basis, should confirm the usefulness of the proxies.

▼ For large-scale emergencies, some agencies use the concept of “hotspots,” mapping areas where levels of food vulnerability overlap with other indicators of vulnerability, such as high rates of HIV/AIDS prevalence. Other vulnerability indicators may include:

- high or growing rates of wasting and stunting;
- high or increasing rates of associated health problems;
- limited health care infrastructure and services;
- increased school drop out rates;
- high STI rates, and
- operational constraints that may heighten the vulnerability of particular populations (poor accessibility or a severe lack of implementation capacity).

► Key resources

WFP Southern Africa Implementation Strategy.

www.wfplogs.org/bulletins/rep_programme.asp

Programming in the era of AIDS: WFP’s response to HIV/AIDS, January 2003.

www.wfp.org/eb

Food Security, Food Aid and HIV/AIDS: WFP Guidance Note.

Frequently Asked Questions on Food Security, Food Aid and HIV/AIDS.

Information Sheet on Nutrition, Food Security and HIV/AIDS.

Background Paper on HIV/AIDS and Orphans: Issues and challenges for WFP.

Food and Education: WFP’s Role in Improving Access to Education for Orphans and Vulnerable Children in Sub-Saharan Africa.

Food Security, Food Aid and HIV/AIDS: Project Ideas to Address the HIV/AIDS Crisis.

WFP Food Distribution Guidelines, 2003 (Provisional version)

UNHCR. 1997. Commodity Distribution; a Practical Guide for Field Staff. UNHCR, Geneva. www.unhcr.ch/

Action sheet 5.2: Plan nutrition and food needs for populations with high HIV prevalence

► Background

This Action sheet outlines the steps required in planning nutritional needs and food aid rations in emergency situations with a high prevalence of HIV. In all emergency situations, an understanding of the local context is paramount in planning rations that will effectively achieve the goals of the intervention. Two of the main objectives of food aid in emergencies are:

- preventing increases in malnutrition;
- preventing excess mortality.

The HIV/AIDS pandemic directly affects many of the causes of both malnutrition and mortality in emergency situations. By threatening the lives of adults of reproductive age, HIV/AIDS exacerbates all four of the underlying causes of child malnutrition:

- insufficient access to food,
- inadequate maternal and child-care practices, and
- poor water/sanitation, and
- inadequate health services.

Therefore, in order for emergency operations to achieve their goals when targeting populations with high prevalence of HIV/AIDS, it becomes even more critical

to plan food baskets that accurately reflect the nutritional and dietary needs of the population.

People living with HIV/AIDS (PLWHA) may have special dietary and nutritional needs. Adequate intake of energy, protein, and micronutrients is essential for coping with the HIV virus and fighting off opportunistic infections. The WHO Expert Consultation on Nutrient Requirements for PLWHA (May, 2003) recommended that an increase of 10% in energy requirements is needed to maintain body weight and physical activity in asymptomatic HIV-infected 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. Available data at the time of the consultation did not permit specific recommendations above and beyond the recommended daily allowance (RDA) for protein, fat or micronutrient requirements; however, adequate consumption of both protein and fat is crucial for people living with HIV/AIDS.⁶

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 PLWHA should be considered when planning rations, and suggested actions are presented in the next section.

► Key actions

Detailed guidance for planning food and nutrition needs in emergencies is provided in *UNHCR/UNICEF/WFP/WHO Food and Nutrition Needs in Emergencies*. The steps listed below are intended to guide the planning of rations and food needs as a component of a minimum response. It is also important that periodic reassessments take place and that the ration/food basket be adjusted accordingly, once the situation stabilizes.

The magnifying effects that HIV/AIDS can have on malnutrition and mortality in emergencies increase the importance of nutritional considerations when designing rations for populations with a high prevalence of HIV/AIDS. In the chart below, potential adjustments for populations with a high prevalence of HIV/AIDS are highlighted in **bold**.

▼ Calculate the energy requirements of the population

- The initial planning figure or energy requirement is 2,100 kcal/person/day.
- Adjust this figure upward or downward based on the following four issues:

Normal Population	Population with High HIV/AIDS Prevalence
Temperature If the temperature is below 20° C, adjust energy requirements upward by 100 kcal for every 5° below 20° C.	
Health or Nutritional Status of the population If either of these is extremely poor, adjust the energy requirements upward by 100–200 kcal.	A high prevalence of HIV/AIDS may be justification for adjusting the energy requirements of a population upward. Consult with a nutritionist (UNICEF, WHO, WFP) to determine if such an adjustment is desirable.
Demographic distribution of the population If the demographic distribution is not normal, there may be a need to adjust the energy requirements upwards or downwards.	HIV/AIDS can have significant effects on the demographic composition of a population that may need to be considered when planning rations. Annex 17⁷ of the Food and Nutrition Needs of the Inter-Agency Guidelines provides a breakdown of the energy requirements of specific population subgroups by age and sex that can be used to adjust requirements.
Activity levels If the population is engaging in medium to heavy activities, there may be a need to adjust the energy requirements higher.	Activity levels are often underestimated in non-refugee situations. Underestimates may have even more detrimental effects in a population with higher basic physiological needs.

▼ Choose food items that meet the energy, protein, fat and micronutrient requirements of the population. Generally, it is recommended that protein and fat sources should contribute 10-12% and 17% respectively of the energy content of the diet.

Note: When selecting food items, keep in mind that protein, vitamins and minerals are particularly important for people with HIV/AIDS. The inclusion of micronutrient fortified blended food and/or milled and fortified cereals should be considered. Milled cereal/flour/meal is preferable to unmilled cereals because of ease of preparation, consumption and digestion, and because it reduces the burden on the caretaker travelling to a mill or pounding grain.

▼ Implement monitoring and follow-up actions, data collection and analysis.

Note: Special care should be taken during monitoring to include HIV/AIDS relevant indicators related particularly to household composition and mortality (parental death, crude and under 5 mortality rates, death of adult family member, etc.) that can be used during analysis to disaggregate the effects of the emergency and the emergency response on households affected by HIV/AIDS.

▼ If necessary, assess the ability of the population to obtain food from other food sources and adjust the ration accordingly. Monitor the situation following any such adjustments.

Practical Example:

The Southern Africa Emergency 2002-2003

The effects of HIV/AIDS on food insecurity have been particularly visible during the Southern Africa Crisis. Three of the six countries targeted by the crisis response had adult HIV prevalence rates exceeding 30%, and all six countries have rates in excess of 12%. As part of the regional response, a reference ration was adopted providing 2198 kcals, 12% from protein and 17% from fat. During the process of calculating the energy requirements, it was agreed to adjust the ration upward from 2100 kcals to 2200 kcals in recognition of the high prevalence of HIV. The ration also included 100 g of fortified blended food in recognition of the importance of vitamins, minerals and protein in fighting off opportunistic infections. Fortification of maize meal with micronutrients was also pursued in the context of a large milling exercise as a key element to address the HIV/AIDS dimension of the emergency. Humanitarian assistance works! The crisis in southern Africa is evolving and so is the response. A food crisis has been averted, thanks to the timely response of the UN, governments, donors and NGO partners. However, the region is still in crisis. Southern Africa still has the highest adult prevalence rates of HIV/AIDS in the world, undermining the coping and recovery mechanisms of people. A concerted, radical and long term response is required to tackle this challenge.

Southern Africa Reference ration

Cereals: 400 g
Pulses: 60 g
Oil: 20 g
Fortified blended food: 100 g

The guidance above is intended primarily for planning food and nutrition needs associated with a general ration. Even when designing other types of activities involving food in emergency situations, however, many of the same considerations apply.

► Key resources

Piwoz E. and Preble E.A., HIV/AIDS and Nutrition: A review of the literature and recommendations for nutritional care and support in sub-Saharan Africa. 2000. Academy for Educational Development. Washington, DC.
www.enonline.net/fex/13/rs5-2.html

Food and Nutrition Technical Assistance (FANTA). 2001. HIV/AIDS: A Guide for Nutrition, Care, and Support.
www.fantaproject.org/inc_features/hiv.htm

UNHCR/UNICEF/WFP/WHO. 2003. Food and Nutrition Needs in Emergencies.

United Nations System Standing Committee on Nutrition. 2001. Nutrition and HIV/AIDS: Report of the 28th Session Symposium held 3-4 April 2001, Nairobi, Kenya. www.unsystem.org/scn/

Action sheet 5.3: Promote appropriate care and feeding practices for PLWHA

► Background

In emergency settings and elsewhere, people living with HIV/AIDS have particular needs in terms of care and nutrition. Good nutrition is essential for health and helps the body protect itself from infections by supporting the immune system. Whether or not food aid is available, better diets can contribute to the improvement or preservation of nutritional status. This becomes a major challenge in emergencies, since people usually face drastically different living situations.

In developing countries, care for PLWHA is provided largely through family members and community-based organizations that work through volunteer networks. In emergency situations, this support is needed more than ever, but these care systems are often disrupted. Efforts should be made to rehabilitate care systems as feasible, strengthening them through on-the-job training and support, and to promote new ones. When undertaking food aid distribution for PLWHA during emergencies, exercise great care to ensure that jealousy and resentment towards the PLWHA do not occur through such “positive discrimination.” Existing networks may be useful in this regard.

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

► Key actions

▼ Identify local institutions and individuals (health centres, schools, social workers, NGOs) operating in the area as well as relevant information materials.

▼ Rapid assessment by local staff (NGO staff, including professional, health workers, extension agents) of:

- existing care systems for chronically sick patients,
- the effects of the crisis on these systems,
- coping strategies,
- training needs, and
- information gaps.

▼ Adaptation of generic existing “nutritional care” guidelines to local needs and possibilities.

▼ Capacity building (including participatory approaches and communication techniques) of relevant local staff, who in turn will be able to inform and assist caregivers and community workers/social mobilizers on:

- special eating needs of PLWHA,
- coping with the complications of HIV/AIDS,
- taking care of PLWHA,
- herbal treatments and remedies.

- ▼ Strengthening of community-based care networks includes:
- identification and capacity-building of community volunteers;
 - incorporation of nutritional care for PLWHA into the programmes of relevant local institutions (health, education, nutrition, rehabilitation); and
 - establishment of reference and support systems for community-based care systems.

► **Key resources**

Living well with HIV/AIDS: a manual on nutritional care and support for people living with HIV/AIDS. FAO/WHO, 2002.

Action sheet 5.4: Support and protect food security of HIV/AIDS affected and at risk households and communities

► Background

HIV/AIDS undermines households and communities. The epidemic disrupts livelihoods, affecting productive activities and increasing the household dependency ratio (due to disease and orphans), and resulting in increased food insecurity and malnutrition.

It is therefore important that emergency response projects and activities give specific attention to protecting and promoting food security of affected and at risk households and communities, combining food and agriculture relief interventions with food aid and nutrition education. Poverty, chronic food insecurity, HIV/AIDS and emergency situations are mutually aggravating phenomena, generating complex scenarios that require committed, integrated and intersectoral responses. In emergency situations, the AIDS epidemic presents an added risk and burden to communities and households, as it builds upon and exacerbates existing vulnerability and impairs prospects of recovery.

► Key actions

- ▼ Review existing food and agriculture needs assessments in order to identify the most food insecure population groups, their main constraints and coping strategies, with particular attention to gender issues.
- ▼ Target known HIV/AIDS affected households to supplement their diets.
- ▼ Gain an understanding⁸ of the specific constraints and strategies of HIV/AIDS affected households and communities. These constraints include labour constraints, loss of knowledge, trends in food consumption, care needs, and gender dimensions.⁹
- ▼ Identify possible food and agriculture emergency relief interventions such as:
 - agriculture production, including conservation farming; home or community gardening; small livestock breeding;
 - access to inputs through supplying vouchers to the most vulnerable households to enable them to purchase priority inputs (seeds, tools, small livestock and basic veterinary services) from input trade fairs;
 - integrate agriculture into home-based care with low labour intensive methodologies;
 - small scale food-processing which can strengthen resilience of these groups and provide alternatives to at-risk behaviours.
- ▼ Provide appropriate inputs, training and technical assistance to local institutions (especially NGOs) to protect and promote household food security while ensuring and

facilitating basic reproductive tasks and increasing security.

- ▼ Ensure the participation of youth, including girls, young women, orphans, and demobilized child soldiers, in training and education activities supporting food production, home economics, and nutrition education.
- ▼ Identify entry point(s) for linking minimum response interventions with long-term food security, livelihoods policies and programmes at local and national levels.
- ▼ Monitor the interventions regularly by systematically including HIV/AIDS considerations.

► Key resources

Incorporating HIV/AIDS considerations into food security and livelihoods projects, FAO 2003.

<ftp://ftp.fao.org/docrep/fao/004/y5128E/y5128E00.pdf>

Guidelines for emergency needs assessment (draft).

Pocket book on integrating HIV/AIDS considerations into food security and livelihoods projects, FAO HIVAIDS programme.

<ftp://ftp.fao.org/docrep/fao/007/y5575e/y5575e00.pdf>

Websites:

<http://www.fao.org/hiv aids/>

http://www.fao.org/es/esn/nutrition/household_hiv aids_en.stm

Action sheet 5.5: Distribute food aid to affected households and communities

► Background: general food distributions

This Action sheet outlines existing options for agencies involved in food distributions. Information herein on the targeting of HIV-affected families and communities is provided in order to guide the choice of distribution modalities.

In emergencies with large-scale food needs, the best way to provide nutritional support to the large number of HIV/AIDS infected and affected persons is through general food distributions. The distribution modality depends upon the objective of the food distribution and upon the targeted population. The ration size should be defined prior to the registration process. The implementation of food distribution and distribution modalities should be planned such that the actual ration size does not significantly differ from the original/planned one.

► Key actions

▼ Review operational strategies with partners to determine the best possible options, taking into account both the needs of the people as well as the practicalities of large-scale registration activities. Demographic profiles, particularly in areas affected by HIV/AIDS, are helpful in

ensuring that distribution methods are fair to families with high dependency ratios.

▼ On the registration form, specify the actual compositions of households. This information should include the number of total beneficiaries, by age and gender. Adjust distribution modalities accordingly.

▼ When a detailed registration is not feasible, distributions should be based on average family size. This figure should agree with national demographic patterns. Sample surveys should be undertaken on a quarterly basis to establish indicative beneficiary data.

▼ The choice of a distribution site and its distance to households is important, particularly for child- and elderly-headed households, because carrying a large (monthly) ration can be difficult. Where feasible, smaller (2 week) rations should be considered in order to reduce the quantity to be carried.

► Background: emergency school feeding programmes

Even in the most complex emergencies, schools often continue to function. The provision of food to school children alleviates hunger, encourages enrolment, attendance, and performance, and helps to reduce the number of school children who drop out. Provision of food can also provide a much-needed safety net for children from households that are not part of general food distribution schemes, ensuring that they receive at least one nutritious meal per day. Additionally, keeping children in school offers them an alternative to harmful or destructive coping activities and helps them to prepare for a productive future.

► Key actions

▼ Establish sentinel sites. A qualitative data collection and monitoring system, collating school attendance and drop out rates on a regular basis, can be used to reveal attendance trends over time. Information collection should be carried out in close collaboration with UNICEF and local partners.

▼ In areas with a high HIV prevalence, school hours may need to be reviewed in order to take into account the caring responsibilities.

▼ School feeding programmes normally require investments to establish kitchens, adequate water and sanitation facilities, and to acquire fuel and utensils for the preparation and consumption of meals. Furthermore, participatory approaches are required to engage Parent/Teacher Associations (PTAs), communities, and households in establishing stock maintenance facilities and in actual food preparation. The distribution and consumption of meals also can disrupt education activities if it is not carefully planned.

The alternative to the distribution of porridge and/or meals is the distribution of biscuits. In emergencies, biscuits are often the only choice, for the following reasons:

- they do not require cooking and utensils, though eating does require a minimum of clean water and sanitation facilities;
- they do not disrupt classes; substantial quantities can be eaten throughout the day under teacher supervision;
- they can be phased out as soon as

enrolment rates return to normal, without harmful impacts on the overall education system; and

- they can be supplanted by longer-term recovery programmes, without compromising critical sustainability requirements.

► Background: alternatives to school feeding programmes for orphans and other vulnerable children

The plight of orphaned children requires broad scale interventions. Children who receive little adult guidance or supervision may have little exposure to social and life skills and may lack any intergenerational knowledge, such as basic agricultural skills. Food can be provided to orphaned children who attend community schools and listening groups in the same way food is provided in school feeding programmes. Such interventions ensure that the maximum number of food-insecure orphans and vulnerable children receive some form of education and that older children become self-reliant in the near future.

► Key actions

There are several programming principles that guide the feeding of orphans and other vulnerable children:

- Interventions aimed at improving the welfare of orphans must not exclude children whose parents are still alive though ailing.
- Reaching vulnerable children before they become orphaned (for example through school feeding), can help keep them in school and away from harm.
- When specifically targeting orphans outside an institutional programme such

as school feeding, food aid should be provided to an entire household rather than solely just to the orphans being cared for in that household. This will prevent food rations intended for one person from being shared by an entire family. Such material assistance for extended and foster families can ease the collective burden of caring for orphans, resulting in an increased willingness by families to take in orphans.

► **Background: home-based care**

Support for home-based care programmes in emergency situations is essential because:

- home-based care programmes limit the risk of opportunistic infections; and
- food aid provided through home-based care programmes is also crucial for households who have become food insecure. Most home-based care programmes are organized around a community network.

► **Key actions**

Food aid agencies should provide dietary support to individuals and families infected and affected by HIV/AIDS. This can include blended fortified foods or fortified cereals combined with a balanced food basket for optimal nutrition.

Issues to consider include:

- the choice of supplemental food products;
- the important role played by volunteers in communities hard hit by the HIV/AIDS pandemic by providing critical services and psychosocial support to the chronically ill and their families. Food aid agencies can choose to provide

food rations to volunteers, helping them offset the need to find food elsewhere, and freeing up their time to serve their communities; however, it is important to make certain that such aid does not create dependency and thus undermine the very spirit associated with volunteerism;

- careful targeting and close collaboration with community-based organizations. Local NGOs are key to ensuring successful activities in this area.

► **Key resources**

WFP Southern Africa Implementation Strategy.

www.wfplogs.org/bulletins/rep_programme.asp

Programming in the Era of AIDS: WFP's Response to HIV/AIDS, January 2003. Available on WFP's WEB site:

www.wfp.org/eb

Information Sheet on Nutrition, Food Security and HIV/AIDS.

Background Paper on HIV/AIDS and Orphans: Issues and challenges for WFP.

Food and Education: WFP's Role in Improving Access to Education for Orphans and Vulnerable Children in Sub-Saharan Africa.

Food Security, Food Aid and HIV/AIDS: Project Ideas to Address the HIV/AIDS Crisis.

WFP Food Distribution Guidelines, 2003. (Provisional version)

UNHCR. 1997. Commodity Distribution; a Practical Guide for Field Staff. UNHCR, Geneva.⁹ www.unhcr.ch/

Action sheet 6.1: Establish safely designed sites

► Background

Suitable, well-selected and soundly planned sites with adequate shelter and integrated, appropriate infrastructure are essential in the early stages of an emergency as they save lives and reduce suffering. Sites in emergencies may take the form of dispersed settlements, mass accommodation in existing shelters or organized camps. Initial decisions on location and layout have repercussions throughout the existence life cycle of a site, including long term effects on protection and delivery of humanitarian assistance.

The purpose of site selection, shelter and physical planning interventions is to meet the physical and primary social needs of individuals, families and communities for safe, secure, and comfortable living space. As much self-sufficiency and self-management as possible should be incorporated into the process.

► Key actions

Where transit centres exist, special attention should be paid to the vulnerability of separated children, especially girls and female-headed households; protection measures need to be in place for them. A specific safe place within the site should be set up for separated children, adolescents

and female-headed households.

The planning of a site is based on an understanding of the emergency situation and on a clear analysis of people's needs for shelter, clothing, and household items. Key actions and indicators are:

- ▼ Establish a team which follows internationally accepted procedures. (See references for the standards.)
- ▼ Establish a multi-sectoral team, comprised of specialists in water and sanitation, nutrition, food, shelter and health; local authorities; men and women from the affected population; and the different humanitarian organizations responding to the crisis.
- ▼ Collect consistent information.
- ▼ Develop profiles of the affected population: demographic profile (gender, age and social grouping), traditional means of land use, building skills, construction methods, lifestyle assessment of public/private space, cooking and food storage, child care and hygienic practices, type of shelter, adopted and actual and potential security risks.
- ▼ Undertake needs assessments of at risk groups. Special attention needs to be given to vulnerable groups, female headed households, and separated children and adolescents.
- ▼ Assess the infrastructure and local resources: level and condition of access roads, quantities of wood required for fuel and construction, available heavy equipment in the area.

- ▼ Assess the physical information. This should include the topography of the land available and suitable for settlement and agriculture, the variety and protection suitability of potential water sources, vulnerable environmental areas, seasonal variations and endemic diseases.
- ▼ Complete an assessment report that includes all of the above information.
- ▼ Make the findings of the assessment available to other sectors, national and local authorities, participating agencies and female and male representatives from the affected population.

It is important to encourage the participation of women in the design and implementation of shelter and site planning. They can help to ensure that they and all family members have access to shelter, clothing, construction materials, food production equipment, health services, community services and other essentials. Women should be consulted about security and privacy, sources and means of collecting fuel for cooking and heating and access to housing and supplies. Specific attention will be needed to respond to gender-based violence, including sexual exploitation.

Some of the vulnerable might be unable to design and build their shelter. Specific action should be taken to ensure that the community will assist them.

Key points for site planning and shelter:

- Place families with chronically ill family members and child headed households closer to facilities.
- Take note of the distance to the water supply. It should be no further than 500

metres from any shelter to the water point.

- Use separate toilet blocks for women and men. Develop individual family toilet blocks for families. (A maximum of 20 people per toilet and not farther than 50 metres from the dwellings.)
- Take note of the distance to the health facility.
- Take note of distances to other communal services such as markets, places of worship, community centres, wood lots, recreational areas, graveyards and solid waste disposal areas.
- Ensure security and protection.
- Support groups that are unable to build their own shelters.
- Train women and adolescents to participate in building activities.

► Key resources

Handbook for emergencies – United Nations High Commissioner for Refugees 1999. Part 3, Chapter 12, Page 132.

Humanitarian Charter and Minimum Standards in Disaster Response – The Sphere Project 2000. Part 2, Chapter 4, Page 171.

Action sheet 7.1: Ensure access to basic health care for the most vulnerable

► Background

In times of crisis, health care services are often severely affected and easily disrupted. Health information systems collapse, health coverage diminishes, communication is difficult, data are fragmented and standardization is scarce. The health coordinator should ensure that health care providers (doctors, medical assistants, nurses, nutritionists) are trained to provide appropriate care and have the necessary equipment and supplies. Lack of coordination, overcrowding of players, security constraints, and competing priorities contribute to widening the gap between expanding needs and diminishing resources.

► Key actions

A rapid assessment should take place to analyse the status of health services, including availability, capacity and accessibility.

▼ Assess availability and capacity.

The following should be included:

- an analysis of the buildings providing health services (those which are physically still in place);
- the number of those facilities functioning per population;
- a list of number and qualifications of

medical staff in each facility (doctors, medical assistants, nurses);

- a list of health staff working in the local villages and in refugee and /or internally displaced persons (IDP) camps;
- an assessment of the range of services provided (care, diagnostic facilities, EPI, MCH) and their quality;
- identification of a reference hospital for referral of severe cases and laboratory confirmation as needed; and
- an assessment of the availability of drugs and medical equipment.

▼ Assess accessibility of health services.

(based also on the above information)

- which and how many health facilities are accessible;
- comparison of the number and type of consultations per month (reality versus what is expected);
- household survey of access to facilities, in order to analyze why utilization is limited.

Reasons for utilization (or under-utilization) might include:

- infrastructure (roads, transport);
- security;
- cost involved (travel, services, treatment);
- salary of medical staff;
- no equipment/supplies available;
- quality of services provided is poor.

▼ Analyze the public health situation.

Public health information should be collected rapidly. This includes information on the pre-crisis situation, specifically public health concerns, major communicable diseases (epidemics, endemic diseases) and capacity.

Current concerns include:

- the risk of outbreaks of communicable diseases;
- presence in the area of other endemic diseases (cholera, meningitis, other diseases);
- the seasonality of diseases like malaria, cholera;
- condition and status of water and sanitation systems;
- status of the population regarding food security; and
- the presence of any other conditions that accelerate the spread of diseases.

The most common diseases to expect in an area affected by an emergency are:

- diarrhoeal diseases
- acute respiratory infections, including TB
- malaria
- measles
- malnutrition
- STI

▼ Identify the most vulnerable.

Among those who need access to health facilities, some are especially vulnerable. Children and women are normally the most severely affected by any crisis. However, the elderly, the disabled, the chronically ill, and those people living with or affected by HIV/AIDS must not be overlooked. The most vulnerable are the unknown and the forgotten.

- Sensitize NGO and agency staff to recognize vulnerability and to develop mechanisms for dealing with women and children who are abused, separated, orphaned or otherwise made vulnerable.

▼ Provide health services at different levels.

Once the public health situation has been evaluated, a decision can be made on whether local public health services can handle the demands on their capacity. If the existing facilities cannot be strengthened to meet the demands, alternative arrangements must be developed. Unless treatment is provided at the right level, people demanding assistance for simple ailments will overwhelm hospitals and health centres. This is why a community based health service is necessary to identify those in real need of health care, and to orient them to the appropriate health service. This is why coordination with community health services is paramount.

Community level health care (clinics, health posts) must be the entry point of health services from the very beginning of an emergency. Local staff will be recruited among the affected community. At this level, the community health workers will deliver outreach services.

Supporting the clinics should be a health centre, handling all but the most complicated medical, obstetrical and surgical cases. It can include a basis laboratory and a central pharmacy.

At the top, there will be a referral service (hospital) that will receive patients from the health centres to provide emergency obstetric and surgical care, as well as treatment for severe diseases, laboratory, and x-rays. This referral hospital can be a local hospital that will be supported and extended for services provided linked to the emergency. A special hospital will need to be established only when the needs cannot be met by the local national hospital.

▼ **Sustain local health services.**

- Provide health care following national/district guidelines.
- Collaborate with other health related NGOs and district health structures in place.
- Avoid duplication of services.
- Bear in mind future integration of services.

▶ **Key resources**

Handbook for emergencies UNHCR.

Action sheet 7.2: Universal precautions

► Background

Because 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. **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. These procedures are essential in preventing the transmission of HIV from patient to patient, from health worker to patient and from patient to health worker.

The guiding principle for the control of infection by HIV and other diseases that may be transmitted through blood, blood products and body fluids is that **all blood products should be assumed to be potentially infectious**.

► Key actions

▼ Emphasize universal precautions.

During the first meeting of health coordinators, emphasize the importance of universal precautions in deterring the spread of HIV/AIDS within the health care setting.

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.

Implementation of the procedures for universal precautions, including the ordering and distribution of necessary supplies, disinfectants and protective clothing, should begin as soon as possible, and must be monitored and evaluated as soon as the situation has stabilized.

▼ Wash hands.

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.

▼ Use protective barriers to prevent direct contact with blood and body fluids.

Ensure a sufficient supply of gloves in all health care settings for all procedures involving contact with blood or other potentially infectious body fluids. Gloves should be discarded after each patient; if this is not possible, they can be washed or sterilized before re-use. All staff handling waste materials and sharp objects for disposal should wear heavy duty gloves.

Where there is a possibility of exposure to large amounts of blood, protective clothing such as proof gowns and aprons, masks, eye shields and boots should be available.

The virus that causes HIV/AIDS can live and reproduce only in a living person. Therefore, following the death of an HIV-infected person, the virus will also die. However, when handling corpses, staff should protect their hands with gloves and cover any wounds on the hands or arms with a plaster or bandage. This is especially important if body fluids are involved.

▼ Promote safe handling and disposal of sharp objects.

All sharps should be handled with extreme care. They should never be passed directly from one person to another, and their use should be kept to a minimum. Do not recap used needles by hand; do not remove used needles from disposable syringes by hand; and do not bend, break, or otherwise manipulate used needles by hand. 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.

▼ Promote safe decontamination of instruments.

Pressure-steam sterilizers are used for cleaning medical instruments between use on different patients. 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.

▼ Dispose of contaminated waste safely.

Heavy-duty gloves should be worn when materials and sharp objects are taken for disposal. Hands should be washed with soap and water as a matter of routine after the removal of gloves, in case the gloves have tiny perforations.

Facilities for the safe disposal of human waste, including placenta and dressings, must be available. Incinerators are the correct choice for such use.

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).

▼ Monitoring

All staff must be supervised to ensure their compliance in the use of universal precautions. Additionally, the ordering and distribution of necessary universal precautions-related supplies such as disinfectants and protective clothing should be monitored and then evaluated as soon as the situation has stabilized.

▼ Treat injuries at work.

See Action sheet 10.2 on post-exposure prophylaxis (PEP) for humanitarian staff.

▼ **Trained staff**

Health staff workers, housekeepers, and cleaners should have a thorough understanding of the principles of universal precautions, should be aware of occupational risks and should use universal precautions with all patients and in all situations.

▼ **Supplies**

The following supplies are recommended as a minimum to prevent the transmission of blood-borne viruses such as HIV. To estimate the quantity of supplies needed, please consult the New Emergency Health Kit 98.

Equipment
Disposable needles and syringes
Burn boxes
Pressure-type sterilizers in all health care settings
Simple incinerators and burial pits (links)
Heavy duty rubber gloves, re-useable gloves, sterile gloves, etc
Masks, gowns, eye protection
Rubber boots
Rubber sheets
Soaps, disinfectants

► **Key resources** needed for universal precautions

▼ **Further information**

MMWR Morb Mortal Wkly Rep 1988; 37(24): 377-88.

The infection prevention course of Engender Health on www.engenderhealth.org/res/onc/about/about-ip.html

Interagency Field Manual for Reproductive Health in Refugee Situations, chapter 2.

Universal Precautions, including injecting safety, WHO/UNAIDS:
<http://www.who.int/hiv/topics/precautions/universal/en/>

Guidelines on Sterilization and Disinfection Methods Effective Against HIV, WHO

Universal precautions for prevention of transmission of HIV and other bloodborne infections, CDC:
<http://www.cdc.gov/ncidod/hip/blood/universa.htm>

Action sheet 7.3: Provide condoms and establish condom supplies

► Background

Condoms offer effective protection against the transmission of STI, including HIV/AIDS, if they are correctly and consistently used. Although most of the world's people have already heard this message, messages *transmitted* are not always *implemented*. One of the most urgent tasks facing relief agencies is to make sure that people have access to the correct information regarding condoms and that condoms are freely available to those who seek them. This includes relief workers.

► Key actions

▼ Supply

Where condom use, promotion and distribution are not deemed appropriate by stakeholders, advocacy efforts need to take this into account. Male and female condoms should be considered essential items in emergency relief supplies. They should be on the checklist of every agency responsible for providing relief supplies, from the World Food Programme and UNHCR to small NGOs. Decisions should be made as to whether it is better to pre-package condoms with other items such as emergency medical or food supplies, or to package them separately but deliver them to the field at the same time, using the same channels as other

relief supplies. This will depend in part on the quantity of condoms to be sent to the field.

▼ Distribution

Agencies must decide how best to distribute the condoms to the public, and how to ensure that they reach vulnerable groups, including women and youth. This decision should always take cultural issues into account, and should involve a thorough discussion with all stakeholders. This will have some bearing on the route used to deliver them to the field. For example, if it is decided that condoms should be distributed at health clinics, they can be shipped there, along with other medical supplies; if condoms are distributed at food distribution points, then they should be sent with food supplies.

▼ Instructions

Culturally appropriate instructions - for example, pictorial representations on how to use condoms and how to dispose of them safely¹⁰ - should be included with the consignments. The public should be informed of how and where to obtain condoms through whatever communication channels are available, for example, radio and posters.

It is important to remember that sexual relationships and networks extend beyond the population group immediately affected by an emergency. Therefore, condoms must also be made available to the wider host community - in bars, brothels and other relevant sites - wherever displaced people engage. Contact should be made with whatever groups are already performing AIDS prevention work in these areas to determine what the needs are, and to coordinate the response.

Condoms should be included routinely in the survival/ration packs supplied to workers going into the field, whether aid agency personnel, military, peacekeepers, or observers.

▼ Procurement and quality

Condoms of good quality are essential both for the protection of the consumer and the credibility of the relief programme. Condom quality is determined by quality at time of manufacture and handling while in the distribution pipeline. If the condoms are of good initial quality, are protected with impermeable foil packaging, and are properly stored (protected from rain and sun, in particular), they are likely to retain much of their original quality. In emergency settings, the turnover of condoms is likely to be relatively quick, and they are not as likely to be exposed to the sun and humidity of open-air market stalls.

The procurement office responsible for bulk purchases in emergencies should require a certificate with each shipment of condoms verifying that they have been quality tested on a batch-by-batch basis by an independent laboratory. There is a varied selection of condoms on the market; thus, if an emergency relief agency's experience of condom procurement is weak, the agency can opt to buy them through an intermediary supplier, such as UNFPA, IPPF or WHO. These organizations can buy bulk quantities of good-quality condoms at low cost. UNFPA keeps supplies of male and female condoms in stock which can be sent to the field on short notice.

▼ Calculating condom supplies

During the acute phase of an emergency there is normally little time to seek the detailed information about sexual behaviour

on which calculation of condom supplies is predicated. The decisions about quantities to send to the field will have to be based on whatever information is available. The estimated size of the affected population is important, as is any available indication of the gender and age make-up of the group. National AIDS programmes, if they are still functional, may have useful information on the sexual behaviour of the affected group.

Female condoms should be made available to any population that has had prior experience with female condoms, and where a demand may be present. If the population was not exposed to female condom programming messages and programmes before the emergency, the introduction of the female condom should be delayed until it becomes possible to conduct a properly coordinated information campaign and other programming activities.

Calculations for condom supplies for a population of 10,000 for 3 months¹¹:

Male condoms for 3 months

Assume:

20% of the population are sexually active males.

Therefore:

$20\% \times 10,000 \text{ persons} = 2,000 \text{ males}$

Assume:

20% will use condoms.

Therefore:

$20\% \times 2,000 = 400 \text{ users of condoms}$

Assume:

Each user needs 12 condoms each month, over 3 months.

Therefore:

$400 \times 12 \times 3 \text{ months} = \mathbf{14,400 \text{ male condoms}}$

Assume:

20% wastage (2,880 condoms)

Therefore:

TOTAL = $14,400 + 2,880 = \mathbf{17,280 \text{ (or 120 gross)}}$

Safe sex leaflets: 400

Female condoms for 3 months

Assume:

25% of the population are sexually active women.

Therefore:

$25\% \times 10,000 \text{ persons} = 2,500 \text{ women}$

Assume:

1% will use condoms.

Therefore:

$1\% \times 2,500 = 25 \text{ users of condoms}$

Assume:

Each user needs 6 condoms each month, over 3 months.

Therefore:

$25 \times 6 \times 3 \text{ months} = \mathbf{450 \text{ female condoms}}$

Assume:

20% wastage (90 female condoms)

Therefore:

$\text{TOTAL} = 450 + 90 = \mathbf{540 \text{ (or 3.8 gross)}}$

Safe sex leaflets: 25

Female condom use leaflets: 25

Follow-on supplies should be modified according to the field situation. (Note that demographic profiles in refugee camps may be very different from the normal demographic profiles; there may, for example, be a disproportionately high number of women and children).

► Key resources

Reproductive health in Refugee situations, an inter-agency field manual, chapters 2 and 5.

Managing condom supply manual. Geneva, World Health Organization, 1995. (document WHO/GPA/TCO/PRV/95.6).

Logistics management; forecasting and procurement. Condom Programming Fact Sheet No. 6. (Document WHO/GPA/TCO/PRV/95.12).

WHO specification and guidelines for condom procurement. Geneva, World Health Organization, 1995. (document GPA/TCO/PRV/95.9).

Manual of Inter-Agency Reproductive Health Kits for Crisis Situations, 3rd Edition, UNFPA, New York 2005, Kit 1, Male and Female Condoms

Condom Promotion—Toolkit for Volunteers, IFRC, ARCHI 2010:
<http://www.ifrc.org/WHAT/health/archi/strategy/condom.htm>

Action sheet 7.4: Establish syndromic STI treatment

► Background

Sexually transmitted infections (STI), including HIV/AIDS, spread fastest where there is powerlessness, poverty, social instability and violence. The disintegration of family and community life among displaced populations disrupts the social norms governing sexual behaviour. In emergencies, populations with different prevalence rates of HIV may interact; the population density in refugee camps and displaced persons camps is high; women and children may be raped or coerced into having sex to obtain basic needs such as shelter, food, security and access to services. All these factors increase the risk of transmission of STI and HIV/AIDS. Uniformed forces may also facilitate the spread of these infections.

The risk of HIV transmission is greatly increased in the presence of other STI in both men and women. In some populations, the risk of new HIV infections attributable to STI is 40% or more. Prevention and control of STI are key strategies in reducing the spread of HIV/AIDS.

Comprehensive management of STI involves:

- reducing the incidence of STI, by preventing transmission through the promotion of safer sex, making

condoms widely available, and

- reducing the prevalence of curable STI through early and effective case finding, treatment, partner notification, and surveillance and monitoring.

► Key actions

▼ Provide early and effective case management.

In the early phase of an emergency it is often impossible to implement all the elements of a comprehensive STI programme. As a minimum, however, syndromic treatment of STI must be available for those who present to the health services with symptoms of a STI.

People presenting with a STI should be managed at the first encounter with any health worker. Services should be user-friendly, private and confidential. Special arrangements (flexible hours, adapted opening times, women providers) may be necessary to ensure that women and young people feel comfortable using health services, and in particular STI services.

▼ Provide syndromic treatment.

Provide guidelines for case management, including case definition and management. Treatment of symptomatic cases should be standardized on the basis of syndromes and should not depend on laboratory analysis. If possible, the national treatment protocol should be used. If a national treatment protocol is not immediately available, a standard WHO protocol should be used at the first encounter, using the most effective drugs (for example, antibiotics to which no antimicrobial resistance is known). (See **Key resources**.) As soon as possible thereafter, introduce locally adapted treatment protocols.

Ensure consistent availability of appropriate drugs.

Orders for initial drug requirements should be based on available data from the country of origin and estimated accordingly. If no such data are available, **Key resources** gives a standard calculation for supplies needed for a population of 10,000 people for 3 months.

▼ Offer counselling.

Partners of patients with a STI are likely to be infected and should be offered treatment. Patients should be counselled to tell their partner(s) to come for treatment. To facilitate this, each patient should be provided with anonymous cards to give to contacts. The card should include the address of the clinic and a code linked to the index patient or to his/her presenting syndrome (for example, a number or a particular colour card for urethral discharge, etc.). This allows health staff to give the contact the same treatment as the index patient. Management and treatment of contacts should be confidential, voluntary and non-coercive. Treatment for patients should *NOT* be withheld until they attend with their partner.

▼ Make condoms available.

Patients should be told to use condoms for the duration of their treatment and should be provided with a sufficient supply of free condoms for this purpose. The use of condoms should be explained and an instruction leaflet given. The continued use of condoms and other options to prevent reinfection should be discussed as well. For individuals who may decline condoms, abstinence from sex may be recommended as an alternative.

▼ Monitor STI indicators.

Data on the number of STI cases presenting for treatment or detected in health services are essential for planning services and as an indicator of trends in STI incidence in the community. Always suspect under-reporting of STI. Managers of health care programmes may want to check for the presence of informal networks of treatment for STI, such as in local markets.

▼ Plan comprehensive STI programmes.

Comprehensive prevention, management and surveillance services for STI should be made available at the earliest opportunity. Conduct a situation analysis as soon as possible to help plan appropriate services. For more information, see **Key resources**.

▼ Train health personnel

Train health personnel to be able to:

- diagnose and treat STI according to a syndromic approach;
- explain the importance of treating the partner; and
- promote and explain the use of condoms.

▼ Essential items for treatment

Sample calculation of supplies to treat 10,000 people for 3 months¹²

Assume:

50% of the affected population are adults

Therefore:

50% of 10,000 = 5,000

Assume:

5% of the adults have an STI

Therefore:

5% x 5,000 = 250 persons

Assume:

20% have genital ulcers

Therefore:

20% x 250 persons = 50

Assume:

50% have urethral discharge

Therefore:

50% x 250 persons = 125

Assume:

30% have vaginitis

Therefore:

30% x 250 persons = 75

Assume:

10% will be treated for cervicitis

Therefore: 10% x 250 persons = 25

Genital ulcers (treat for syphilis and chancroid)

Benzathine Benzyl-penicillin 2.4 units, 1 dose	50
Syringes, disposable, 5ml	50
Needles, disposable, 21G	100
Water for injection 10ml	50
Cotton wool, absorbent, not sterile, 100g	3
Chlorhexidine sol. 5%, 1 liter	3
Erythromycin 500mg tablets (4/day x 7 days)	1,400

Urethral discharge (treat for gonorrhoea and chlamydia)

Ciprofloxacin 500mg (single dose)	125
Doxycycline 100mg tablets (2/day x 7 days)	1,750

Vaginitis (treat for candidiasis and trichomonas)

Metronidazole 250mg tablets (2 g single dose or 500mg 2/day x 7 days)	2,000
Clotrimazole 500 mg pessaries (single dose)	100

Cervicitis (treat for gonorrhoea and chlamydia)

Ciprofloxacin 500mg1 (single dose)	20
Doxycycline 100mg tablets (2/day x 7 days)	280

For pregnant women:

Cefixime 400mg tablets (single dose)	20
Erythromycin 500mg tablets (4/day x 7 days)	560

Condom distribution

Condoms (20 gross)	3,000
Safe sex leaflets	100
Poster for syndromic diagnosis of STI	1
Safety box, for used syringes and needles – Capacity 5L	4
Envelope, plastic, 10 x 15 cm – pack of 100 (for drugs/tabs distribution)	10

► Key resources

Guidelines for the Management of Sexually Transmitted Infections, WHO/HIV_AIDS/2001.01
[www.who.int/docstore/hiv/STIManagemntguidelines/ who_hiv_aids_2001.01](http://www.who.int/docstore/hiv/STIManagemntguidelines/who_hiv_aids_2001.01)

Guidelines for Sexually Transmitted Infections Surveillance WHO/CDS/CSR/EDC/99.3.

Alder M, Foster S, Grosskurth H, Richens J, Slavin H. Sexual Health and Health Care: Sexually Transmitted Infections — Guidelines for Prevention and Treatment. Health and Population Occasional Paper. Department for International Development, London. 1996.

Manual of Reproductive Health Kits for Crisis Situations, 2nd edition, UNFPA, New York 2003, Kit 5.

Inter-Agency Field Manual for reproductive health in refugee situations, Chapter 5.

Fact sheets on Sexually Transmitted Diseases and Young People, WHO:
<http://www.who.int/inf-fs/en/fact186.html>

Training Manual on STD Case Management/The Syndromic Approach for Primary Health Care Settings - A Facilitators training package, WHO:
<http://www.wpro.who.int/NR/rdonlyres/2E4A6567-7F1F-484F-8C5D-A1DE3AF4C050/0/FacilitatorsVersion.pdf>

Controlling Sexually Transmitted Disease, Johns Hopkins University:
<http://www.infoforhealth.org/pr/19edsum.shtml>

Action sheet 7.5: Ensure IDU appropriate care

► Background

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. The most rapidly spreading HIV epidemics in the world are among injecting drug users.

Emergency situations have the potential to greatly increase the vulnerability of individuals to drug use and associated HIV infection through a number of mechanisms:

Emergency situations may affect the availability of drugs in the community. For example, drug trafficking is often linked to other criminal activity such as arms trafficking, and may be facilitated through civil disruption. Illicit drug production and trafficking may be used to finance arms purchases and conflict. Where drug production and trafficking occur, local drug use usually follows. Usual drug supplies may be interrupted, so drug users may resort to using new drugs and more efficient ways of using drugs, such as changing from opium and heroin smoking to heroin injecting.

Among drug users risk behaviours may be more prevalent in emergency situations.

For example, sharing of drug injecting equipment may be common in crowded settings such as refugee camps and detention centres, especially when availability of needles and syringes is low.

Stress associated with emergency situations increases the vulnerability of individuals to use drugs to relieve their symptoms.

The non-rational use of injectable opioids for treatment of pain and drug dependence can introduce non-injecting drug users to drug injecting. Intoxication from drug use (including alcohol) can be associated with increased sexual risk behaviour, including sexual abuse. Sex work and drug use are also closely linked.

► Key actions

There are some extremely effective interventions for reducing HIV transmission among injecting drug users. In most communities injecting drug use is illegal and drug injecting populations are stigmatized, marginalized and hidden. Therefore most interventions are controversial and may not be supported by local authorities and the community. In such cases, special attention needs to be given to public education and advocacy to gain support from the community and authorities.

▼ Undertake rapid informal assessment.

A rapid situation assessment should be very informal, consisting of discussions with a few key informants. It is essential to make a brief assessment that will 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. A number of rapid assessment tools are available that can be used for assessment and planning responses. (See **Key resources**.)

▼ **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 access to sterile needles and syringes.**

Injecting drug users need to have uninterrupted and ready access to sterile injecting equipment where possible. 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, with more frequent injecting occurring among cocaine and amphetamine injectors. Health workers, positioned at points where injecting equipment is distributed, need to be educated about the reasons for providing equipment to drug injectors, with an emphasis placed on the objective of preventing HIV transmission. A system for collecting and disposing of used injecting equipment is crucial to reduce the circulation time of used equipment in the community. Where access to sterile injecting

equipment is not guaranteed, efforts should be made to provide injecting drug users with access to bleach and clean water for cleaning their equipment.

▼ **Provide treatment in emergency settings.**

Most resource-constrained settings have very few, if any, services for treating drug dependence. In emergency situations, such services may not be available at all. In settings where drug dependence may be prevalent, 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).

▼ **Perform careful assessment.**

The illegal status of drug use and the hidden nature of drug using populations demands that, as soon as the situation stabilizes, a careful assessment be undertaken before planning and implementing interventions for injecting drug users. This assessment should gather information on: the populations involved in drug use and their mixing patterns; types of drugs used; drug use behaviours, attitudes and beliefs; local laws, rules and regulations relating to drug use and how authorities deal with drug users; and resources available to assist drug users (e.g., needle and syringe access, outreach education programmes, drug dependence treatment services).

As a result of this careful assessment other activities should be set up to complement those undertaken in emergency.

▼ Offer risk reduction information and counselling.

If given adequate information on risks of injecting and strategies for reducing their risks, drug users are likely to change their behaviours. This information can be provided through simple pamphlets (best developed in association with drug users to ensure appropriate terminology and description of local drug use patterns) or through information and counselling provided by health and social workers. Peer education approaches can be very effective, whereby current or ex-drug users are trained to provide outreach education to other drug users.

▼ Provide drug dependence treatment.

Where treatment services do exist, health care workers should be made aware of referral channels and procedures. The most effective opioid dependence treatment for preventing HIV transmission is methadone maintenance.

▼ Provide HIV/AIDS care for injecting drug users.

Drug users should have equitable access to the same HIV/AIDS treatment and care offered to other individuals infected with HIV. There is no justification for excluding drug users from HIV/AIDS treatment.

▼ Avoid use of parenteral drugs for treating patients.

There are many examples of drug users learning to inject drugs from health care workers who have treated them with therapeutic injections (for example, treating a heroin smoker for withdrawal with an injection of buprenorphine). Where possible, the use of therapeutic drugs should be limited to non-injectable forms.

▼ Provide primary prevention of drug use.

Recognizing the increased risks of illicit drug use in emergency situations, consideration should be given to drug prevention education, particularly among young people. Such education programmes, however, should not replace the need to provide the HIV prevention strategies referred to above in communities where drug use is already occurring.

▼ Prevent sexual transmission of HIV among drug users.

Injecting drug users should be targeted with safer sex information and education programmes, condom provision and ready access to treatment of sexually transmitted infections.

► Key resources

Principles for preventing HIV infection among drug users. WHO Regional Office for Europe (1998), Copenhagen, Denmark.

Manual for Reducing Drug Related Harm in Asia; Macfarlane Burnet Centre for Medical Research (1999) [pdf file, 370 pages, 4.8 mb].

Treatment, care and support of injecting drug users living with HIV/AIDS. Medecins Sans Frontieres (2000).

Drug Abuse and HIV/AIDS: Lessons Learned. UNAIDS Best Practice Collection/ODCCP Studies on Drug and Crime (2001).

HIV Risk Reduction in Injecting Drug Users. Ball A, Crofts N (2002) in HIV/AIDS Prevention and Care in Resource

Constrained Settings: Handbook for the Design and Management of Programs, Family Health International, Arlington, USA.

Manual on Risk Reduction for Drug Users in Prisons. Trimbos Institute (2001), Utrecht, The Netherlands

The Rapid Assessment and Response guide on injecting drug users. Draft for Field Testing. World Health Organization (1998), Geneva.

The Technical Guide to Rapid Assessment and Response (TG-RAR) Internet publication, WHO/HIV/2002.22

Action sheet 7.6: Manage the consequences of sexual violence

► Background

The health care provider's responsibility is to provide appropriate care to survivors/victims of sexual violence, to record the details of the history, the physical examination, and other relevant information, and, with the person's consent, to collect any forensic evidence that might be needed in a subsequent investigation. It is not the responsibility of the health care provider to determine whether a person has been raped. That is a legal determination.

Health care services must be ready to respond compassionately to survivors/victims of sexual violence. The health coordinator should ensure that all staff are sensitised to sexual violence and are aware of and abide by **medical confidentiality**. Health care providers (doctors, medical assistants, nurses, etc.) should establish an **agreed-upon protocol** for the care of rape survivors/victims, and this protocol should be in line with relevant national protocols and accepted international standards (see key reference materials below). Health care providers must know how to provide care according to established protocols and have the necessary equipment and supplies. For more information and detailed guidance on the actions in this Action Sheet, see *"Clinical*

Management of Rape Survivors, Developing protocols for use with refugees and internally displaced persons."

Female health care providers should be recruited as a priority, but a lack of trained female health workers should not prevent the provision of services for survivors of rape.

All health care providers must be aware of relevant laws and policies governing health care providers in cases of sexual violence. For example, there may be laws that permit legal abortion in cases of sexual violence. In addition, health care providers will interact with the police in cases where the survivor/victim (or in the case of a child, her family) wishes to pursue legal justice. In many countries, there are police forms that must be completed by the health care provider. Providers need to know how to complete these forms. Some countries have laws mandating health care providers to report cases of sexual violence to police or other authorities. These laws present difficult challenges to the health care providers in terms of medical confidentiality and respect for the survivor's/victim's choice if she does not want to pursue legal action and does not want anyone to know about the abuse. When there are mandatory reporting laws in place, many survivors do not disclose sexual violence to health care providers because of fears of public scrutiny. Another consideration related to legal action is that the health care provider may be required to testify in court about the medical findings observed during the examination. With this in mind, it is often prudent to have a national health care provider conduct the exam because s/he will most likely be available if case comes to court (international staff rotate out more quickly).

► Key actions

Actors in the health sector should develop an agreed-upon protocol for care for survivors/victims of sexual violence. Health care providers in each health service should be trained in the use of the protocol. Activities of the protocol should include the following key actions. Activities of the protocol should include the following key actions.

▼ Prepare the survivor

- Before starting a physical examination, prepare the victim/survivor. Insensitive examinations may contribute to the emotional distress of the victim/survivor
- Introduce yourself and explain key procedures (e.g., pelvic exam)
- Ask if she wants to have a specific support person present
- Obtain the consent of the victim/survivor or a parent if the victim is a minor
- Reassure the victim/survivor that she is in control of the pace of the examination and that she has the right to refuse any aspect of the examination she does not wish to undergo
- Explain that the findings are confidential

▼ Perform an examination

- At the time of physical examination, normalize any somatic symptoms of panic or anxiety, such as dizziness, shortness of breath, palpitations and choking sensations that are medically unexplained (i.e. without organic cause). This means explaining in simple words that these body sensations are common in people who are very scared after having gone through a very frightening

experience, and that they are not due to disease or injury; rather, that they are part of experiencing strong emotions, and will go away over time when emotion becomes less.

- Conduct the medical examination only with the survivor's consent. It should be compassionate, confidential, systematic, and complete following an agreed upon protocol.

▼ Provide compassionate and confidential treatment as follows

- Treatment of life threatening complications and referral if appropriate
- Treatment or presumptive treatment for STIs
- Post-exposure prophylaxis for HIV (PEP), where appropriate
- Emergency contraception
- Care of wounds
- Supportive counselling
- Discuss immediate safety issues and make a safety plan
- Make referrals, with survivor's consent, to other services such as social and emotional support, security, shelter, etc. (See: *Guidelines for Gender-Based Violence Interventions in Humanitarian Settings, Focusing on Prevention of and Response to Sexual Violence in Emergencies*)

▼ Collect minimum forensic evidence

- Local legal requirements and laboratory facilities determine if and what evidence should be collected. Health workers should not collect evidence that cannot be processed or that will not be used
- Counsel the survivor about taking evidence if she may eventually want to

take the case to court. Ensure her that the information will only be released to the authorities with her consent

- For all cases of sexual violence a careful written recording should be kept of all findings of the medical examination that can support the survivor’s story, including the state of her clothes. The medical chart is part of the legal record and can be submitted as evidence if the survivor decides to bring the case to court.
- Keep samples of damaged clothing (only if you can give the survivor replacement clothing) and foreign debris present on her clothes or body, which can support her story.
- If a microscope is available, a trained health care provider or laboratory worker can examine wet-mount slides for the presence of sperm, which proves penetration took place.

Checklist of supplies needed to manage survivors of rape

1. Protocol	Available
Written medical protocol in language of provider	
2. Personnel	Available
Trained (local) health care professionals (on call 24 hours a day)	
A “same language” female health worker or companion in the room during examination	
3. Furniture/Setting	Available
Room (private, quiet, accessible, with access to a toilet or latrine)	
Examination table	
Light, preferably fixed (a torch may be threatening for children)	
Access to an autoclave to sterilize equipment	
4. Supplies	Available
“Rape Kit” for collection of forensic evidence, including:	
• Speculum	
• Tape measure for measuring the size of bruises, lacerations, etc.	
• Paper bags for collection of evidence	
• Paper tape for sealing and labelling	
Set of replacement clothes	
Resuscitation equipment for anaphylactic reactions	
Sterile medical instruments (kit) for repair of tears, and suture material	
Needles, syringes	
Cover (gown, cloth, sheet) to cover the survivor during the examination	
Sanitary supplies (pads or local cloths)	
5. Drugs	Available
For treatment of STIs as per country protocol	
PEP drugs, where appropriate	
Emergency contraceptive pills and/or IUD	
For pain relief (e.g. paracetamol)	
Local anaesthetic for suturing	
Antibiotics for wound care	
6. Administrative supplies	Available
Medical chart with pictograms	
Consent forms	
Information pamphlets for post-rape care (for survivor)	
Safe, locked filing space to keep confidential records	

► Key resources

Clinical Management of Rape Survivors. Developing protocols for use with refugees and internally displaced persons, revised edition. WHO/UNHCR, 2005.

<http://www.who.int/reproductive-health/emergencies/index.en.html>

Inter-Agency Reproductive Health Kits for Crisis Situations, 3rd edition. UNFPA, New York 2005, Kit 3, Rape Treatment.

IAWG Inter-Agency Field manual for Reproductive Health in Refugee Situations. UNHCR/UNFPA/WHO, 1999.

Chapter 4.

<http://www.rhrc.org/pdf/iafmch4.pdf>

Guidelines for Gender-Based Violence Interventions in Humanitarian Settings, Focusing on Prevention of and Response to Sexual Violence in Emergencies, Field test version. IASC, 2005.

<http://www.humanitarianinfo.org/iasc/publications.asp>

MISP fact sheet, Women's Commission for Refugee Women and Children, 2003.

http://www.rhrc.org/pdf/fs_misp.pdf

For more information on prevention and response to sexual violence and exploitation also see: Action sheet 3.1: Protection/ Minimum response: Prevent and respond to sexual violence and exploitation

Action sheet 7.7: Ensure safe deliveries

► Background

Before comprehensive Prevention of Mother to Child Transmission programmes can be considered, basic interventions to prevent excess neonatal and maternal morbidity and mortality must be put in place. This is one of the objectives of the Inter-Agency Minimum Initial Service Package for Reproductive Health (MISP).

► Key actions

▼ Provide clean delivery kits.

Provide clean delivery kits for use by mothers or birth attendants to promote clean home deliveries.

The first priority is that a delivery be safe, clean and without trauma. The population affected by the emergency will include women who are in the later stages of pregnancy, and who will therefore deliver within the first few weeks. Early in an emergency, births will often take place outside the health facility without the assistance of trained health personnel. Delivery kits for home use should be made available to these women. The kits are very simple, and can be used by the women themselves, family members, or traditional birth attendants (TBAs). They can be ordered or made up on site.

A delivery kit includes: one plastic sheet, two pieces of string, one clean (new) razor blade, and a bar of soap, along with instructions for use.

▼ Provide midwife delivery kits.

Provide midwife delivery kits to facilitate clean and safe deliveries at the health facility.

Approximately fifteen percent of pregnancies will develop some complication. Complicated births require skilled attendants and should be referred to a health centre that can provide basic essential obstetric care. Essential care includes parenteral antibiotic treatment, oxytocic drugs, parenteral treatment for eclampsia and manual removal of placenta.

The supplementary unit of the New Emergency Health Kit 1998 has all the materials needed to ensure safe and clean delivery in the health centre. UNFPA also supplies these materials. Skilled birth attendants (midwives, doctors) should strictly adhere to universal precautions and should avoid, to the degree possible, invasive procedures such as artificial rupture of membranes or episiotomy during deliveries. Such procedures may increase the risk of transmission of the HIV virus from the mother to the baby.

▼ Establish a referral system to manage obstetric emergencies.

Approximately three to seven percent of pregnancies will require a caesarean section. These and other additional obstetric emergencies need to be referred to a hospital capable of performing comprehensive essential obstetric care (basic care plus surgery, anaesthesia and safe blood transfusion). A

referral system that manages these obstetric complications must be available as soon as possible for use by the population 24 hours a day. Where feasible, an existing facility can be used and supported to meet the needs of the population. If this is not feasible, due to distance or disruption, an appropriate referral facility should be provided (for example, a tent hospital).

It is necessary to coordinate policies, procedures and practices to be followed with the referral facility and authorities. Be sure there is sufficient transport, qualified staff and materials to cope with the demand.

▼ Organize comprehensive services for antenatal, delivery and postpartum care.

It is essential to plan for the provision of antenatal, postnatal, and postpartum care services, and for their quick integration into primary health care. Otherwise, these services may be unnecessarily delayed. When planning, include the following activities:

- Collect background information. (See Action sheet 2.1: Assess baseline data.)
- Identify suitable sites for the future delivery of this care. (See Action sheet 6.1: Establish safely designed sites.)
- Assess staff capacity and plan to train/retrain staff.
- Order equipment and supplies for comprehensive reproductive health services.

► Key resources

A formula based on the Crude Birth Rate (CBR) is used to calculate the supplies and services required.

Calculating supplies and services required with a CBR of three to five percent per year

Assume:

Population of 10,000
CBR = 4%/year (40 live births/1,000 population)

Therefore:

Total live births per year:
 $10,000 \times 0.04 = 400$
Total live births per three month period:
 $(10,000 \times 0.04) / 4 = 100$

More examples of estimations link IAWG Reproductive Health in refugee situations, an Inter-Agency Field Manual, WHO/UNFPA/UNHCR 1999

Checklist for Safe Motherhood Services

1. Clean delivery kits for home use	Available
2. Basic essential obstetric kits for the health centre	
3. Surgical obstetric and safe blood transfusion kits for the referral level	
4. Identification of a referral system for obstetric emergencies	
5. One health centre for every 30,000 to 40,000 people	
6. One operating theatre and staff for every 150,000 to 200,000 people	
7. One midwife (trained and functioning) for every 20,000 to 30,000 people	
8. One CHW/TBA (trained) for every 2,000 – 3,000 people	
9. Community beliefs and practices relating to delivery are known	
10. Women are aware of services available	

IAWG Reproductive Health in Refugee Situations, an Inter-Agency Field Manual, WHO/UNFPA/UNHCR 1999

Reproductive Health Kits for Emergency Situations, Kit 2, 6, 8, 9, 10, 11, 12

For more information on safe delivery, see: WHO Safe Motherhood documents.

WHO New Emergency Health Kits (NEHK).

Publications on mother-to-child transmission, UNAIDS:
<http://www.unaids.org/Unaids/EN/In+focus/Topic+areas/Mother-to-child+transmission.asp>

Publications on mother-to-child transmission, WHO:
<http://www.who.int/hiv/pub/mtct/en/>

Resources on reproductive health, WHO:
<http://www.who.int/reproductivehealth/publications/>

Prevention of mother-to-child transmission, UNICEF
http://www.unicef.org/publications/index_4414.html, www.unicef.org/aids/index_preventionMTCT.html

Preventing HIV infection in pregnant women, UNFPA:
<http://www.unfpa.org/hiv/prevention/hivprev2a.htm>

Reproductive Health for Refugees Consortium resources:
<http://www.rhrc.org/resources>, www.prb.org/pdf/GBVpressrelease2page1.pdf

Field-friendly Guide to Integrate Emergency Obstetric Care in Humanitarian Programs. Women's Commission, RHRC, New York 2005,
http://www.rhrc.org/pdf/EmOC_ffg.pdf

Action sheet 7.8: Ensure safe blood transfusion services

► Background

The efficacy of HIV transmission through transfusion of infected blood is close to 100%. 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. (See references: The Clinical Use of Blood Handbook. WHO 2001.)
- Use blood substitutes whenever possible: simple crystalloids (physiological saline solutions for intravenous administration) and colloids. (See references: The Clinical Use of Blood Handbook. WHO 2001.)

▼ Select safe donors.

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

Selection of safe donors can be promoted by giving clear information to potential donors regarding when it is appropriate or inappropriate to give blood, and by using a

donor questionnaire. Blood from voluntary, non-remunerated donors is safer than blood from paid donors.

- In emergency situations, people are often motivated to become blood donors.

Unfortunately, those who give blood under pressure or for payment are least likely to reveal their unsuitability for donating blood. Therefore, use of their blood poses a potentially greater risk of transmitting infection. This also applies to family members under pressure to give blood for a relative. Potential donors must be interviewed in a sensitive and understanding manner. All personal information given by the donor must be treated as strictly confidential.

▼ Test all blood donated for transfusion.

- Screening for HIV, Hepatitis B and, if possible, also for hepatitis C and syphilis, should be carried out using the most appropriate assays. Use simple or rapid tests in acute emergency situations. Results of the HIV tests must be unlinked to the donor, until a voluntary counselling and testing service can be put in place after the emergency. Results of all tests must be treated as strictly confidential.
- Time permitting, the following blood tests should be performed:
 - ABO grouping;
 - RhD typing (testing the donated blood for RhD for all transfusions to females in reproductive age group);
 - cross-matching to rule out ABO compatibility.

Group O RhD negative blood could be used if no time available for grouping and cross matching.

▼ Implementation

In the field, clear policies, protocols and guidelines should be available for:

- the recruitment and care of donors;
- appropriate use of blood for transfusion; and
- the safe disposal of potentially dangerous wastes products such as used blood bags, needles and syringes.

To ensure an efficient and well-coordinated service, it will be necessary to appoint a person well experienced in emergency work as the focal point. His or her main responsibilities will be to:

- assess needs and organize delivery of essential supplies for the collection, testing and transfusion of blood;
- indicate conditions in the field: ambient temperature and humidity; available storage facilities for consumables and non-consumables, security of the storage facilities, refrigeration;
- provide the criteria for receiving blood and blood products;
- indicate quantities and specifications (size of blood bags);
- indicate the site and time of delivery of supplies and details of contact person(s) at the receiving end (including addresses, telephone and fax numbers, etc.);
- confirm receipt of supplies, state and condition upon receipt, and ensure delivery to the correct field site;
- monitor and evaluate the process to ensure that supplies are meeting needs;
- re-order in time for future deliveries, and plan ahead.

Appeals for blood donors should be made through the most appropriate channels of communication that exist. This is likely to be the radio. The messages should indicate who should and should not come forward to donate blood, and where and to whom they should report.

The coordination of the provision of safe blood transfusion for the displaced population should be done with the local hospital in the area. Support to the hospital, in the form of basic supplies like reagents or blood bags, might prove critical for both the local and displaced populations.

► **Key resources** Essential items for collection, testing and transfusion of 1000 units of whole blood

Item Description	Usual or preferred presentation	Recommended quantity	Remarks
Perishable items: must be stored at 2°C to 8°C			
Anti-A blood group reagent, monoclonal	5 ml vials	20 x 5 ml	
Anti-B blood group reagent, monoclonal	5 ml vials	20 x 5 ml	
Anti-D blood group reagent (Saline/ monoclonal)	5 ml vials	20 x 5 ml	
HIV 1+2 Simple/rapid tests	100 tests	12 x 100	
HBsAg simple/rapid tests	100 tests	12 x 100	
HCV simple/rapid tests	100 tests	12 x 100	
Phosphate buffered (normal) saline	1 L	12 L	
Consumables: non-perishable			
Single blood collection bags, CPD-A1 (needle must be in-built, preventing re-use)	200 pieces	6 x 200 pieces	Size will differ depending on usual practice for the area 250/350/450 ml
Transfusion set, blood, sterile, with fixed vein needle 18Gx1.5" with inline filter and injection port	100 sets	12 x 100 sets	
IV catheter, 20Gx1/4", sterile, disposable, with wing	50 pieces	10 x 50 pieces	
IV catheter, 22Gx1", sterile, disposable, with wing	50 pieces	10 x 50 pieces	
IV catheter, 23Gx3/4", sterile, disposable, with wing	50 pieces	5 x 50 pieces	
Vacutainer tube 10ml, siliconized	100 tubes	12 x 100 tubes	
Pasteur pipettes with integral bulb, disposable plastic non-sterile, 3 ml graduated in 0.5 ml	500 pipettes	5 x 500 pipettes	
Blood lancets, sterile, disposable	200	10 x 200	
Gauze swab, 8-ply, 10x10cm	100 swabs	50 x 100 swabs	
Plaster, surgical, Tenso, 6x2cm	1000 pieces	5 x 1000 pieces	
Plaster, Albuplast, 9.14x5cm	6 pieces	10 x 6 pieces	
Markers, fine point, permanent black glassware etc.	10 markers	5 x 10 markers	
Impregnated medicated swabs, chlorhexidine or isopropanol	100 pieces	20 x 100	
Test tubes, round bottom, polystyrene, 75 x 10 mm	100 tubes	50 x 100 tubes	
Microscope slides, 25x75mm, glass	50	100 x 50 slides	
Syringe 5ml, hypo, disposable	100 syringes	12 x 100	
Needle, hypo, disposable, 21Gx1.5", Luer, sterile	100 needles	12 x 100	
Needle, hypo, disposable, 23Gx1", Luer, sterile	100 needles	5 x 100	
Haemoglobin Colour Scale	Starter kit Refills	5 x starter kits 50 x refills	
Glove operation latex, disposable, sterile, anatomically shaped, size 6.5 and 7.5	50 pairs	5 x 50 pairs	
Sharps container, disposable, 2 litre capacity		50	
Waste bags, 15 L, black plastic	100 per roll	4 x 100	
Sodium chloride 0.9%, 1 L + set vacutainer for IV human use	20 Vacutainers	200 x 20	Bulk item; appx. weight 4000 Kg
Recommended stationery			
Blood donor forms		1200	
Labels for blood bags		1500	
Laboratory register, hard-back, A4		10	
Transfusion request forms		1000	
One-off items – (If above are re-ordered, these should not be repeated.)			
Sphygmomanometer		5	
Surgical scissors		10	
Tourniquets, arm, adjustable		10	
Domestic body weighing scale, range 0 – 150 Kg		2	
Spring balance for weighing donated blood, range 250 – 600 gm		12	
Test tube racks, 30 holes, plastic		4	
Insulated cool box, 10 L		2	

The Clinical Use of Blood in Obstetrics, Paediatrics, Surgery & Anaesthesia, Trauma & Burns. Module. WHO 2001, 337 pp. English and Spanish. French and Portuguese in preparation.

The Clinical Use of Blood in Obstetrics, Paediatrics, Surgery & Anaesthesia, Trauma & Burns. Module and Handbook.

WHO policy on selection of blood donors, Weekly Epidemiological Record, 1993,44:321- 3.

Aide-Mémoire on Blood Safety for National Blood Programmes. Information sheet. May 2002 WHO/BCT/02.03Arabic/Chinese/English/French/Portuguese/Russian/

Aide-Mémoire on Quality Systems for Blood Safety Information sheet. May 2002. WHO/BCT/02.02 English. Other languages in preparation.

Manual of Inter-Agency Reproductive Health Kits for Crisis Situations, 3rd Edition, UNFPA, New York 2005, Kit 12, Safe Blood Supplies:

Blood donor recruitment – Toolkit for volunteers, IFRC, ARCHI 2010:
<http://www.ifrc.org/WHAT/health/archi/strategy/blood1.htm>

Safe Blood and Blood Products. Distance Learning Materials containing five modules:
Introductory module: guidelines and principles for safe blood transfusion practice
Module 1: safe blood donation
Module 2: screening for HIV and other infectious agents
Module 3: blood group serology

Trainer's guide WHO 2001. 631 pp. Chinese/English/French/ Portuguese/Russian/Spanish

Websites

www.who.int/bct/Main_areas_of_work/BTS/BTS.htm

www.who.int/bct/Resource_Centre.htm#bts

www.who.int/bct/index.htm

Action sheet 8.1: Ensure children's access to education

► Background

Traditionally, education was not seen as a central part of humanitarian action, which tended to focus more on direct life saving interventions. In recent years, however, the importance of education has been increasingly appreciated, with emphasis on education included within consolidated appeals and emergency programmes as an integrated part of the overall emergency response.

Given the long-lasting and chronic nature of so many of today's emergencies (Sudan: 19 years; Somalia: 12 years; Sierra Leone: 10 years), it is vital that education continue throughout the emergency; otherwise, there is the real risk that post conflict reconstruction will be carried out by an uneducated and illiterate population.

In addition, education can provide an important protective function for children caught up in emergencies. The normality and stability provided by daily schooling is psychologically important. Schools are places not only for the teaching of traditional academic subjects, but also for the dissemination of life-saving messages. Schools are effective sites for mine-risk education, HIV/AIDS awareness, and for the promotion of human rights, tolerance

and non-violent conflict resolution. Children learn quickly, and can impart their knowledge in turn to other members of the household, especially in the areas of sanitation and nutrition.

Within HIV/AIDS affected areas and population groups, schooling is of particular importance, as parents may not be in a condition to transmit to their children the basic requisite life skills related to food, nutrition, health and agriculture. Thus, the provision of vocational skills should also be considered from an early stage. Appropriate nutrition education at school (including nutritional care of PLWHA) is also key, as it better equips students to deal with HIV/AIDS infection and disease, and can indirectly have an impact on households.

Children and young people who are in school are more likely to delay the age of first sex - particularly if they get support and learn skills to postpone starting sex - and will seek to learn the life skills needed to protect themselves from HIV/AIDS. They are also less likely to join the military and armed groups where sexual abuse can be common.

► Key actions

- ▼ Keep children, particularly those at the primary school level, in school or create new schooling venues when schools do not exist.
- ▼ Protect places where children gather for education from recruitment by armed groups and from sexual exploitation. Communities should ensure that teachers are not abusing children and that schools are not seen as sites for the recruitment of children into fighting forces.

- ▼ Link humanitarian services (such as special food packages for families tied to attendance) with schools in order to increase attendance levels, to promote a culture that values education, and to promote schools as vital community institutions, not merely a place where children go.
- ▼ Monitor drop-out to determine if and why children are leaving school.
- ▼ If children are dropping out of school because of lack of food, school feeding should be provided. Assistance with school fees, materials and uniforms should be provided as necessary to facilitate children's access to schools.
- ▼ Provide facilities for games and sports at school.
- ▼ Provide psychosocial support to teachers who are coping with their own psychosocial issues as well as those of their students. Such support may help reduce negative or destructive coping behaviours.
- ▼ Brief teachers on the code of conduct which prohibits sex with children. When teacher training takes place, include discussion of the code of conduct.
- ▼ Try to accommodate children who cannot attend school all day because they are caring for an ailing parent or have been orphaned; one solution may be to offer shorter schooling hours at different times of the day.
- ▼ Consider the addition of school gardens and home economics activities.

- ▼ Provide materials to assist teachers (for example, "School in a box" and recreation kits that include HIV/AIDS life skills materials).

► Key resources

Inter Agency Network on Education in Emergencies (INEE):

www.ineesite.org

Global Information Networks in Education: www.ginie.org

UNICEF Life skills website: www.unicef.org/programme

Stepping Stones training package on gender HIV, communication and relationship skills:

www.steppingstonesfeedback.org

UNICEF School in a box and recreation in a box. To order: unicef@unicef.org

Action sheet 9.1: Provide information on HIV/AIDS prevention and care

► Background

Communication in emergency situations is essential to assist people in maintaining or adopting behaviours which minimize the risk of contracting HIV/AIDS, and in accessing services and assistance for those living with or affected by HIV/AIDS. In emergencies, communication activities can be disrupted. It is therefore essential to provide people with the necessary information to minimize the spread of HIV/AIDS, to access basic services, and to receive appropriate advice and assistance to cope with the disease and its consequences, and to be aware of their rights.

► Key actions

▼ Assemble a communications team.

Many of the regular communication partners (teachers, religious leaders) may be unavailable during a disaster. It is important to assemble a team of communications specialists from organizations active in relief and security work, from the government counterparts and from capable volunteers within the affected population, including young people. This will ensure coordination with and integration within functioning programmes and access to the most vulnerable populations.

▼ Assess the situation.

Assessment should focus on understanding the local HIV/AIDS situation and its interaction with the emergency situation, with particular attention to people's behaviours, perceptions and coping mechanisms. Check if there is already a situation analysis on HIV/AIDS, and if so which changes the emergency created. For example:

- Which groups of people are on the move and which have settled?
- Are these the "usual" vulnerable groups or have new ones now been created?
- Where is violence prevalent and where can people congregate safely?
- Where are relief services active? How are they structured? Do they reach any of the vulnerable groups of people identified above, offering an opportunity to integrate communication activities?
- What specific services are available for HIV/AIDS prevention and for supporting those living with or orphaned by HIV/AIDS?
- What other communication efforts are being made? This is an opportunity to integrate HIV/AIDS communication into the work of other sectors.
- What communication channels are still functional? Which would be most effective in reaching the priority groups?

▼ Develop a Communication Plan.

A communication plan for emergency situations focuses on finding a way to communicate to and with the most vulnerable groups. Thus, general awareness and long-term social changes would need to be temporarily suspended in favour of targeted interventions, until some degree

of stability has been achieved. These tasks require that emergency staff:

- identify the most vulnerable groups: women without partners, orphans, child soldiers, etc.
- identify the means of accessing these groups: use person-to-person methods where people gather for humanitarian assistance, at health centres, water points, and interim centres for separated children and/or demobilized child soldiers. Enlist young people to communicate with other young people, women with other women, men with men, soldiers with soldiers, where appropriate. Use functional media such as radio, public address systems, megaphones, and print.
- create opportunities for dialogue on HIV/AIDS issues and related concerns among the specified groups, as well as condom demonstration and "practice." Outcomes of the discussion might include clarification of issues, information exchange, problem solving, and modification of services.
- if simple materials are available in the languages of the population and appropriate to the emergency situation, make them available in prominent gathering places, including toilet and bathing facilities.
- work with humanitarian workers to develop key messages they feel they can deliver, adapting the key messages shown below for specific groups (young people, parents, humanitarian workers and others). Develop a "memory aid" and identify realistic but acceptable models for condom demonstrations, including female condoms, if available.
- focus the messages on available services and commodities

(setting up referral systems where feasible), preventive behaviors, and the unacceptability of sexual abuse and exploitation. Use language and terms understood by the majority of the population.

- keep messages current with the changing security and humanitarian aid situation.
- incorporate religious leaders into education. Given their moral legitimacy, they can often play a crucial role restoring order and establishing functioning programmes.

8 FACTS ON HIV/AIDS

1. A virus called HIV causes AIDS. HIV damages the body's defense system, making it difficult to fight illnesses, and eventually causing death. A person who has HIV can pass it on to others even though he or she appears healthy. There is no cure for AIDS, so preventing infection in the first place is the only way to stay AIDS-free.
2. The HIV virus is found in the following fluids: blood, semen (including pre-ejaculated fluid), vaginal secretions, and breast milk. The virus is most frequently transmitted sexually. Women get sexually transmitted infections (STI), including HIV, from men twice as easily as men get them from women. Girls and young women are at high risk to get STI because their organs are not mature and are easily attacked by germs.
3. People who have STI are at greater risk of being infected with HIV and of transmitting their infection to others. Common signs of an STI include pain during urination, pain in the abdomen or during sexual intercourse, discharge from the penis or vagina, and genital sores. Some people with STI experience few or no symptoms. People with any of these signs should seek prompt treatment; they should avoid sexual intercourse or practice safer sex (non-penetrative sex or sex using a condom), and inform their partners.

4. The risk of sexual transmission of infections including HIV can be reduced if people do not have sex, or if people have safer sex, that is, sex without penetration or sex using a condom.

5. Consistent and correct use of condoms is the only effective means of preventing HIV/AIDS infection among sexually active people. Consistent use means using the condoms issued by the humanitarian services or clinic from start to finish each and every time a person has vaginal, oral or anal sex. Correct use means practicing the steps shown during condom demonstrations during educational sessions. Ask your nearest humanitarian worker your questions about condoms and HIV/AIDS.

6. HIV can also be transmitted when the skin of an infected person is cut or pierced, causing bleeding. Therefore, it is very important to avoid contact with the blood of another person. HIV is not transmitted by: hugging, shaking hands; casual, everyday contact; using swimming pools, toilet seats; sharing bed linen, eating utensils, food; mosquito and other insect bites; coughing, sneezing.

7. Despite the disintegration of social order, rape and forced sex are never acceptable. The high frequency of such practices in emergencies puts women, girls and boys at high risk of infection.

8. If you are well fed (sufficient and varied diet), you will be in a better position to fight disease.

▼ **Monitor.**

Focus monitoring on the use of services and commodities, and on adjusting the communication plan.

► **Key resources**

Voluntary Counselling and Testing (VCT), Technical update, UNAIDS
http://www.unaids.org/html/pub/publications/irc-pub01/jc379-vct_en_pdf.htm

Policy statement on HIV testing, UNAIDS/WHO
http://www.unaids.org/html/pub/una-docs/hivtestingpolicy_en_pdf.htm

Rapid HIV tests: guidelines for use in HIV testing and counselling services in resource-constrained settings, WHO:
<http://www.who.int/hiv/pub/vct/en/rapidhivtestsen.pdf>

UNICEF. The Right to Know Project. 2002.

Hieber, L (2001) Lifeline Media: Reaching Populations in Crisis. A guide to developing media projects in conflict situations, Versoix: Media Action International.

Singal, A. and Rogers, E. (2003) Combating AIDS: Communication strategies in action, New Delhi: Sage Publications.

UNICEF (2000) Involving People, Evolving Behavior, Southbound, Penang.

UNHCR (1995) Reproductive Health in Refugee Situations: An Inter-Agency Field Manual.

CDC or WHO. Instruction sheets on condom use.

Stepping Stones. An award-winning training on HIV/AIDS, gender issues, communication and relationship, Actionaid, <http://www.actionaid.org>

HIV/AIDS rapid assessment guide, FHI <http://www.fhi.org/NR/rdonlyres/evtjsjyoitissfvez7qoi3qhey5vgu5dxukffl3xgjltna5nsxrdbu4tj7wakyoyaoyzz7etrkjp/rhassessmentguide.pdf>

Johns Hopkins Centre for Communication Programmes.
<http://www.jhuccp.org/resources>

Websites:

www.jhuccp.org

www.fhi.org

www.aed.org

www.phishare.org/documents/

TheSynergyProject/421/

www.communit.com

Action sheet 10.1: Prevent discrimination by HIV status in staff management

► Background

In the management of an organization, discrimination for any reason leads to a climate of distrust and ineffectiveness. Discrimination based on HIV status is not merely an unjustified action against the individual; among staff unfamiliar with HIV/AIDS, such discrimination increases stigma and prejudice against those infected. Management must establish a climate of trust and understanding free of fear of stigmatization, discrimination and loss of employment.

There should be no discrimination against workers on the basis of real or perceived HIV status. Discrimination and stigmatization of people living with HIV/AIDS inhibits efforts aimed at promoting HIV/AIDS prevention: if people are frightened of the possibility of discrimination, they may conceal their status, and are more likely to pass on the infection to others. Moreover, they are not likely to seek treatment and counselling.

Workplace information and education programmes are essential to combat the spread of the epidemic and to foster greater tolerance for workers with HIV/AIDS. Effective education can significantly reduce HIV-related anxiety and stigmatization,

minimize disruption in the workplace, and bring about attitudinal and behavioural changes. Better awareness on how to prevent getting HIV infection will contribute to decreasing stigmatization of those infected.

► Key actions

▼ Provide information in the workplace.

Ensure provision of basic materials on HIV/AIDS and the means of transmission (handouts), through the workplace medical service or in informal meetings. Ensure that all workers have adequate information on their organization's policy on HIV/AIDS and the support available to them.

▼ Understand human rights.

By increasing awareness of human rights, organizations will contribute to the development of a healthy work force where individuals feel secure. Through a higher level of organization (staff associations), the rights of the workers are better protected, and this provides less room for social inequality and better balance in the power structures of the organization. All staff members should also have, and be made aware of, equal rights for care and treatment of any illness they may have. Basic materials on human rights and HIV/AIDS can be made available through the staff association, or through unofficial staff meetings.

▼ Provide and maintain confidentiality.

There is no justification for asking job applicants or workers to disclose HIV-related personal information. Nor should co-workers be obliged to reveal such personal information about fellow workers. Awareness of this confidentiality is important in empowering the workers and the staff associations in their dialogue with

management. Ensure that medical records are kept in a safe, locked facility, and that the medical staff and human resource managers are aware of the confidential nature of the information.

▼ **Support social dialogue.**

The successful implementation of a workplace HIV/AIDS policy and programme requires co-operation and trust among employers, workers and their representatives. Emphasis must also be given to the leadership roles of employers' and workers' organizations in breaking the silence around the HIV/AIDS and promoting action. Ensure that HIV/AIDS is adequately addressed in meetings between employers and workers.

▼ **Engage in liaison and advocacy.**

The international and national organizations should ensure active promotion for a better understanding of the HIV/AIDS epidemic and its impact in the workplace, and should promote equal rights among members of the workforce.

▶ **Key resources**

UNAIDS/WHO/UNHCR Guidelines on HIV/AIDS Interventions in Emergencies, 1996 (currently being revised).

The ILO Code of Practice on HIV/AIDS.

Action sheet 10.2: Provide post exposure prophylaxis (PEP) for humanitarian staff

► Background¹³

Post exposure prophylaxis (PEP) is a short-term antiretroviral treatment that reduces the likelihood of HIV infection after potential exposure, either occupationally or through sexual intercourse. Within the health sector, PEP should be provided as part of a comprehensive universal precautions package that reduces staff exposure to infectious hazards at work.

While PEP treatment was originally designed for medical workers accidentally exposed to HIV during their work (for example, by a needlestick injury), the value of PEP treatment is now recognized for other situations involving possible exposure to HIV (for example, through sexual assault or occupational accident).

The risk of transmission of HIV from an infected patient through a needlestick is less than one percent. The risk for transmission of HIV from exposure to infected fluids or tissues is believed to be lower than for exposure to infected blood. The risk of exposure from needlesticks and other means exists in many settings where protective supplies are limited and the rates of HIV infection in the patient population are high. The availability of PEP may reduce the

occurrence of occupationally acquired HIV infection in health care workers.

The availability of PEP for health workers will serve to increase staff motivation and willingness to work with people infected with HIV, and may help to retain staff concerned about the risk of exposure to HIV in the workplace. There is significant debate on the need to use PEP after sexual exposure. PEP can be offered to staff in cases of rape when the likelihood of HIV exposure is considered high.

The proper use of supplies, staff education, and supervision should be outlined clearly in institutional policies and guidelines. Regular supervision by management in health care settings can help to reduce the risk of occupational hazards in the workplace. If injury or contamination result in exposure to HIV infected material, post exposure counselling, treatment, follow-up, and care should be provided. Post exposure prophylaxis (PEP) with antiretroviral treatment may reduce the risk of becoming infected.

► Key actions

▼ Prevent exposure.

Prevention of exposure remains the most effective measure to reduce the risk of HIV transmission to health workers. Priority must be given to training health workers in prevention methods, including universal precautions, and to providing them with the necessary materials and protective equipment. Staff should also know about risks of acquiring HIV sexually, and be able to access condoms easily, and understand the confidentiality of STI treatment services.

▼ Manage occupational exposure to HIV.

- First Aid should be given immediately after the injury: wounds and skin sites exposed to blood or body fluids should be washed with soap and water, and mucous membranes flushed with water.
- The exposure should be evaluated for potential to transmit HIV infection (based on body substance and severity of exposure).
- PEP for HIV should be provided when exposure to a source person with HIV has occurred (or in the likelihood that the source person is infected with HIV).
- The exposure source should be evaluated for HIV infection. Testing of source persons should only occur after obtaining informed consent, and should include appropriate counselling and care referral. Confidentiality must be maintained.
- Clinical evaluation and baseline testing of the exposed health care worker should proceed only after they have given their informed consent.
- Exposure risk reduction education should occur, with counsellors reviewing the sequence of events that preceded the exposure in a sensitive and non-judgmental way.
- An exposure report should be drafted and submitted.

▼ Provide PEP treatment.

PEP treatment has not been proven to prevent the transmission of HIV virus. However, research studies suggest that if the medication is initiated as quickly as possible after potential HIV exposure - that is, ideally within 2 hours and not later than 72 hours following such exposure - it may be beneficial in preventing HIV infection.

Combination therapy is recommended, as it is believed to be more effective than a single agent. Dual or triple drug therapy is recommended.

The therapeutic regimen will be decided on the basis of drugs taken previously by the source patient and known or possible cross resistance to different drugs. The seriousness of exposure and the availability of the various ARVs in that particular setting may also determine the regimen. The combination and the recommended doses, in the absence of known resistance to zidovudine (ZVD) or lamivudine in the source patient, are:

- ZDV 250-300mg twice a day
- Lamivudine 150 mg twice a day

If a third drug is to be added:

- Indinavir 800 mg 3 times a day or Efavirenz 600 mg once daily (not recommended for use in pregnant women)

ARV therapy (available as a PEP “kit”) should be provided according to institutional protocol, or when possible, through consultation with a medical specialist. Expert consultation is especially important when exposure to drug resistant HIV may have occurred. Once PEP has begun, health care workers have ready access to a full month’s supply of ARV therapy. A treatment of four weeks is recommended (28 days).

▼ Provide necessary human resources, infrastructure and supplies.

Institutional guidelines for PEP should be in place. HIV testing, counselling, and antiretrovirals must be available. It is crucial that effective universal precautions are in place and that an uninterrupted supply of protective materials (gloves, sharp

boxes) is available, and that safe disposal of hazardous material occurs. An infection control specialist, staff counsellor and health care worker trained in HIV/AIDS care are beneficial into ensuring that PEP is provided. Health NGOs are encouraged to develop their own occupational PEP policy. Occupational PEP supplies are available through UNFPA and UNICEF procurements services.

▼ Manage PEP.

An example of managing PEP: the UN Guidelines.

- Medication is initiated as soon as feasible after exposure, ideally within 2 hours and not later than 72 hours.
- The UN medical doctor can make the necessary arrangement for evacuation of the patient to a location with adequate medical facilities, to continue the PEP treatment.
- PEP treatment starter kits are available for all people with a UN contract (and their families) who are exposed to the HIV virus because of sexual assault or occupational accident.
- PEP treatment starter kits are sent to all UN Resident Coordinators.

► Key resources

Recommendations for Postexposure Prophylaxis CDC MMWR. www.cdc.gov/hiv/treatment.htm-prophylaxis

WHO. Guidance Modules on Antiretroviral Treatments. Module 7: Treatments following exposure to HIV. Module 9: Ethical, societal issues relating to antiretroviral treatments.

Post exposure preventive treatment starter kits, Guidelines.

AIDS and HIV infection, information for UN employees and families.

Antiretroviral Therapy for Potential Non occupational Exposures to HIV www.cdc.gov/hiv/media/pepfact.html

Endnotes

Chapter 1

¹ IASC is composed of full members (FAO, OCHA, UNDP, UNFPA; UNHCR, UNICEF, WFP and WHO) and Standing Invitees (ICRC, IFRC, IOM, RSG-IDPs, OHCHR, World Bank and three NGO consortia: Steering Committee for Humanitarian Response (SCHR), Interaction, and International Council of Voluntary Agencies (ICVA).

Chapter 4

² In this context, human rights abuses refer particularly to those that increase vulnerability to HIV infection such as sexual violence, and those that discriminate against people infected or affected by HIV/AIDS.

³ Coordination of emergency response and Coordination of HIV/AIDS-related programmes and projects.

⁴ See Action sheet. 7.3 for condom calculation.

⁵ See Action sheet 7.3 for condom calculation.

⁶ The science related to nutrition and people living with HIV/AIDS is evolving rapidly. WHO has convened an expert consultation on potential adjustments to energy requirements of PLWHA and recommendations will be forth coming.

⁷ P. 43, in Food and Nutrition needs in emergencies.

⁸ Through exchange of information, interviews with key informants (local institutions, affected households), and review of existing information.

⁹ This should be systematically incorporated into emergency food and agriculture needs

assessments in high HIV/AIDS prevalence areas.

¹⁰ An example of instructions on condom use are given in “The male condom: UNAIDS technical update.”

¹¹ From: Manual of Reproductive Health Kit for Crisis Situations, 2nd Edition, UNFPA, 2003.

¹² Manual of Reproductive Health Kit for Crisis Situations, 2nd edition, UNFPA, New York 2003. (*The antibiotics in this example are selected for the early phase of an emergency, because no antimicrobial resistance to them is known. National syndromic treatment protocols should be introduced as soon as possible.*)

¹³ This document is adapted from WHO/TSH Document on PEP.

The *Guidelines for HIV/AIDS interventions in emergency settings* provide valuable information for organizations and individuals involved in developing responses to HIV/AIDS during crises. Topics covered include:

- Prevention and preparedness
- Responding to sexual violence and exploitation
- Food aid and distribution
- Safe blood supply
- Condom supply and usage
- Special groups: women and children, orphans, uniformed services personnel, refugees
- Safe deliveries
- Universal precautions
- Post exposure prophylaxis
- Workplace issues, and
- Handling discrimination

The *Guidelines* include a Matrix, designed to present response information in a simplified chart, which can be photocopied readily for use in emergency situations.

The *Guidelines* also include a companion CD-ROM, which provides all the information in the printed *Guidelines* document, as well as documents in electronic format (Acrobat/PDF, Word, HTML). Designed for ease of use, the CD-ROM launches automatically on most computers, and uses simple browser-style navigation.

Published by the Inter-Agency Standing Committee, the *Guidelines* give responders a versatile tool for quickly and easily accessing the latest information on HIV/AIDS in emergency settings.

