

GUIDELINES

for Addressing HIV in Humanitarian Settings



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These guidelines were developed through an interagency process with participation by United Nations (UN) organizations, nongovernmental organizations, the International Red Cross and Red Crescent Movement and the International Organization for Migration.

The IASC was established in 1992 in response to UN General Assembly resolution 46/182, which called for strengthened coordination of humanitarian assistance. The resolution set up the IASC as the primary mechanism for facilitating interagency decision-making in response to complex emergencies and natural disasters. The IASC comprises representatives of a broad range of UN and non-UN humanitarian partners, including UN agencies, nongovernmental organizations and organizations such as the World Bank and the International Red Cross and Red Crescent Movement.

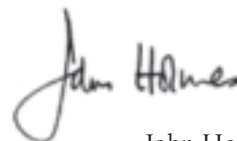
FOREWORD

In 2004, the Inter-Agency Standing Committee (IASC) issued the guidelines *Addressing HIV/AIDS Interventions in Emergency Settings* to help guide those involved in emergency response, and those responding to the epidemic, to plan the delivery of a minimum set of HIV prevention, care and support interventions to people affected by humanitarian crises.

This revised version of the guidelines, *Addressing HIV in Humanitarian Settings*, draws on the experiences of governments; UN, inter-governmental and nongovernmental organizations; and the Red Cross Red Crescent movement; and on recent developments in the field.

The guidelines have been updated to take into account improvements in humanitarian coordination; the growing understanding that antiretroviral therapy can be provided in low-resource settings, including in conflict zones; how quality HIV programming can be achieved when resources and personnel are pooled; and a shared concern that an understanding of all the facets of HIV prevention, treatment, care and support, and of the relevant human rights considerations, is an essential part of preparedness for humanitarian crises.

The IASC's HIV Task Force will actively promote and monitor the field utilization of these guidelines in 2010. They will also ensure systematic collection and consolidation of lessons learnt so that the guidelines can be updated further in due course.



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List of abbreviations

AFASS	acceptable, feasible, affordable, sustainable and safe
AIDS	acquired immunodeficiency syndrome
ART	antiretroviral therapy
ARV	antiretroviral
CD4	cluster of differentiation 4
CERF	central emergency response fund
HIV	human immunodeficiency virus
IASC	Inter-Agency Standing Committee
IAWG	Inter-Agency Working Group
INEE	Inter-Agency Network for Education in Emergencies
MISP	minimum initial service package
PEP	post-exposure prophylaxis
PMTCT	prevention of mother-to-child transmission
STI	sexually transmitted infection
VCT	voluntary counselling and testing

Chapter 1. Introduction

Background

Every year, millions of people around the world are affected by humanitarian crises, both natural (earthquakes, floods, droughts, etc.) and human-made (e.g. external and internal conflicts). A significant proportion of the people affected by these crises are people living with HIV.

HIV has considerably exacerbated the effects of humanitarian crises in many countries. The growing number of humanitarian crises, which are often linked to displacement, food insecurity and poverty, increase vulnerability to HIV and negatively affect the lives of people living with HIV.

The UN General Assembly adopted, in December 2005, a resolution to scale up HIV prevention, treatment, care and support, with the aim of coming as close as possible to the goal of universal access to treatment for all those who need it by 2010. There is a general consensus that universal access targets cannot be reached without addressing HIV prevention, treatment, care, support and mitigation in situations of humanitarian crises. It is universally agreed that any response to HIV in humanitarian crises must take human rights and gender into account.

HIV vulnerabilities and risks in humanitarian crises

The factors that determine HIV transmission during humanitarian crises are complex and depend on the context. Existing gender inequalities may be further exacerbated, making women and children disproportionately more vulnerable to HIV. For example, as a consequence of loss of livelihood and lack of employment opportunities, sex work and sexual exploitation may increase. Mass displacement may lead to the separation of family members and the breakdown of community cohesion and of the social and sexual norms that regulate behaviour. Women and children may be used by armed groups and be particularly vulnerable to HIV infection as a result of sexual violence and exploitation. Rape may be used as a means of warfare.

People living with HIV and other key populations at higher risk of exposure to HIV may require specific measures to protect themselves against neglect, discrimination and violence.

HIV service needs in humanitarian situations

Essential services that existed beforehand may be disrupted during situations of humanitarian crises. People may no longer have access to information about HIV prevention, to condoms or to services for PMTCT. People living with HIV often suffer from disruption of ART and treatment for opportunistic infections. Their health is put at risk because their nutritional needs are not met, and palliative and home-based care may be disrupted. Orphans and other vulnerable children may have lost contact with their care providers. HIV prevention, treatment, care and support programmes existing before the onset of the crisis may have to be re-established.

Purpose of the guidelines

These *Guidelines for Addressing HIV in Humanitarian Settings* aim to assist humanitarian and AIDS organizations to plan the delivery of a minimum set of HIV prevention, treatment, care and support services to people affected by humanitarian crises.

These guidelines are a revised version of a document entitled *IASC Guidelines for HIV/AIDS Interventions in Emergency Settings*. These guidelines take into account the progress made in the implementation of humanitarian coordination and the latest evidence about the feasibility of providing ART in low-resource settings.

These guidelines concentrate on the integration of HIV into the humanitarian response to crises, with a particular focus on two phases: the minimum initial response, which outlines a set of HIV-related interventions to be carried out during the early stages of any emergency *regardless of the specific local or epidemiological context of the epidemic*; and the expanded response, during which additional core HIV interventions should be planned and implemented as soon as possible, taking into account the local contexts and priorities, the epidemiological profiles and the capacity of different sectors to deliver the interventions.

Target audience

These guidelines have been developed for mid-level programme planners and implementers from agencies involved in providing humanitarian assistance. Some agencies may specialize in HIV programme implementation, while others may integrate elements of HIV programming into their humanitarian assistance activities. Not all organizations may be implementing activities within all sectors. These guidelines have been designed in order that the user can refer to sectoral responses as well as relevant actions that should be addressed across all sectors.

HIV scenarios and use of the guidelines

These guidelines are generic and can be applied to, and/or adapted to suit, any humanitarian setting in different epidemic scenarios. Interventions outlined in the minimum initial response package are activities that are required under all circumstances, including in settings with low HIV prevalence. Where the epidemic is concentrated among specific groups/populations, special considerations and strategies should be applied.

In addition to the minimum initial response package, a multisectoral expanded response is required to prevent further transmission of HIV. At the same time, significant support needs to be provided to the large number of individuals, families and communities already affected by the epidemic. Some of the interventions described, including those relating to (larger-scale) treatment programmes, food assistance and livelihood support to HIV-affected communities, and the care and support of orphans, apply primarily to countries with generalized epidemics and a high HIV prevalence, where large numbers of people living with HIV struggle to cope with the additional stress created by the humanitarian crisis.

Overview of the guidelines

The guidelines consist of four chapters:

Chapter 1 provides the reader with the necessary background information on HIV and humanitarian crises and provides an overall outline of the guidelines.

Chapter 2 focuses on coordination arrangements, planning and resource mobilization.

Chapter 3 provides information on the sectoral response to HIV in humanitarian settings for nine key sectors:

- HIV awareness raising and community support;
- Health;
- Protection;
- Food security, nutrition and livelihood support;
- Education;
- Shelter;
- Camp coordination and camp management;
- Water, sanitation and hygiene;
- HIV in the workplace.

The action framework (the matrix) summarizes the overall response by sector and type of response required: preparedness (indicated by a green column heading), minimum initial response (a red column heading) and expanded response (an orange column heading). Each set of interventions under each sector corresponds to an action sheet. The action sheets provide the rationale for and context in which the required actions need to take place, a description of the required actions themselves for the minimum initial response, followed by actions for the expanded response and a list of resource materials for further guidance.

All actions should be undertaken in accordance with other guidelines, international standard operating procedures and standards of quality.

Chapter 4 describes the key monitoring and evaluation activities for the response to HIV in humanitarian settings and proposes a set of HIV prevention, treatment, care and support indicators for both the minimum initial and expanded response phases.

Chapter 2. Coordination of the HIV response in humanitarian settings

When a new humanitarian crisis occurs, the humanitarian country team, under the leadership of the UN Resident Coordinator/Humanitarian Coordinator and in consultation with the government, normally adopts the cluster approach for the coordination of the humanitarian response. This approach aims to improve the predictability, effectiveness and accountability of the humanitarian response by grouping humanitarian actors (including UN agencies, national and international nongovernmental organizations, the International Red Cross and Red Crescent Movement and civil society) in sectoral groups that are normally called ‘clusters’ (although sometimes the government of a country may prefer to call them ‘sectors’). Each cluster is headed by a Cluster Lead Agency whose role is to facilitate a coordinated response in support of national capacity.

In these situations the UNAIDS Country Coordinator will become a member of the Humanitarian Country Team, and it is his or her role to ensure a link between the humanitarian response and existing pre-crisis HIV coordination mechanisms and programming capacities in the country. Normally these include the national AIDS programme, which consists of national ministries, nongovernmental organizations and other country-level HIV actors, and the UN Joint Team on AIDS which brings together UN agencies in supporting the national/local capacity to respond to the HIV epidemic.

The heads of the Cluster Lead Agencies are accountable to the UN Resident Coordinator/Humanitarian Coordinator for ensuring that HIV as a priority cross-cutting issue is appropriately addressed in all aspects and stages of the response. To facilitate this, the Cluster Leads should nominate a focal point to promote and support the mainstreaming of HIV in the work of the cluster. This focal point should be selected from among the cluster participants and should be prepared to play this operational role.

To facilitate inter-cluster coordination on issues related to HIV during the emergency, the Inter-Cluster Coordination Group, comprised of the Cluster Coordinators, may invite these focal points for strategic and operational discussions on the planning and implementation of multisectoral responses to HIV.

In cases where there is a humanitarian crisis but the cluster approach is not being implemented, the UNAIDS country coordinator should seek guidance from the UN Resident Coordinator/Humanitarian Coordinator on the humanitarian coordination mechanism in place and ensure that appropriate linkages are established between that mechanism and the UN Joint Team on AIDS and the national AIDS programme. It is important that all organizations working on HIV in the country coordinate their activities and share their data.

Needs assessments and information management

As already explained, essential HIV prevention, treatment, care and support services may be disrupted during a humanitarian crisis. Such emergency-specific needs should be assessed to determine which interventions are required, the nature and scale of the assistance needed, which interventions should be prioritized and how the available resources should be allocated.

HIV elements must also be integrated into all sectoral initial rapid assessments; for example, health and nutrition should include an assessment of the needs of people living with HIV and of other vulnerable groups. It is also important that any needs assessment data should be disaggregated by sex and age.

In certain situations (i.e. in settings of very high prevalence or where there is a risk of rapid HIV spread in specific groups, such as injecting drug users), specific stand-alone HIV rapid assessments may need to be carried out.

It is important that all HIV-related information and data be shared within the HIV coordination mechanism and any existing sectoral humanitarian bodies.

Preparedness, contingency planning and early recovery

All key humanitarian and HIV actors, including the UN, nongovernmental organizations, intergovernmental organizations, the International Red Cross and Red Crescent Movement and national counterparts, should integrate HIV in all plans and activities. Such planning must take place across the spectrum from preparedness and contingency planning, to emergency implementation, to transition and recovery. Early recovery, sustainable recovery and a return to longer-term development should be planned from the outset of a crisis. In addition, the national AIDS strategic plans should address the HIV needs of those affected by humanitarian crises.

Based on risk and vulnerability mapping, needs assessments and situation analyses, effective planning should include:








- Gap analysis;
- Identifying priorities for HIV prevention, treatment and care, and practical and social support;
- Developing strategies to ensure that responses address these priorities in an effective and coordinated manner;
- Consultations to determine which sector, cluster or agency takes the lead in addressing these priorities.

Mobilizing resources

When a humanitarian crisis occurs and new HIV vulnerabilities and service needs arise, there are essentially four ways of obtaining funds:

- Inclusion of HIV elements into humanitarian planning and appeals processes (flash and consolidated appeals) and into proposals for grants from the UN Central Emergency Response Fund (CERF). CERF has specific guidance on the HIV activities that can be funded under these funds.
- Reprogramming regular HIV funds from national sources, bilateral donors and the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund).
- Allocating existing funds for HIV to the humanitarian response.
- Mainstreaming HIV programming within other proposals for funding.

Resource materials

-  *Inter-Agency Standing Committee. 68th Working Group Meeting. HIV in Humanitarian Situations, Global and Country-level Coordination Mechanisms*, 2007, available at http://www.aidsandemergencies.org/cms/documents/Concept_Paper.doc.
-  *United Nations Office for the Coordination of Humanitarian Affairs, UNAIDS. Joint Letter to Humanitarian Coordinators and UNAIDS Country Coordinators in Countries with Designated Humanitarian Coordinators, on Coordination of HIV in Humanitarian Situations*, 2008, available at http://www.undp.org/cpr/iasc/content/docs/Feb08_LInks/Doc8.pdf.
-  *Cluster Working Group on Early Recovery, UNDG-ECHA Working Group on Transition. Guidance Note on Early Recovery*. Geneva, 2008, available at http://www.humanitarianreform.org/humanitarianreform/Portals/1/cluster%20approach%20page/clusters%20pages/Early%20R/ER_Internet.pdf.
-  *United Nations Office for the Coordination of Humanitarian Affairs. Humanitarian Reforms and Cluster Approach*. Geneva, 2005, available at <http://ocha.unog.ch/humanitarianreform/Default.aspx?tabid=70>.
-  *United Nations Office for the Coordination of Humanitarian Affairs. Applying for CERF Grants*, available at <http://ochaonline.un.org/cerf/WhatistheCERF/RapidResponsegrants/tabid/2841/language/en-US/Default.aspx>.
-  *United Nations Office for the Coordination of Humanitarian Affairs. Revised Guidelines for Flash Appeals*, 2009, available at <http://ochaonline.un.org/OchaLinkClick.aspx?link=ocha&docId=1108853>.
-  *Inter-Agency Standing Committee. Inter-Agency Contingency Planning Guidelines for Humanitarian Assistance*, 2007, available at <http://www.humanitarianinfo.org/iasc/downloaddoc.aspx?docID=4454&type=pdf>

Chapter 3. Action framework (matrix)

Table 1. Action framework

Sector	Preparedness	Action sheet title	Minimum initial response	Expanded response
HIV awareness-raising and community support	<ul style="list-style-type: none"> Develop information, education and communication materials and manage stocks Map people living with HIV and community support networks Familiarize staff with existing guidance on community mobilization as outlined in the IASC Guidelines on Mental Health and Psychosocial Support 	<ol style="list-style-type: none"> Raise HIV awareness and empower communities 	<ol style="list-style-type: none"> Establish an awareness and community support group Disseminate existing messages and material using appropriate channels 	<ul style="list-style-type: none"> Further assess the local HIV situation Expand HIV prevention and awareness programmes
Health	<ul style="list-style-type: none"> Ensure training for standard precautions, blood safety and waste management Provide guidance to people living with HIV on treatment adherence and on counselling and establish confidential registers and medication cards Ensure that system acuity management includes HIV health mapping Conduct assessment on key populations at higher risk of exposure to HIV Train community health workers on HIV Ensure a buffer stock of commodities and treatment Advise people living with HIV on where and how to access services if a natural disaster or complex emergency arises 	<ol style="list-style-type: none"> Prevent HIV transmission in health-care settings Provide access to good-quality condoms Provide post-exposure prophylaxis (PEP) for occupational and non-occupational exposure Manage sexually transmitted infections (STI) 	<ol style="list-style-type: none"> Establish standard precautions and emphasize their importance in health-care settings Segregate and store all waste from patients, collect it daily and dispose of infectious waste appropriately Ensure safe blood supply and rational use of blood Ensure the supply of good-quality condoms Ensure access to condoms and information on proper condom use Include PEP in the clinical management of rape survivors Provide PEP for occupational exposure Provide syndromic treatment of patients presenting with STI symptoms at the first encounter Provide presumptive STI treatment as part of the medical management of rape survivors 	<ul style="list-style-type: none"> Provide all health facility staff (including drivers, janitors, cleaners) with training/a refresher course on standard precautions Ensure the establishment of long-term environmentally friendly waste management options Establish/restore blood bank services Plan and conduct expanded condom promotion campaigns Adapt messages and multiply information channels and condom outlets Train medical staff on the clinical management of rape Establish and expand a multisectoral gender-based violence coordination mechanism/working group at the national, regional and local levels Train health-care and auxiliary staff on standard precautions to prevent occupational exposure Ensure a comprehensive public health package for STI control Establish comprehensive STI case management at first contact Ensure quality care in STI programmes

Sector	Preparedness	Action sheet title	Minimum initial response	Expanded response
		<p>5. Prevent mother-to-child transmission (PMTCT)</p> <hr/> <p>6. Provide care for people with HIV-related illnesses</p> <hr/> <p>7. Provide antiretroviral therapy (ART) to those in need</p> <hr/> <p>8. Provide basic health care and support to key populations at higher risk of exposure to HIV</p>	<p>5.1 Ensure clean and safe deliveries</p> <p>5.2 Continue antiretroviral (ARV) drugs for pregnant women already on ARV drugs</p> <p>5.3 Provide ARV drugs for PMTCT where the mother is known to be HIV-positive</p> <p>5.4 Provide treatment, care and support for infants</p> <p>5.5 Provide infant-feeding guidance for HIV-positive mothers</p> <p>5.6 Ensure the availability of contraceptives</p> <hr/> <p>6.1 Provide co-trimoxazole prophylaxis for HIV-related illnesses</p> <hr/> <p>7.1 Identify people requiring continuation of ART</p> <p>7.2 Provide ART to those previously on treatment</p> <hr/> <p>8.1 Ensure that key populations at higher risk of exposure to HIV have access to HIV prevention interventions for sexual transmission of HIV</p> <p>8.2 Ensure that known injecting drug users have access to clean injecting equipment</p>	<p>Establish comprehensive maternal and newborn care services</p> <p>Establish integrated PMTCT programmes</p> <p>Establish comprehensive infant-feeding counselling for mothers and support for infants exposed to HIV</p> <p>Establish appropriate and effective family planning services</p> <ul style="list-style-type: none"> Provide prophylaxis of other uncomplicated opportunistic infections Treat basic uncomplicated opportunistic infections Ensure access to vaccinations Ensure access to nutritional care and support <p>Ensure continuation of care services for people living with HIV, including home-based care</p> <ul style="list-style-type: none"> Establish voluntary counselling and testing services Initiate and scale up ART programmes <p>Expand interventions targeting key populations at higher risk</p> <ul style="list-style-type: none"> Expand interventions targeting sex workers, men who have sex with men and transgender people <p>Provide injecting drug users with access to harm reduction services</p>
Protection	<p>Review existing laws and policies concerning people living with HIV and key populations at higher risk of exposure to HIV</p> <p>Promote and advocate access to HIV-related services for people living with HIV and key populations at higher risk of exposure to HIV</p> <p>Review and prepare for continuation of legal referral systems for people living with HIV</p> <p>Ensure that systems are in place to document HIV-related human rights violations, including in situations where children are separated, unaccompanied and/or are orphans</p>	<p>1. Protect against HIV-related human rights violations</p> <hr/> <p>2. Protect orphans and unaccompanied, separated and other vulnerable children and youth</p> <hr/> <p>3. Protect the population from gender-based violence</p>	<p>1.1 Monitor allegations of HIV-related human rights violations</p> <p>1.2 Ensure HIV service provision that respects human rights</p> <p>1.3 Establish protection for women and girls</p> <hr/> <p>2.1 Register, monitor and support vulnerable children</p> <p>2.2 Trace families of unaccompanied and separated children and attempt to reunite them</p> <p>2.3 Provide unaccompanied and separated children with the same essential information and services as all children</p> <hr/> <p>3.1 Develop a coordinated response for gender-based violence prevention and response</p> <p>3.2 Develop programmes addressing gender-based violence</p>	<p>Conduct full assessment of the human rights situation</p> <ul style="list-style-type: none"> Mainstream a human-rights-based approach into all HIV programmes Build local capacity to address human rights needs Respond to protection threats by taking appropriate community guided actions <ul style="list-style-type: none"> Re-establish or set up appropriate child protection mechanisms Establish and support care arrangements Build capacity for working with orphans and other vulnerable children <ul style="list-style-type: none"> Ensure that HIV is integrated into a multisectoral gender-based violence response Ensure gender-based violence programmes take into account key populations at higher risk of exposure to HIV

Sector	Preparedness	Action sheet title	Minimum initial response	Expanded response
<p>Food security, nutrition and livelihood support</p>	<p>Preposition supplies in the country and at regional hubs Determine criteria for food assistance to affected individuals and communities Develop agreement on procurement of stocks, transport and distribution of commodities Train staff and partners on (a) integration of HIV interventions in food and nutrition programmes and (b) integration of food security, nutrition and livelihoods skills in support of people living with HIV and orphans and other vulnerable children Integrate HIV proxy indicators (household headed by children or elderly, presence of a chronically ill person in a household) into food security and vulnerability analyses</p>	<p>1. Ensure food security, nutrition and livelihood support</p> <p>2. Provide nutritional support to people living with HIV</p>	<p>1.1 Target and distribute food assistance to HIV-affected communities and households 1.2 Integrate HIV into existing food assistance and livelihood support programmes and food security, nutrition and livelihoods in HIV projects and activities 1.3 Introduce specific measures to protect/adapt the livelihoods of HIV-affected households and support homestead food production</p> <p>2.1 Ensure adequate nutrition and care for vulnerable people living with HIV 2.2 Respond to the specific needs of pregnant and lactating women living with HIV and their children</p>	<p>Adapt agricultural methods and build capacity Provide appropriate relief inputs and training to vulnerable and affected households to restore/rebuild livelihoods Adapt food distribution rations for hyperendemic settings</p> <p>Expand nutrition and care programmes for vulnerable people living with HIV Integrate nutritional support with other services Strengthen the capacity of people living with HIV and those on ART to provide for their nutritional needs</p>
<p>Education</p>	<p>Ensure HIV is included in all formal and non-formal education methods Train teachers and auxiliary staff on HIV, sexual violence and exploitation, and life skills Ensure sufficient stocks of key HIV and life skills educational materials and curricula Establish systems to monitor, supervise and respond to violence and abuse and HIV-related stigma and discrimination Facilitate access to education for children affected and infected by HIV</p>	<p>1. Promote access to relevant and protective education for all children and young people</p>	<p>1.1 Ensure that young people, including those affected by HIV, participate in planning, implementation and evaluation of education programmes 1.2 Provide all children and young people with free access to formal and non-formal education 1.3 Provide needs- and outcome-based participatory life-skills-based HIV education 1.4 Provide enabling and protective learning environments for all children and young people 1.5 Facilitate access to essential HIV health services for learners and staff</p>	<p>Refer affected children and young people to specialist services</p>
<p>Shelter</p>	<p>Ensure the safety of potential sites by designing shelter that decreases vulnerability to HIV and that accommodate the needs of people living with HIV Train staff in the understanding of HIV vulnerability as well as the needs of people living with HIV with regard to the design of sites, camps, urban housing and shelter environments</p>	<p>1. Integrate HIV in shelter activities</p>	<p>1.1 Select sites that are safe and secure 1.2 Integrate HIV prevention messages into shelter programmes</p>	<p>Allocate shelter and land in a non-discriminatory manner</p>
<p>Camp coordination and camp management</p>	<p>Ensure familiarity with existing available HIV programmes and services and how to access these Ensure HIV is included in a comprehensive population profile</p>	<p>1. Integrate HIV in camp coordination and camp management</p>	<p>1.1 Establish HIV-sensitive camp governance mechanisms and services 1.2 Mainstream HIV into camp coordination and camp management</p>	<p>Assess the situations of the affected camp population and plan appropriate programmes Expand camp governance mechanisms that protect people against HIV infection and promote the rights of people living with HIV</p>

Sector	Preparedness	Action sheet title	Minimum initial response	Expanded response
Water, sanitation and hygiene	Train partners in HIV-related considerations for water, sanitation and hygiene programming	1. Integrate HIV in water, sanitation and hygiene programmes	<p>1.1 Ensure that people living with HIV and their carers have access to an appropriate and sufficient quantity and quality of water, sanitation and hygiene services</p> <p>1.2 Ensure that water, sanitation and hygiene programmes minimize the risks of violence against vulnerable groups, including people living with HIV</p> <p>1.3 Integrate HIV prevention messages into water, sanitation and hygiene programmes to help dispel misconceptions about HIV</p>	<p>Assess/monitor the impacts of water, sanitation and hygiene programmes on HIV vulnerability</p> <p>Expand/provide HIV education and hygiene education programmes</p> <p>Ensure access to appropriate water, sanitation and hygiene services in high-prevalence settings</p>
HIV in the workplace	<p>Adopt (agencies) workplace policies and programmes (including training of staff)</p> <p>Establish and disseminate code of conduct</p> <p>Preposition PEP kits and other HIV prevention and treatment commodities</p> <p>Train uniformed services, including for minimization of the risk of sexual violence and exploitation and HIV-related discrimination</p> <p>Deploy kits/medical kits to include HIV prevention and information, education and communication materials</p>	1. Implement HIV in workplace programmes	<p>1.1 Provide HIV information and education</p> <p>1.2 Provide condoms, PEP kits and access to other services</p>	<p>Expand HIV in the workplace programmes</p> <p>Support partners in establishing and implementing HIV in the workplace policies and programmes</p>

3.1. HIV awareness-raising and community support

Action sheet 3.1.1. Raise HIV awareness and empower communities

Successful HIV prevention and care of people living with HIV necessitates awareness among individuals and communities of the risk of infection and an understanding of how to prevent it.

In humanitarian crisis settings, however, such as a natural disaster or conflict, people may be more vulnerable to HIV, yet at the same time information on HIV and prevention measures may not be a high priority in the community. Simple measures to raise awareness on information about rights and where to access HIV prevention and treatment services, and to empower communities to provide needed support, can help to minimize any negative effects of the crisis.

Minimum initial response

Action 1. Establish an awareness and community support team

- Include representatives of the community in the team (people living with HIV, if possible), ensuring sex and age balance and clear definitions of their roles.
- Review available HIV data, information needs and community support priorities.
- Identify a small number of priority actions for communication and support that can be taken immediately, taking into account available information on modes of transmission and infection rates. It is essential to match the response to the epidemic, for example taking into account if HIV is mainly concentrated among sex workers and men who have sex with men. If generalized, information must also be disseminated more widely.
- Determine which, if any, communication channels are still functioning and which would be most effective in reaching priority groups given the local and cultural context of the humanitarian settings.
- Establish contact with representatives of networks of people living with HIV and other community-based organizations to identify their information and support needs.
- Identify other ongoing communications efforts and gauge opportunities to integrate HIV awareness into the different sector/cluster communication activities.

Action 2. Disseminate existing messages and materials, using appropriate channels

- Disseminate culturally appropriate and field-tested messages and materials on HIV prevention, on the prevention of, and available services for responding to, gender-based violence and on AIDS treatment and care via radio and at public gatherings, health centres, schools, water points, food distribution points, temporary centres and camp meetings.
- Provide information about how to access ART (normal services through clinics, etc., are often disrupted in humanitarian settings) (see action sheet 3.2.7).

Expanded response





Action 1. Further assess the local HIV situation

- Assess, and where necessary take action on, changes in people's behaviours, perceptions and coping mechanisms as a result of the humanitarian crisis.
- Develop new and/or adapt and disseminate existing information messages and materials to the particular humanitarian setting.

Action 2. Expand HIV prevention and awareness programmes

- Work with existing community prevention and care networks and aim to align them with local and national structures.
- Advocate for the inclusion of people representing affected communities in local and national coordination forums.

Resource materials

-  UNAIDS. *Intensifying HIV Prevention: UNAIDS Policy Position Paper*. Geneva, UNAIDS, 2005, available at http://data.unaids.org/publications/irc-pub06/jc1165-intensif_hiv-newstyle_en.pdf.
-  UNAIDS. *Practical Guidelines for Intensifying HIV Prevention: Towards Universal Access*. Geneva, UNAIDS, 2007, available at http://data.unaids.org/pub/Manual/2007/20070306_prevention_guidelines_towards_universal_access_en.pdf.
-  UNAIDS. *Policy Brief on the Greater Involvement of People Living with HIV (GIPA)*. Geneva, UNAIDS, 2007, available at http://data.unaids.org/pub/BriefingNote/2007/JC1299_Policy_Brief_GIPA.pdf.
-  UNAIDS, Inter-Agency Task Team on HIV and Young People. *Global Guidance Brief on HIV Interventions for Young People in Humanitarian Emergencies*. New York, United Nations Population Fund, 2008, available at http://www.who.int/child_adolescent_health/documents/pdfs/iatt_hivandyoungpeople_emergencies.pdf.

3.2. Health

The following action sheets outline the essential actions that the health sector must take to prevent HIV transmission and to provide care and support to people living with HIV in the minimum initial response and beyond. These are in line with a number of international commitments and processes.

The reduction of HIV transmission is a component of the minimum initial service package (MISP) for reproductive health in emergencies. The MISP outlines the actions needed to respond to the priority life-saving reproductive health needs of populations (including people living with HIV) in the early phase of an emergency. In addition to reduction of HIV transmission, the MISP includes prevention of excess neonatal and maternal morbidity and mortality, the prevention and clinical management of sexual violence and coordination and planning activities as critical minimum actions. The MISP is a Sphere standard and is designed to be implemented without a needs assessment, since documented evidence already justifies its use.

The concept of the MISP was developed by the Inter-Agency Working Group (IAWG) on Reproductive Health in Crises as a result of the 1994 International Conference on Population and Development. The IAWG also designed a set of prepackaged reproductive health kits, which include medicines, equipment and medical supplies to implement the MISP. The IAWG reproductive health kits are complementary to the Inter-Agency Emergency Health Kit 2006.

Addressing HIV in humanitarian settings is also essential to achieving international commitments (such as those by G8 members and, subsequently, Heads of States and Governments at the 2005 UN World Summit) for universal access to HIV prevention, treatment care and support by 2010. Without scaled-up efforts to address the HIV needs of populations of humanitarian concern, universal access targets cannot be reached in countries affected by complex emergencies and humanitarian crisis, nor in post-conflict and early recovery settings.

Action sheet 3.2.1. Prevent HIV transmission in health-care settings

The prevention of HIV transmission in health-care settings (hospitals, health-care clinics, during vaccination campaigns, etc.) is a priority during all phases of a crisis. Essential to this are the following actions: ensuring the application of standard precautions, establishing safe and rational blood transfusion practices and the correct disposal of waste.

The standard precautions are a simple set of procedures to be used at all times in the care of all patients to minimize the risk of transmission of blood-borne and other pathogens. These procedures are vital in the prevention of HIV transmission from patient to patient, from health-care provider to patient and from patient to health-care and related staff. Standard precautions are an important part of the MISP and should be in place at the immediate onset of a crisis. The guiding principle of the standard precautions is to assume that all blood products and body fluids are potentially infectious.

Waste generated in health-care facilities includes a broad range of materials, such as blood, body tissues, chemicals, diagnostic samples, medical devices, pharmaceuticals, soiled dressings and used needles and syringes. Poor management of health-care waste potentially exposes health staff, cleaners, waste handlers, patients and others in the community to infection, including of HIV. Proper disposal procedures must be implemented in order to minimize this risk.

Transfusion of blood infected with HIV is almost 100% likely to transmit HIV to the recipient. During a humanitarian crisis, rational and safe blood transfusion measures should be put in place. This can be arranged with the local health facilities in close collaboration with the ministry of health.

Minimum initial response

Action 1. Establish standard precautions and emphasize their importance in health-care settings

A. Emphasize the importance of standard precautions within health-care settings

- Stress the importance of standard precautions within health-care settings in coordination meetings.
- Strengthen implementation of standard precautions procedures by organizing on-the-job information-sharing/training sessions for health-care providers, housekeepers, drivers, cleaners and other auxiliary staff.
- Establish a supervision system to ensure compliance with the standard precautions protocols.

B. Establish standard precautions

- Provide health-care staff with clear standard precautions protocols based on international best practice.
- Ensure facilities and supplies for frequent hand washing.
- Order and distribute all necessary supplies (see checklist below).

- Make available, where there is a possibility of exposure to large amounts of blood, protective clothing such as waterproof gowns and aprons, masks, eye shields and boots.
- Make a checklist of standard precautions available that outlines the essential steps to take in the ward, as well as steps to disinfect and sterilize equipment in sterilization areas. Supervisors can also use these checklists to ensure that health workers comply with all the standard precautions steps.
- Post clearly visible standard precautions protocols in wards and sterilization areas.

Checklist of resources needed for standard precautions

- Sharps boxes
- Disposable needles and syringes
- Heavy-duty rubber gloves, disposable gloves, sterile gloves
- Masks, gowns, eye protection
- Pressure-type sterilizers in all health-care settings
- Rubber boots
- Rubber sheets
- Simple incinerators and burial pits
- Soaps, antiseptics, disinfectants

Action 2. Segregate and store all waste from patients, collect such waste daily and dispose of infectious waste appropriately

A. Segregate and store all waste from patients

- Segregate all medical waste materials at the point of generation according to their type.
- Collect infectious non-sharp waste in washable polyvinyl chloride (PVC) containers with a capacity of 40–50 litres. Cardboard containers lined with a plastic bag are also an option.
- Collect used sharps (needles, glass ampoules and vials) in sharps boxes or other puncture-proof containers. Plastic containers can be used when no other options are available.

B. Collect waste daily, especially in warm climate areas

- Use a cart or trolley for internal transport.
- Train staff handling medical waste in appropriate handling procedures and provide them with protective equipment (gloves, boots and a blouse/shirt are minimum requirements).

C. Dispose of infectious waste appropriately

- Incinerate all waste, including human waste such as placentas and soiled dressings, or dispose of it in protected pits.
- Use simple short-term solutions such as De Montfort Mark 7 incinerators in the grounds of the health facility, or transport the waste safely to a functioning nearby incinerator if one is available.
- If no incinerator is available, bury sharps, ampoules and vials in a fenced pit 1 to 2 metres wide and 2 to 5 metres deep and at least 10 metres from any water source.

Action 3. Ensure a safe blood supply and a rational use of blood

A. Appoint an experienced person to be in charge of blood transfusion services whose responsibilities will be to:

- Ensure that staff know how and have supplies to reduce the need for blood transfusions.
- Ensure that standard operating procedures for blood transfusions are in place in a central location, as well as at the place where each procedure is performed.
- Inform staff on protocols and ensure that procedures are followed at all times.
- Assign responsibility and hold medical staff in the health facility accountable.
- Ensure that safe donors are recruited.
- Ensure that laboratory facilities have sufficient supplies.

B. Ensure the rational use of blood

- Transfuse blood only in life-threatening circumstances and when there is no other alternative.
- Use medicines to prevent or reduce active bleeding (oxytocin, adrenaline) and blood substitutes to replace lost volume wherever possible.
- Ensure safe transfusion practices at the bedside and the safe disposal of blood bags, needles and syringes.

C. Select safe donors

- Only collect blood from voluntary unpaid blood donors at low risk of acquiring transfusion transmissible infections.
- Select safe donors through a donor questionnaire and by giving clear information to potential donors on requirements for blood safety.

D. Screen all blood for transfusion for HIV and other transmissible infections

- Screen all blood for transfusion for HIV, hepatitis and syphilis in line with national protocols or the latest updated standards provided by the World Health Organization (WHO).
- Do not reveal the results of screening tests to donors. Refer them to counselling and testing services once these are established (in the expanded phase).
- Perform ABO grouping and cross-matching and RhD (rhesus blood group, D antigen) typing, especially when transfusing blood to women of reproductive age.

Expanded response

Action 1. Provide all health facility staff (including drivers, janitors and cleaners) with training/refresher training on standard precautions as soon as the situation allows.







Action 2. Ensure the establishment of long-term environmentally friendly waste management options as soon as the situation allows.

- In general, non-burn technologies such as autoclaving should be preferred to incineration technologies.

Action 3. Establish/restore blood bank services as soon as the situation allows

- Ensure a comprehensive quality control system covering the entire transfusion process, from donor recruitment to the follow-up of recipients of transfusion.
- Refer blood donors who want to know their HIV status for voluntary counselling and testing services as soon as such services are operational.
- Make policies, protocols, guidelines and job descriptions available for staff working with blood and blood products.

Resource materials

-  World Health Organization. *Standard Precautions in Health Care, WHO Epidemic and Pandemic Alert and Response*. Geneva, World Health Organization, 2006, available at <http://www.who.int/csr/resources/publications/StandardPrectHC.pdf>.
-  World Health Organization. *Safe Health-care Waste Management*. Geneva, World Health Organization, 2004, available at http://www.who.int/water_sanitation_health/medicalwaste/en/hcwmpolicye.pdf.
-  World Health Organization. *Health Care Waste Management: Fact Sheet No.281*. Geneva, World Health Organization, 2004, available at <http://www.who.int/mediacentre/factsheets/fs281/en/index.html>, http://www.who.int/topics/medical_waste/en/, http://www.healthcarewaste.org/en/115_overview.html.
-  World Health Organization. *Aide-memoire for National Blood Programmes*. Geneva, World Health Organization, 2002, available at http://www.who.int/bloodsafety/transfusion_services/en/Blood_Safety_Eng.pdf.
-  World Health Organization. *The Clinical Use of Blood*. Geneva, World Health Organization, 2002, available at http://www.who.int/bloodsafety/clinical_use/en/Handbook_EN.pdf.
-  World Health Organization. *Inter-Agency Emergency Health Kit*. Geneva, World Health Organization, 2006, available at <http://www.drugdonations.org/mrhealthkit.pdf>.

Action sheet 3.2.2. Provide access to good-quality condoms

Male and female condoms are essential items in emergency relief supplies. If they are used correctly and consistently (during every act of sexual intercourse), condoms offer effective protection against the transmission of STI, including HIV, and unwanted pregnancies. Providing access to free condoms to prevent the transmission of HIV is one of the objectives of the MISp.

Minimum initial response

Action 1. Ensure the supply of good-quality condoms

- Ensure that the procurement office responsible for bulk purchases for emergencies adds a certificate to all shipments declaring that the condoms have been quality tested on a batch-by-batch basis by an independent laboratory.
- Agencies with limited experience of condom procurement should procure them through the United Nations Population Fund (UNFPA) or WHO. These organizations can rapidly ship bulk quantities of good-quality condoms to the field as part of the reproductive health kits. As well as male condoms, female condoms should also be distributed if it is known that female condoms were used by the affected population before the humanitarian crisis.
- In order to retain much of their original quality, keep condoms in their original packaging (aluminium foil or plastic cover) and protect them from rain, heat and sun.
- Use the inter-agency reproductive health kits, including kit¹ 1A (male condoms) and kit 1B (female condoms). These kits contain sufficient condoms to cover the needs of a population of 10 000 people for three months as well as leaflets explaining the appropriate use of male and female condoms.

Action 2. Ensure access to condoms and information on proper condom use

- Distribute male condoms and, where appropriate, female condoms free of charge in a wide range of places—clinics and health centres, bars, brothels, community centres and other settings where people, including young people, meet socially.
- Provide information leaflets on the proper use of condoms (in some areas these will be needed in different languages as well as with pictorial representations and with information on safe disposal as well as use).
- Involve stakeholders (such as health and community workers, traditional and religious leaders, adolescents, sex workers, etc.) in decision on culturally acceptable delivery sites.
- Utilize possible existing networks of, for example, community health workers and community-based distributors for condom distribution.

Table 2. Calculations for condom supplies for a population of 10 000 for three months

Male condoms for three months	Female condoms for three months
Assume: 20% of the population are sexually active males	Assume: 25% of the population are sexually active females
Therefore: 20% × 10 000 persons = 2000 males	Therefore: 25% × 10 000 persons = 2500 women
Assume: 20% will use condoms.	Assume: 1% will use condoms.
Therefore: 20% × 2000 = 400 users of condoms	Therefore: 1% × 2500 = 25 users of condoms
Assume: Each user needs 12 condoms each month, over three months	Assume: Each user needs six condoms each month, over three months
Therefore: 400 × 12 × 3 months = 14 400 male condoms	Therefore: 25 × 6 × 3 months = 450 female condoms
Assume: 20% wastage (2880 condoms)	Assume: 20% wastage (90 female condoms)
Therefore:	Therefore:
TOTAL = 14 400 + 2880 = 17 280 (or 120 gross)	TOTAL = 450 + 90 = 540 (or 3.8 gross)

¹ http://www.rhrc.org/resources/general_fieldtools/unfpa_rhkit.htm.

Expanded response




Action 1. Plan and conduct expanded condom promotion campaigns

- If needed, conduct knowledge, attitude, practice and behaviour surveys in order to plan awareness campaigns targeting different groups in the community, assuming this has not been done before. Assess the main factors that prevent the use of condoms by different groups of people.
- Pay particular attention to reach injecting drug users, men who have sex with men, sex workers and their clients, and address cultural, religious and legal issues and barriers, where necessary.
- If the humanitarian crisis has resulted in large numbers of refugees and other displaced people in the area, be sensitive to their different cultures (for example, refugees often move from areas of low HIV prevalence to those of higher prevalence and therefore may have received less or no education on HIV prevention).

Action 2. Adapt messages and multiply information channels and condom outlets

- Produce condom promotion messages for youth that stress ‘dual protection’ (using another method of family planning with condom use to ensure optimal pregnancy prevention) and that young people have access to other methods of family planning (see action sheet 3.2.5).
- Inform the public on how and where to obtain condoms through whatever communication channels are available, for example radio and posters.
- Inform the community about the proper use of condoms, in order to avoid misuse.
- Coordinate with groups already performing HIV prevention work in these areas in order to determine what the needs are, and harmonize messages.
- Where necessary, re-establish the distribution channels and outlets that existed before the crisis; for example, through social marketing programmes, community health workers and community-based distributors.

Resource materials

-  Office of the United Nations High Commissioner for Refugees. *Promoting the Female Condom to Refugees*. Geneva, Office of the United Nations High Commissioner for Refugees, 2006, available at <http://www.unhcr.org/protect/PROTECTION/4462f3e82.pdf>.
-  Office of the United Nations High Commissioner for Refugees. *Reproductive Health Kits for Emergency Situations*. New York, Office of the United Nations High Commissioner for Refugees, 2007, available at http://www.rhrc.org/resources/general_fieldtools/unfpa_rhkit.htm.
-  Office of the United Nations High Commissioner for Refugees. *Reproductive Health in Refugee Situations: an Inter-Agency Field Manual, revised manual*. Geneva, Office of the United Nations High Commissioner for Refugees, 2009, available at <http://www.unfpa.org/emergencies/manual/>, <http://www.who.int/reproductivehealth/topics/emergencies/en/index.html>.

Action sheet 3.2.3. Provide post-exposure prophylaxis (PEP) for occupational and non-occupational exposure

Scaling-up PEP services is particularly important in humanitarian settings for both occupational and non-occupational exposure to HIV.

PEP refers to services provided to prevent HIV infection in an exposed individual. It is part of a comprehensive set of services that include first aid, exposure risk assessment, counselling and, depending on the outcome of the exposure assessment, prescription of a 28-day course of antiretroviral (ARV) drugs, with appropriate support and follow-up and, when appropriate, emergency contraception and presumptive treatment for STI.

Occupational exposure is an exposure to blood-borne pathogens sustained by an individual in the course of their work. This type of exposure should not be assumed to affect health-care-related workers only; others may be exposed to blood and other potentially infectious body fluids while performing their work.

Non-occupational exposure to HIV infection is an exposure sustained by an individual outside of the work setting. This includes sexual assault (rape), sharing drug injection equipment among injecting drug users, or condom failure in discordant couples.

General principles

- Provide PEP to people potentially exposed to HIV as soon as possible, but within 72 hours of the incident. Do not provide PEP to people who present themselves more than 72 hours after the incident.
- PEP should not be provided to a person who is known to be HIV-positive.
- Voluntary counselling and testing is recommended within one week of the exposure. However, it should not be a prerequisite for the provision of PEP.
- Counselling and testing should never be mandatory nor should the provision of PEP be delayed while waiting for the test results.
- The WHO/International Labour Organization PEP guidelines recommend a **two-drug regimen** (where possible in a fixed-dose combination) for 28 days.
- If the person exposed may not be able to return to the health-care setting after seven days, a 28-day supply should be made available rather than a seven-day starter pack.
- A standard three-drug combination should only be proposed in settings where the background drug resistance to ART exceeds 15%, particularly in occupational settings.
- Nevirapine should never be provided as PEP medication.

Minimum initial response

Action 1. Include PEP in the clinical management of rape survivors

- Provide compassionate treatment, information and psychological first aid (i.e. practical and very basic psychological support) to rape survivors. In order to make services accessible to all rape survivors, health-care providers should ensure that services are confidential, respectful and safe.
- Inform the community of the availability of services for rape survivors and of the importance of seeking such services as soon as possible.
- Ensure, where possible, that female health workers are available to provide post-rape care. However, a shortage of trained female health workers should not prevent the provision of services for survivors of rape.
- Identify or develop national clinical management of rape protocols and ensure that the package of services provided includes the following:
 - Treatment of life-threatening complications.
 - Provision of examination, treatment and psychological first aid in a private and safe environment, while ensuring confidentiality.
 - Documentation of findings during the examination. Forensic samples should be collected if agreed to by the survivor. Do not collect evidence that cannot be processed or that will not be used.
 - Cleaning and care of wounds and provision of vaccination as per protocol.
 - Provision of presumptive treatment for STI (see action sheet 3.2.4).
 - Offer of PEP based on the risk assessment as soon as possible and up to 72 hours after the rape.
 - Offer of emergency contraception to women and girls who have been raped as soon as possible and up to 120 hours after the rape.

- Discussion of immediate safety and protection issues for the survivor and a safety plan made.
- Link, with the survivor's consent, to other available mental and psychosocial support (see action sheets 3.3.3).
- Ensure full collaboration with appropriate gender-based violence coordination mechanisms.

Action 2. Provide PEP for occupational exposure

Follow protocols on occupational exposure and implement these interventions in the following order:

- Administer first aid immediately after the injury, wash wounds and skin, **without rubbing**, with mild disinfectant or saline water and flush mucous membranes with water.
- Evaluate the source of exposure for potential to transmit HIV.
- Counsel the source patient, maintain confidentiality and ensure follow-up support.
- Consult with the exposed worker and undertake a risk assessment. The consultation should include, where indicated, support regarding PEP/antiretroviral adherence, follow-up and management of side-effects, advice to the exposed worker to use precautions, including safer sex practices, to prevent secondary transmission during the next three months or until their HIV status is known. Link to mental health and psychosocial support as needed.
- Provide PEP when indicated.
- Provide condoms.
- Complete an exposure report and submit according to agreed-upon protocols.







Expanded response

Action 1. Train medical staff on the clinical management of rape

Action 2. Establish and expand multisectoral gender-based violence coordination mechanism/working group at the national, regional and local levels

Action 3. Train health-care and auxiliary staff on standard precautions to prevent occupational exposure (see action sheet 3.2.1)

Resource materials

-  World Health Organization, International Labour Organization. PEP to Prevent HIV Infection: Joint WHO/ILO guidelines on post-exposure Prophylaxis (PEP) to Prevent HIV Infection. Geneva, World Health Organization, 2007, available at http://whqlibdoc.who.int/publications/2007/9789241596374_eng.pdf.
-  World Health Organization, Office of the United Nations High Commissioner for Refugees. Clinical Management of Rape Survivors. Developing protocols for use with refugees and internally displaced persons, revised edition. World Health Organization, Office of the United Nations High Commissioner for Refugees, 2004, available at <http://whqlibdoc.who.int/publications/2004/924159263X.pdf>.
-  Office of the United Nations High Commissioner for Refugees. Antiretroviral Medication Policy for Refugees: the UN Refugee Agencies' Antiretroviral Medication Policy for Refugees. Geneva, Office of the United Nations High Commissioner for Refugees, available at http://data.unaids.org/pub/Report/2007/20070326_unhcr_art_en.pdf.
-  Inter-Agency Standing Committee. Guidelines for Gender-based Violence Interventions in Humanitarian Settings. Focusing on Prevention of and Response to Sexual Violence in Emergencies. Geneva, Inter-Agency Standing Committee, 2005, available at http://www.humanitarianinfo.org/iasc/content/subsidi/tf_gender/gbv.asp.
-  World Health Organization, Office of the United Nations High Commissioner for Refugees, United Nations Population Fund. *An e-learning Program on Clinical Management of Rape*, 2009, available at www.unhcr.org.
-  United Nations Children's Fund. *Caring for Survivors of Sexual Violence*, 2009, available at www.unicef.org.

Action sheet 3.2.4. Manage sexually transmitted infections (STI)

Humanitarian crises increase people's vulnerability to all STI, not just HIV. This is true even in low-prevalence settings, as during such crises, and for a variety of reasons, people may be more likely to have unprotected sex. These STI, including syphilis, gonorrhoea and herpes simplex virus 2 (HSV2), may accelerate the transmission of HIV sexually.² It is therefore important to provide some level of STI management in humanitarian crises.

In crisis situations, comprehensive laboratory-based STI management is unlikely to exist. Syndromic diagnosis and treatment of STI should be made available at the primary-care level as part of the minimum initial response.

Minimum initial response

Action 1. Provide syndromic treatment to patients presenting with STI symptoms at the first encounter

- Integrate STI syndromic diagnosis and treatment in the services provided by primary health-care facilities.
- Provide syndromic treatment to all patients presenting with a symptom of a STI, such as genital ulcers, at the first visit.
- Where possible, use the antibiotics in the national syndromic treatment protocols. If these are not available, WHO recommended first-line antibiotics should be provided; ensure adequate supplies.
- Ensure confidentiality and privacy during STI consultations and advise STI patients to ask their partners to seek treatment.
- Make condoms available to those treated for STI (see action sheet 3.2.2).

Action 2. Provide presumptive STI treatment as part of the clinical management of rape survivors

- Make available protocols for post-rape treatment, including presumptive STI treatment (and PEP), and inform health-care providers about their use (see action sheet 3.2.3). Presumptive treatment for STI is indicated where there are no symptoms to guide syndromic management.
- Inform the community of the importance of seeking health services in the event of sexual violence (see action sheet 3.3.3).

Expanded response

Action 1. Ensure a comprehensive public health package for STI control

- Increase public awareness of STI.
- Conduct campaigns to promote safer sex and condom use.
- Ensure comprehensive STI case management at first contact.
- Ensure that all segments of the population have access to STI services.
- Put in place mechanisms for early detection of infections
- Integrate STI prevention, screening and care into other services (such as screening of pregnant women, family planning services, adolescent health services).

Action 2. Establish comprehensive STI case management

- Diagnosis (clinical, laboratory or syndromic) and treatment in line with national protocols.
- Provide patient education.
- Ensure individual education on and provision of condoms in a STI clinic.
- Set up partner notification and proper STI case management.

² World Health Organization, UNAIDS. *STI Interventions for Preventing HIV: Appraisal of the Evidence*, 2008.

Action 3. Ensure quality of care in STI programmes

- Make available accessible, affordable, appropriate services.
- Ensure updated national STI management protocols.
- Train health workers in STI care.
- Ensure a sustainable supply of effective STI drugs.
- Guarantee confidential contact tracing systems.
- Ensure monitoring and supervision of clinics.

Resource materials

-  World Health Organization. *Guidelines for the Management of Sexually Transmitted Infections*. Geneva, World Health Organization, 2003, available at <http://www.who.int/reproductivehealth/publications/rtis/9241546263/en/index.html>.
-  World Health Organization. *Sexually Transmitted and other Reproductive Tract Infections—a Guide to Essential Practice*. Geneva, World Health Organization, 2005, available at <http://whqlibdoc.who.int/publications/2005/9241592656.pdf>.
-  World Health Organization. *Prevention and Management of Sexually Transmitted and Reproductive Tract Infections (Standards for Maternal and Neonatal Care)*. Geneva, World Health Organization, 2006, available at http://www.who.int/making_pregnancy_safer/publications/Standards1.2N.pdf.
-  World Health Organization. *Global Strategy for the Prevention and Control of Sexually Transmitted Infections 2006 - 2015: Breaking the Chain of Transmission*. Geneva, World Health Organization, 2007, available at <http://www.who.int/reproductivehealth/publications/rtis/9789241563475/en/index.html>.
-  World Health Organization. *Training Modules for the Syndromic Management of Sexually Transmitted Infections*, 2nd ed. Geneva, World Health Organization, 2007, available at <http://www.who.int/reproductivehealth/publications/rtis/9789241593407/en/index.html>.

Action sheet 3.2.5. Prevent mother-to-child transmission (PMTCT)

HIV may be transmitted to the infant during pregnancy, delivery or through breastfeeding. If no interventions are provided, an estimated 20–25% of the infants of HIV-infected women will acquire HIV up to and including during delivery. Access to contraception, safe deliveries, ARV treatment and optimal infant feeding practices are necessary in order to reduce HIV transmission to the infant and to promote child survival.

Minimum initial response

Action 1. Ensure clean and safe deliveries

The *MISP for Reproductive Health in Crises* recommends the following key actions:

- Provide clean delivery kits to visibly pregnant women and birth attendants with an explanation on how to use them. Community kits come in two types—Part 2A: Mother's Kit and Part 2B: Attendant's Kit.³
- Provide midwife delivery kits (Clinical Delivery Assistance kit) to facilitate clean and safe deliveries at the health facility.
- Establish a referral system to manage obstetric emergencies, including transport and communications systems, access to obstetric care and safe blood in the event of a transfusion.

Action 2. Continue ARV drugs for pregnant women already on ARV drugs

- Pregnant women eligible for PMTCT services may be taking ARV drugs, either as prophylaxis to reduce vertical transmission to the child or as ART for life. It is important that in both instances the pregnant women should be able to continue on the same regimen without interruption.
- Pregnant women already receiving co-trimoxazole should continue prophylaxis throughout pregnancy and post-partum.

Action 3. Provide ARV drugs for PMTCT where the mother is known to be HIV-positive

- PMTCT ARV drug regimens vary depending on the stage at which the mother and/or infant enter the services. Where feasible the national protocols should be followed, where not available follow the WHO protocols.

Action 4. Provide treatment, care and support for infants

- In settings where the diagnosis of HIV in children born to HIV-positive mothers may be delayed due to a lack of laboratory testing capacity, it is recommended that these children should commence co-trimoxazole at around four to six weeks of age or on first contact with health services.
- Ensure that all HIV-exposed infants are enrolled in the national immunization programmes.

Action 5. Provide infant feeding guidance for HIV-positive mothers

Women who are HIV-positive should be supported to make an informed decision about infant feeding.

- The most appropriate infant feeding option for an HIV-positive mother depends on her individual circumstances and should take into account the specific circumstances of the humanitarian crisis.
- Exclusive breastfeeding is recommended for HIV-infected women for the first six months of life unless replacement feeding is acceptable, feasible, affordable, sustainable and safe (AFASS) for them and their infants before that time.
- If replacement feeding is still not AFASS after six months, when complementary feeding needs to be introduced, continuation of breastfeeding with additional complementary foods is recommended. All breastfeeding should stop once a nutritionally adequate and safe diet without breast milk can be provided.

³ Available from http://www.rhrc.org/resources/general_fieldtools/unfpa_rhkit.htm.

Action 6. Ensure availability of contraceptives

- Ensure that condoms are available (see action sheet 3.2.2), since the consistent and correct use of condoms continues to be the most effective contraceptive method that protects against acquiring and transmission of HIV, other STI and unintended pregnancy.
- At the start of a crisis, contraceptives should be available to meet demand. Prevention of unintended pregnancies is an important component of PMTCT.

Expanded response

Action 1. Establish comprehensive maternal and newborn care services

In humanitarian crises settings, where the health infrastructure may be weak or destroyed, maternal health services represent a pragmatic entry point for providing HIV interventions tailored to the needs of pregnant and post-partum women.

- Establish comprehensive services for antenatal, delivery and postpartum care.
- Strengthen comprehensive emergency obstetric care service.
- Establish comprehensive infant feeding support programmes, including breastfeeding support, at the household level.
- Partner involvement in PMTCT+ programmes is important in order to ensure support within families

Action 2. Establish integrated PMTCT programmes

- Ensure training on PMTCT programmes at the health centre, referral and community levels.
- Establish confidential and safe voluntary counselling and testing in antenatal services.
- Ensure that all pregnant women living with HIV receive ARV medicines, either ART for life or combined ARV drugs for prophylaxis, in order to reduce vertical transmission, in line with WHO recommendations.






Action 3. Establish comprehensive infant feeding counselling for mothers and support for infants exposed to HIV

- Expand and improve infant feeding counselling and support programmes that include promotion of mother–infant simulation activities.
- Ensure that infants are enrolled in national immunization programmes, including a dose of the standard measles vaccine at six months.

Action 4. Establish appropriate and effective family planning services

- Expand and improve condom programmes (see action sheet 3.2.2).
- Establish high-quality family planning services through appropriate training of staff and the availability of an appropriate range of contraceptive choices.
- Establish counselling and family planning services that provide information on the effectiveness and safety of contraceptive methods to prevent pregnancy and the risk of HIV transmission to the infant. Discordant couples should also be counselled on the risks of HIV transmission.

Resource materials

-  World Health Organization. Rapid advice: use of antiretroviral drugs for treating pregnant women and preventing HIV infection in infants. Geneva. World Health Organization, 2009, available at:
http://www.who.int/hiv/pub/mtct/rapid_advice_mtct.pdf
-  World Health Organization. Rapid advice: revised WHO principles and recommendations on infant feeding in the context of HIV. World Health Organization, 2009, available at:
http://whqlibdoc.who.int/publications/2009/9789241598873_eng.pdf
-  World Health Organization, United Nations Population Fund. *Sexual and Reproductive Health of Women Living with HIV/AIDS: Guidelines on Care, Treatment and Support for Women Living with HIV/AIDS and their Children in Resource-constrained Settings*. Geneva, World Health Organization, 2006, available at:
<http://www.who.int/hiv/pub/guidelines/sexualreproductivehealth.pdf>
-  United Nations Population Fund, Engender Health. *HIV Prevention in Maternal Health Services: Programming Guide*. New York, United Nations Population Fund, 2004, available at:
https://www.unfpa.org/upload/lib_pub_file/319_filename_hiv_prevention_MH_program_gde.pdf
-  Office of the United Nations High Commissioner for Refugees, Emergency Nutrition Network. *Guidance on Infant Feeding and HIV in the Context of Refugees and Displaced Populations*. Geneva, Office of the United Nations High Commissioner for Refugees, 2008, available at:
<http://www.enonline.net/pool/files/ife/hiv-and-infant-feeding-guidelines-hcr-final-7-08.pdf>

Action sheet 3.2.6. Provide care for people with HIV-related illnesses

In humanitarian crises, people living with HIV are vulnerable to sickness and death, as the treatment, care and nutritional support many need may be disrupted. Health and relief workers should identify people living with HIV and ensure that they receive the care and support they need. This may include visits to patients' homes and other shelters.

Many people living with HIV who do not yet need ART or have not been enrolled in treatment programmes are vulnerable to various opportunistic infections, including bacterial, fungal, parasitic and viral infections, because of their depleted immune system. The proper management of these infections improves the quality and length of people's lives and may postpone the need for ART.

Co-trimoxazole prophylaxis is a simple, well-tolerated and cost-effective intervention for adults and children living with HIV. It is used for the prevention and treatment of a wide range of infections, including *Pneumocystis jirovecii* pneumonia and toxoplasmosis in adults and children living with HIV.

Minimum initial response

Action 1. Provide co-trimoxazole prophylaxis for HIV-related infections

- Ensure that all confirmed HIV-positive persons (either through a positive test, by showing a treatment card or by patient enrolment number), with symptoms (stage II, III and above) can start and continue their co-trimoxazole treatment.
- Provide co-trimoxazole prophylaxis to all newly diagnosed individuals and babies born to HIV-positive women (see action sheet 3.2.5).

Expanded response

As soon as it is possible, feasible and affordable, provision of prophylaxis for major opportunistic infections should be started. Capacity (infrastructure, trained personnel and availability of drugs) for initiation and expansion of therapeutic management of uncomplicated opportunistic infections should be established as early as possible in the recovery phase. Ensure that care programmes are established for children living with HIV.

Action 1. Provide prophylaxis of other uncomplicated opportunistic infections

- Ensure knowledge of the local epidemiological patterns of fungal infections and prescribe antifungal prophylaxis in high-incidence areas, especially where ART is not yet available.
- Prescription of isoniazid preventive treatment for a limited period can be used as a prophylactic measure in order to decrease the risk of a first or recurrent episode of tuberculosis in people living with HIV.
- Ensure access to appropriate malaria prevention and treatment programmes in malaria endemic areas.

Action 2. Treat basic uncomplicated opportunistic infections

- Establish proper linkages between tuberculosis and HIV coinfection as a priority intervention, especially in settings with a high potential for pulmonary tuberculosis transmission.
- Establish linkages with the national tuberculosis control programme.
- Establish treatment programmes for opportunistic infections such as pneumonia, toxoplasmosis, oral, oesophageal and genital candidiasis, herpes simplex infection, cryptococcus, penicilliosis, persistent diarrhoea and persistent fever.

Action 3. Ensure vaccinations

- Ensure routine childhood and catch-up vaccinations for adults and children living with HIV in line with WHO recommendations.

Action 4. Ensure access to nutritional care and support (see also action sheet 3.4.2)





- Establish evidence-informed nutrition interventions and undertake routine assessments of diet and nutritional status.
- Assess diets of people living with HIV in order to ensure that the protein and micronutrient intake are adequate for the patient's energy needs.

- Where people living with HIV do not have the means to meet the required dietary needs, additional supplementary feeding should be provided.

Action 5. Ensure access to family planning

- Ensure that people living with HIV have access to family planning and counselling.
- Ensure access to dual protection with both condoms and another method.

Resource materials

-  Médecins sans Frontières. *Clinical HIV/AIDS Care Guidelines for Resource-poor Settings*, 2nd ed. Brussels, Médecins sans Frontières, 2006, available at <http://telemedicine.itg.be/telemedicine/Uploads/MSF%20Guidelines%202006%2030%20June%20MSF.pdf>.
-  World Health Organization. *Integrated Management of Adolescent and Adult Illnesses*. Modules on *Acute Care* (2004), *Chronic HIV Care* (2006), *General Principles of Good Chronic Care*. Geneva, World Health Organization, available at <http://www.who.int/3by5/publications/documents/imai/en/>.
-  World Health Organization. *TB/HIV: a Clinical Manual*, 2nd ed. Geneva, World Health Organization, 2004, available at <http://whqlibdoc.who.int/publications/2004/9241546344.pdf>.
-  World Health Organization. *Guidelines on Co-trimoxazole Prophylaxis for HIV-related Infections among Children, Adolescents and Adults—Recommendations for a Public Health Approach*. Geneva, World Health Organization, 2006, available at <http://www.who.int/hiv/pub/guidelines/ctxguidelines.pdf>.

Action sheet 3.2.7. Provide antiretroviral therapy (ART) to those in need

ART reduces the replication of HIV, reverses the development of immunodeficiency and limits the incidence of opportunistic infections and diseases. ARV drug delivery has been shown to be feasible, affordable and effective in resource-constrained settings through a public health approach.

Continuation of ART for those already on treatment prior to the crisis should be considered a priority intervention and part of the minimum initial response to HIV, even during the acute phase of an emergency.

Initiation of ART for people affected by the humanitarian crisis and who need it should be started as early as possible and is considered an essential component of the expanded humanitarian response. The benefits of starting ART should be weighed against the risk of a sudden disruption of ARV drug supply.

Minimum initial response

Action 1. Identify people requiring continuation of ART

- Identify people receiving ART through existing health-care records or patient cards, if available, and attempt to locate them, keeping in mind confidentiality issues.
- Use existing networks of people living with HIV as well as other community networks to disseminate information about continuing ART services (see action sheet 3.1.1).
- Where applicable, establish a hotline informing people on ART where they can receive treatment.
- Provide condoms to people on ART (see action sheet 3.2.2).

Action 2. Provide ART to those previously on treatment

- Use patients' treatment cards to determine the regimen and plan the continuation of care.
- Provide first-line ART regimens in the acute phase of an emergency (while the second line should be made available as soon as it is possible and affordable).
- Match the regimen with what is available and in accordance with the existing treatment protocol of the country. In the event of cross-border movement, the national protocol of the host country should be given priority.
- Where replacement ART is necessary, the regimen should be matched with equivalent available first-line drugs without interrupting treatment from one first-line regimen to another, if possible: follow WHO protocols and guidance on treatment interruption (see resource materials).
- Patients previously treated with protease inhibitors should be changed to a first-line regimen until second-line regimens become available. People receiving protease inhibitors due to the toxicity of the first-line regimens should have close clinical monitoring when changing back to a first-line regimen. If toxicity recurs and second-line regimens are not available, ART should be discontinued.
- Ensure that ART stocks are available for at least three months.

Expanded response

Action 1. Ensure continuation of care services for people living with HIV, including home-based care

- Where community networks are still functional, support these networks for the provision of community home-based care.
- Establish new community home-based care systems, where applicable.
- Ensure proper psychosocial support and rotation of staff providing community home-based care systems to prevent burn-out.
- Establish provision of basic nursing care and management of opportunistic infections (see action sheet 3.2.6).
- Ensure proper management of both acute and chronic symptoms and terminal care.

Action 2. Provide access to voluntary counselling and testing (VCT)

- Establish access to client initiated VCT and expand where appropriate to provider initiated VCT, ensuring confidentiality and consent.

- Ensure that HIV testing is accompanied by the following conditions: confidentiality, counselling, voluntary and informed consent. Mandatory HIV testing must never be considered, as this comprises a violation of the individual's rights (see action sheet 3.3.1).
- Establish linkages with and referral to other services such as STI and tuberculosis clinics.
- Put in place quality assurance mechanisms.

Action 3. Initiate and scale up ART programmes

- Ensure capacity-building and training of staff to provide appropriate ART care, including paediatrics.
- Initiate ART for all eligible people living with HIV, including children, based on clinical staging alone or combined with total lymphocyte count if the CD4 count is not available.
- As soon as the situation stabilizes and a better treatment management system is in place, an acceptable, effective and affordable second-line treatment should be made available to patients who need it.

Resource materials

-  World Health Organization. Rapid advice: antiretroviral therapy for HIV infection in adults and adolescents. World Health Organization, 2009, available at http://www.who.int/hiv/pub/arv/rapid_advice_art.pdf
-  Office of the United Nations High Commissioner for Refugees. *Antiretroviral Medication Policy for Refugees: the UN Refugee Agencies' Antiretroviral Medication Policy for Refugees*. Geneva, Office of the United Nations High Commissioner for Refugees, 2007, available at http://data.unaids.org/pub/Report/2007/20070326_unhcr_art_en.pdf.
-  Office of the United Nations High Commissioner for Refugees, World Health Organization. *Policy Statement on HIV Testing and Counselling for Refugees, Internally Displaced Persons and Other Persons of Concern to UNHCR*. Geneva, Office of the United Nations High Commissioner for Refugees, World Health Organization, 2009. <http://www.unhcr.org/refworld/category,POLICY,,SPEECH,,4b13ba212,0.html>
-  United Nations Children's Fund. *Scale up of HIV-related Prevention, Diagnosis, Care and Treatment for Infants and Children: A Programming Framework*. Geneva, United Nations Children's Fund, World Health Organization, 2009, available at http://www.unicef.org/aids/files/OMS_PAEDS_Programming_Frameworks_WEB.pdf.
-  International Federation of Red Cross and Red Crescent Societies. *HIV Prevention, Treatment, Care and Support, Series of Eight Training Modules*. World Health Organization, International Federation of Red Cross and Red Crescent Societies, Southern Africa HIV and AIDS Information Dissemination Service, 2004, available at <http://www.ifrc.org/what/health/tools/hiv-training.asp>.
-  World Health Organization. *Palliative Care: Symptom Management and End-of-life Care*. Geneva, World Health Organization, 2004, available at http://www.who.int/hiv/pub/imai/primary_palliative/en/index.html.
-  World Health Organization. *IMAI Materials for Patient and Community*. Geneva, World Health Organization, available at <http://www.who.int/hiv/pub/imai/patient/en/index.html>.
-  Office of the United Nations High Commissioner for Refugees, Southern African HIV Clinicians Society. *Clinical Guidelines for Antiretroviral Therapy Management for Displaced Populations: Southern Africa*. Office of the United Nations High Commissioner for Refugees, Southern African HIV Clinicians Society, 2007, available at <http://www.unhcr.org/protect/PROTECTION/4683b0522.pdf>.

Action sheet 3.2.8. Provide basic health care and support to key populations at higher risk of exposure to HIV

In many regions of the world, HIV is concentrated among groups of people who are at higher risk of exposure to the virus—injecting drug users, men who have sex with men and sex workers (both women and men) and their partners. Since they are often marginalized even in stable settings, they may be further exposed to stigma and discrimination, police harassment, gender-based violence and other human rights violations or neglect after or during a crisis, and there may be resistance to giving such groups the attention they need. Nevertheless, unless efforts to maintain or even expand services for these groups are made, HIV cannot be effectively prevented from spreading in such humanitarian situations.

While little is known about the behaviour of men who have sex with men in crisis situations, patterns of drug use and sex work may change, and these need to be monitored and taken into account when planning interventions. For example, more women may be pushed into sex work in exchange for shelter, protection and food, and may be less aware than regular sex workers of the risks of unprotected sex. Drug use patterns may also be affected as sterile injecting materials may run out and more drug injectors share equipment. Some people may also change from smoking opiates to injecting, as has been observed in some protracted crises in Asia. People already engaging in HIV risk behaviours are probably likely to continue to do so during a crisis, and therefore need access to life-saving interventions.

Minimum initial response

Action 1. Ensure that key populations at higher risk of exposure to HIV have access to HIV prevention interventions for sexual transmission of HIV

- Distribute free condoms with appropriate information material in hot-spot areas or, where feasible, to known sex workers, men who have sex with men and injecting drug users (see action sheet 3.2.2).
- Encourage known sex workers, men who have sex with men and injecting drug users to access STI services.
- Provide, as required, PEP, emergency contraception, presumptive treatment of STI, condoms and psychosocial support to rape survivors.

Action 2. Ensure that known injecting drug users have access to clean injecting equipment

- Provide injecting drug users with clean needles and syringes at their request, together with information about safer injection practices, condoms, HIV and STI.
- Inform injecting drug users about places where clean needles are available.

Expanded response

Action 1. Expand interventions targeting key populations at higher risk of exposure to HIV

- Establish and strengthen linkages with key populations at higher risk through community-based organizations and assess their situation.
- Use peer education and peer support to reach and provide services to key populations at higher risk.
- Ensure that health facilities are user-friendly for, and do not discriminate against, key populations at higher risk.

Action 2. Expand interventions targeting sex workers, men who have sex with men and transgender people

- Assess their situation, including HIV and STI risk and vulnerability, to guide comprehensive programme interventions.
- Ensure that the user groups are proactively involved in the design and delivery of programmes.
- Ensure that the health sector will provide a full range of priority interventions (including access to condoms, management of STI, HIV treatment and care, and PMTCT either through health centres or through community outreach programmes).



Action 3. Provide injecting drug users with access to harm reduction services

- Assess the drug use situation, including HIV risks and the vulnerability and service needs of injecting drug users.
- Enrol injecting drug users in harm reduction programmes and encourage secondary distribution to other injecting drug users. Raise awareness of the importance of the safe disposal of needles and other equipment and where and how to do it.
- Establish programmes for people with opiate dependency where appropriate, including substitution therapy with methadone or buprenorphine.
- Provide mental health and psychosocial support through a combination of community-based support and specialized services.



Resource materials

-  UNAIDS. *Guidance Note on HIV and Sex Work*. Geneva, UNAIDS, 2009, available at http://data.unaids.org/pub/BaseDocument/2009/jc1696_guidance_note_hiv_and_sexwork_en.pdf.
-  UNAIDS et al. *A Framework for Monitoring and Evaluating HIV Prevention Programmes for Most-at-risk Populations*. Geneva, UNAIDS, 2007, available at http://data.unaids.org/pub/Manual/2007/20070420_me_of_prevention_in_most_at_risk_populations_en.pdf.
-  Inter-Agency Task Team on HIV and Young People. *Global Guidance Brief on HIV Interventions for Most-at-risk Young People*. New York, United Nations Population Fund, 2008, available at http://www.who.int/child_adolescent_health/documents/pdfs/iatt_hivandyoungpeople_mostatrisk.pdf.
-  Office of the United Nations High Commissioner for Refugees, World Health Organization. *Rapid Assessment of Alcohol and Other Substance Use in Conflict-affected and Displaced Populations: a Field Guide*. Geneva, Office of the United Nations High Commissioner for Refugees, World Health Organization, 2008, available at http://www.who.int/mental_health/emergencies/unhcr_alc_rapid_assessment.pdf.



Injecting drug users

-  World Health Organization. *Policy and Programming for HIV/AIDS Prevention and Care among Injecting Drug Users*. Geneva, World Health Organization, available at http://www.who.int/hiv/pub/prev_care/policyprogrammingguide.pdf.
-  World Health Organization, United Nations Office on Drugs and Crime, UNAIDS. *Position Paper—Substitution Maintenance Therapy in the Management of Opioid Dependence and HIV/AIDS Prevention*. Geneva, World Health Organization, 2004, available at http://www.who.int/substance_abuse/publications/treatment/en/index.html.

Men who have sex with men

-  World Health Organization. *Rapid Assessment and Response: Adaptation Guide on HIV and Men Who Have Sex with Men*. Geneva, World Health Organization, 2004, available at http://www.who.int/hiv/pub/prev_care/en/msmrrar.pdf.
-  UNAIDS. *Policy Brief: HIV and Sex between Men*. Geneva, UNAIDS, 2007, available at http://data.unaids.org/pub/BriefingNote/2006/20060801_Policy_Brief_MSM_en.pdf.

Sex workers

-  World Health Organization. *The Sex Work Toolkit—Targeted HIV/AIDS Prevention and Care in Sex Work Settings*. Geneva, World Health Organization, 2005, available at www.who.int/entity/3by5/en/toolkitfactsheet.pdf.
-  World Health Organization, UNAIDS. *Violence against Women and HIV/AIDS: Critical Intersections. Violence against Sex Workers and HIV Prevention*. Geneva, World Health Organization, 2005, available at <http://www.who.int/gender/documents/sexworkers.pdf>.

3.3. Protection

Protection aims to ensure that everyone (irrespective of their age, sex or social status) is able to enjoy their rights on an equal basis, in safety, with dignity, including in times of internal or external displacement. A well-coordinated effort and preparation are essential to provide protection and assistance to displaced persons.

International law sets out the rights of every individual and the responsibility of States and other authorities to ensure the protection of these rights. When working with domestic systems and alternative dispute resolutions, international law provides clear and objective criteria for the protection of children, people living with HIV and key populations at higher risk of exposure to HIV. A human-rights-based approach is central to any effective response to HIV in humanitarian crises settings, as it helps to reduce vulnerability to HIV and stigma and discrimination against people living with HIV.

The international human rights system has explicitly recognized HIV as prohibited grounds for discrimination. It also provides special measures for the protection of vulnerable groups such as women and children, which includes their right to enjoy and make informed decisions about their health.

Children are entitled to special protection under international law, as highlighted by the UN Committee on the Rights of the Child in its General Comment on HIV/AIDS and the rights of children.⁴ In particular, the general principles of the Convention on the Rights of the Child—including non-discrimination (Article 2), the best interests of the child (Article 3), the right to life, survival and development (Article 6) and participation of the child (Article 12)—should guide the response in all cases involving children.

In humanitarian situations, some of the basic human rights norms and fundamental freedoms that require protection under human rights and refugee and humanitarian law include the following:

<ul style="list-style-type: none"> • The highest attainable standard of health and health care. • Access to information and material aimed at the promotion of their social, spiritual and moral well-being and physical and mental health. • Preventive health care, sex education and family planning education and services. • An adequate standard of living. • Non-separation from parents. • Privacy. • Protection from violence. • Special protection and assistance by the State. 	<ul style="list-style-type: none"> • Social security, including social insurance. • Education and leisure. • Protection from economic and sexual exploitation and abuse, and from illicit use of narcotic drugs. • Protection from abduction, sale and trafficking, as well as torture or other cruel, inhuman or degrading treatment or punishment. • Physical and psychological recovery and social reintegration.
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International human rights law contains a number of rights that are of direct relevance to those living with or otherwise affected by HIV. These include the right to the following:⁵

<ul style="list-style-type: none"> • Life, liberty and security of the person. • Non-discrimination, equal protection and equality before the law. • Freedom of movement. • An adequate standard of living. • Equal access to education. 	<ul style="list-style-type: none"> • Privacy. • Work. • Freedom of peaceful assembly and association. • Marry and to found a family. • Be free from torture and cruel, inhuman or degrading treatment or punishment. • Seek and enjoy asylum. 	<ul style="list-style-type: none"> • Freedom of opinion and expression and to freely receive and impart information. • Social security, assistance and welfare. • Share in scientific advancement and its benefits. • Participate in public and cultural life.
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⁴ *HIV/AIDS and the Rights of Children, General Comment No. 3* (2003) of the UN Committee on the Rights of the Child, CRC/GC/2003/3, in particular paragraphs 5 and 6.

⁵ Based on the *International Guidelines on HIV/AIDS and Human Rights* (Office of the United Nations High Commissioner for Refugees, UNAIDS, 2006, pp. 80–103) and General Comment No. 3 (2003) of the UN Committee on the Rights of the Child, para. 6. See also Guiding Principle 19(3) of the Guiding Principles on Internal Displacement.

Action sheet 3.3.1. Protect against HIV-related human rights violations

Human rights are relevant to HIV in two ways: first, violation of human rights can increase vulnerability to, and risk of, HIV infection. Secondly, the rights of people living with and affected by HIV must be respected, protected and fulfilled in order to mitigate the effects of HIV on their lives. A rights-based approach is therefore key to any effective response to HIV in humanitarian crises settings. A rights-based response requires programmes to respect human rights principles and standards; they must be participatory, inclusive, non-discriminatory and empowering in their design, implementation and objectives.

Minimum initial response

Action 1. Monitor allegations of HIV-related human rights violations

- Monitor allegations of HIV-related human rights violations such as violence against people living with HIV, denial of access to health, education, food and other support, segregation and violation of the right to privacy.
- Share information with national competent agencies for possible redress, taking into account confidentiality and protection issues that may arise. Ensure that the relevant humanitarian partners are aware of recurring protection challenges and that appropriate and relevant changes are made to the delivery of humanitarian assistance with regard to the violations.
- Ensure that people living with HIV are not limited in their right to asylum, deprived of their liberty or restricted in their freedom of movement based on actual or perceived HIV status.
- Monitor any HIV testing that may have been established and oppose mandatory testing for HIV. All HIV testing should take place under conditions of confidentiality, with informed consent and with counselling in line with international standards. It is important to ensure that people have access to information on the voluntary character of any HIV testing.
- Monitor whether adequate protection and access to HIV prevention, treatment, care and support is being provided to vulnerable populations.

Action 2. Ensure HIV service provision that respects human rights

- Put in place policies and structures to ensure respect for confidentiality and privacy among service providers. Personal data, and data on HIV status in particular, are confidential and should not be shared without the prior informed consent of the individual concerned.
- Give children the same rights to privacy as adults and support their participation in decisions about their health care, oppose mandatory testing and provide opportunities for children to provide informed consent during VCT based on the evolving capacities of the child.
- Establish early social support services to ensure that people infected with and affected by HIV have equal access to essential services.
- Ensure that communication with the media does not break confidentiality policies.
- Ensure that those populations at higher risk of exposure to HIV are represented in community-level HIV protection measures (see action sheet 3.2.8).

Action 3. Establish protection for women and girls

- Identify and assess women and girls at risk of HIV and gender-based violence, monitor their needs and institute appropriate immediate responses, including preliminary registration. Involve them in these processes.
- Establish a confidential complaints process for women to report their concerns.
- Register household ration cards in the names of women rather than men in order to ensure that women have greater control over food (see action sheet 3.4.1.).
- Ensure that women and men participate in establishing the location of, designing and maintaining water and sanitation facilities and ensure the safety, privacy and dignity of such facilities.
- Involve trusted community members (women, girls, as well as men and boys) in community services and protection monitoring.

Action 4. Prevent and respond to sexual exploitation and abuse

- Make staff (including staff of implementing and operational partners) aware of, and promote adherence to, the six core principles relating sexual exploitation and abuse, which state that:
 - Sexual exploitation and abuse by humanitarian workers constitutes gross misconduct and are grounds for termination of employment.
 - Sexual activity with children (persons under the age of 18) is prohibited regardless of the age of majority/ consent locally. Mistaken belief regarding 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.
 - Sexual relationships between UN staff and beneficiaries of assistance are strongly discouraged as they undermine the credibility and integrity of humanitarian assistance.
 - If a humanitarian worker is suspicious of sexual exploitation and abuse by a fellow worker, he or she must report such concerns via established reporting mechanisms.
 - Humanitarian workers, and managers in particular, are obliged to create and maintain an environment that prevents sexual exploitation and abuse and that promotes the implementation of the code of conduct.
- Disseminate the core sexual exploitation and abuse principles and organizational strategy to all staff.
- Ensure that uniformed services are aware that sexual exploitation and abuse are forbidden and that they have a duty to protect women and children from such acts.
- Provide all staff (national and international) with information on how to protect themselves from sexual exploitation and abuse, on the reporting and referral mechanisms for cases of sexual exploitation and abuse and on service delivery points.
- Appoint a focal point on sexual exploitation and abuse (if not already in place) and inform communities of the existence and roles of the sexual exploitation and abuse focal point.
- Make managers aware of their responsibility to support systems and policies that create an environment that prevents and responds to sexual exploitation and abuse.

Expanded response

Action 1. Conduct a full assessment of the human rights situation

- Continue to actively monitor all allegations of human rights violations.
- Determine the capacity gaps at all levels—State, civil society and others—in protecting vulnerable populations, including people living with HIV.

Action 2. Mainstream a human-rights-based approach into all HIV programmes

- Review and assess HIV programmes for compliance with national, regional and international standards in HIV programming, and address gaps.
- Ensure that the principles of equality and non-discrimination, accountability and the rule of law, participation and inclusion, and universality and indivisibility of rights, are incorporated into all programmes.







Action 3. Build local capacity to address human rights needs

- Provide training for and support community-based initiatives that promote and protect human rights. Provide training and resources to community leaders, women's groups, youth associations and networks of people living with HIV.
- Ensure the participation of the community (women, young people and other vulnerable or key populations at higher risk of exposure to HIV) and people living with HIV in any initiatives on human rights.

Action 4. Respond to the protection threats by taking appropriate, community-guided action

- Train and support relevant community stakeholders to raise awareness on HIV, combat stigma and discrimination and promote human rights, including gender equality and universal access to prevention, treatment, care and support.
- Learn from and build on community-level successes in responding to threats and, where appropriate, disseminate the strategies that the community (or a relevant segment of the community) has developed to protect itself.

Resource materials

-  Global Protection Cluster Working Group. *Handbook for the Protection of Internally Displaced Persons*. Geneva, Global Protection Cluster Working Group, 2007, available at http://www.humanitarianreform.org/humanitarianreform/Portals/1/cluster%20approach%20page/clusters%20pages/Protection/Protection%20Handbook/IDP%20Handbook_Complete_FINAL%20Jan%2008.pdf.
-  Office of the United Nations High Commissioner for Human Rights, UNAIDS. *The International Guidelines on HIV/AIDS and Human Rights: 2006 Consolidated Version*. UNAIDS, Geneva, 2006, available at http://www2.ohchr.org/english/issues/hiv/docs/consolidated_guidelines.pdf.
-  Office of the United Nations High Commissioner for Human Rights. International human rights treaties. Available at <http://www2.ohchr.org/english/law/index.htm#core>.
-  Office of the United Nations High Commissioner for Human Rights. *Training Manual on Human Rights Monitoring*. Geneva, United Nations, 2001, available at <http://www.ohchr.org/Documents/Publications/training7Introen.pdf>.
-  Office of the United Nations High Commissioner for Refugees. *Note on HIV/AIDS and the Protection of Refugees, IDPs and Other Persons of Concern*. Geneva, Office of the United Nations High Commissioner for Refugees, 2006, available at <http://www.unhcr.org/publ/PUBL/444e20892.pdf>.
-  Office of the United Nations High Commissioner for Refugees. *UNHCR Handbook for the Protection of Women and Girls*. Geneva, Office of the United Nations High Commissioner for Refugees, 2007, available at <http://www.unhcr.org/protect/PROTECTION/47cfa9fe2.pdf>.

Action sheet 3.3.2. Protect orphans and unaccompanied, separated and other vulnerable children and youth

Unaccompanied children and those separated from family, orphans and other vulnerable children are at a high risk of violence, including sexual violence. In the absence of family protection, forms of abuse can intensify in conflict and post-conflict settings. In addition, unaccompanied children have limited access to education, health care, livelihoods and basic necessities compared with peers who are with their parents, guardians or customary care-givers.

Unaccompanied children may also be more susceptible to recruitment or abduction into the armed forces or armed groups, who may subject them to violence, sexual slavery and abuse. All of these actions can expose children to HIV, especially in areas with a high HIV prevalence. Every effort should be made to protect children from abuse, to ensure that their rights are protected and to provide an adequate response when children have been abused and exploited. It is important to ensure that for all humanitarian interventions the best interests of children and respect for their rights remain priority considerations.

Minimum initial response

Action 1. Register, monitor and support vulnerable children

At the onset of any emergency, take steps to ensure preliminary registration and documentation of all children at the earliest possible time.

- Collaborate and coordinate activities closely with the other clusters/sectors, especially camp coordination and camp management, shelter and education, to register, monitor and support vulnerable children and those who are infected or affected by HIV (see action sheets 3.4.1, 3.4.2 and 3.5.1).

Action 2. Trace families of unaccompanied and separated children and attempt to reunite them

- Work with known and competent organizations to establish sound and ethical mechanisms to trace families, ensuring that the rights of the child to information and participation in decisions that affect them are respected and are appropriate and in accordance with the child's capability.
- Verify family relations and ensure non-discrimination and the child's safety prior to reunification. Families receiving information about a child's HIV status should also receive relevant treatment, care and support information, as well as referral to specialized services available in the community.

Action 3. Provide unaccompanied and separated children with the same essential information and services as all children

- Ensure that unaccompanied and separated children have equal and effective access, like all other children, to food, safe shelter and other material support in order to reduce exposure to violence or exploitation.
- Inform all children in a child-friendly and clear manner of their entitlements to assistance at no cost.
- Target child-headed households with food support and other forms of assistance in order to reduce exposure to HIV through sexual exploitation.
- Provide all children with information on their rights, including information on access to safe and confidential mechanisms for reporting violations. Ensure confidentiality.
- Refer all children who have been sexually abused to age-appropriate psychosocial, health, social security and legal services as soon as possible (see action sheets 3.2.3 and 3.3.3).
- Ensure access to education for all children, including those living with HIV or in the care of people living with HIV (see action sheet 3.5.1).

Expanded response

Action 1. Re-establish or set up appropriate child protection mechanisms

- Work with communities and national authorities to establish clear referral mechanisms and protocols (including child protection databases and case management systems).
- Establish appropriate psychosocial support and training programmes, including livelihood support, as required to prepare children better for social reintegration.
- Include livelihood support in national plans of action for orphans and other vulnerable children.






Action 2. Establish and support care arrangements

- Establish or support existing temporary care arrangements that provide a protective family environment. Where possible, bring unaccompanied and separated siblings together.
- Consult the child (depending on his or her age) regarding placement decisions.
- Establish community-based monitoring mechanisms to ensure that children in care remain safe. Periodically review the situation of children placed in care arrangements.
- Identify more durable, non-discriminatory, long-term solutions in consultation with the affected children.

Action 3. Build capacity for working with orphans and other vulnerable children

- Provide training for all staff on children's rights (including the right to privacy and participation), child protection issues and codes of conduct. Everyone involved should be aware of the specific needs and vulnerability of children, including orphans and unaccompanied and separated children, in relation to HIV.

Resource materials

-  Office of the United Nations High Commissioner for Human Rights, United Nations Children's Fund, Save the Children. *Action for the Rights of Children (Module on Separated Children, updated in December 2004)*, available at <http://www.savethechildren.net/arc/>.
-  Office of the United Nations High Commissioner for Refugees. *Guidelines on Determining the Best Interests of the Child*. Geneva, Office of the United Nations High Commissioner for Refugees, 2008, available at <http://www.unhcr.org/protect/PROTECTION/4566b16b2.pdf>.
-  Office of the United Nations High Commissioner for Refugees. *The UNHCR Tool for Participatory Assessment in Operations*. Geneva, Office of the United Nations High Commissioner for Refugees, 2006, available at <http://www.unhcr.org/publ/PUBL/450e963f2.html>.
-  United Nations Children's Fund. *The Lost Ones: Emergency Care and Family Training for Separated Children from Birth to Five Years*. New York, United Nations Children's Fund, 2007, available at <http://www.unhcr.org/cgi-bin/texis/vtx/refworld/rwmain?docid=468e2f632>.
-  International Committee of the Red Cross, International Rescue Committee, Save the Children UK, United Nations Children's Fund, Office of the United Nations High Commissioner for Refugees, World Vision. *Inter-Agency Guiding Principles on Unaccompanied and Separated Children*. Geneva, Office of the United Nations High Commissioner for Refugees, 2004, available at <http://www.unhcr.org/4098b3172.html>.

Action sheet 3.3.3. Protect the population from gender-based violence

Acts of gender-based violence are among the most common forms of violence in many countries and affect the lives of women, girls, boys and men worldwide. In humanitarian crises settings, rape and sexual exploitation as well as other forms of violence are common.

Gender-based violence occurs in all societies, but the conditions linked to forced displacement, including conflict, breakdown of the rule of law, and collapse of family and community structures, may increase both the frequency and the brutality of such violence. Such violence may have long-term consequences; for example, women who have been raped may be rejected by their husbands and families, resulting in sex work being their only option for survival. Gender-based violence can also increase an individual's vulnerability to STI, including HIV.

Gender-based violence is a violation of human rights and in some circumstances will also constitute a war crime.⁶

Minimum initial response

Action 1. Develop a coordinated response for the prevention of and response to gender-based violence

- Establish a multisectoral working group on gender-based violence that includes members of women's groups, youth representatives and representatives of other relevant community-based organizations, and ensure links to and sharing of information with cluster/sector coordination mechanisms (including protection and health).
- Participate in a coordinated situation analysis of gender-based violence.⁷
- Ensure that HIV issues are identified and addressed in the gender-based violence response, including access to HIV prevention, treatment, care and support for survivors of sexual assault and exploitation, including key populations at higher risk of exposure to HIV.

Action 2. Develop programmes addressing gender-based violence

- In collaboration with community and local leaders, develop and publicize a programme on the prevention of and response to gender-based violence, including clear and acceptable referral and reporting that respects confidentiality and the rights of survivors.⁸
- Provide all survivors of gender-based violence with access to confidential health and psychosocial support services, including PEP to prevent HIV transmission (see action sheet 3.2.3).
- Ensure that all interventions and services for child survivors are guided by the best interests of the child and the right of the child to life, survival and development, non-discrimination and participation.
- Contribute to the establishment of psychosocial support coordination programmes.⁹

Expanded response

Action 1. Ensure that HIV is integrated into a multisectoral gender-based violence response

- Conduct information campaigns and train staff on international human rights law and the links between HIV and gender-based violence.
- Identify or develop national legal protocols on gender-based violence in accordance with international guidance¹⁰ and ensure the integration of HIV concerns.

⁶ Rome Statute of the International Criminal Court, available at http://www.icc-cpi.int/NR/rdonlyres/EA9AEFF7-5752-4F84-BE94-0A655EB30E16/0/Rome_Statute_English.pdf.

⁷ Inter-Agency Standing Committee. *Guidelines for Gender-based Violence Interventions in Humanitarian Settings* (action sheet 2.1). Geneva, Inter-Agency Standing Committee, 2005. Available at http://www.humanitarianinfo.org/iasc/pageloader.aspx?page=content-subsi-tf_gender-gbv

⁸ Inter-Agency Standing Committee. *Guidelines for Gender-based Violence Interventions in Humanitarian Settings*. Geneva, Inter-Agency Standing Committee, 2005.

⁹ Inter-Agency Standing Committee. *Guidelines for Mental Health and Psychosocial Support in Emergency Settings*. Geneva, Inter-Agency Standing Committee, 2008. Available at http://www.who.int/hac/network/interagency/news/iasc_guidelines_mental_health_psychosocial_upd2008.pdf


¹⁰ Inter-Agency Standing Committee. *Guidelines for Gender-based Violence Interventions in Humanitarian Settings*. Geneva, Inter-Agency Standing Committee, 2008.

- Develop an interagency strategy that mobilizes law enforcement actors, women's rights groups, men and communities to prevent sexual violence and exploitation and other forms of gender-based violence, such as early marriage and female genital mutilation/cutting.
- Establish structures, including referral and protection services, to hold perpetrators of gender-based violence responsible, while ensuring that the confidentiality and decisions of survivors are respected at all times.
- Work with the early recovery sector to establish self-reliance and livelihood programmes, paying particular attention to the needs of survivors of gender-based violence.

Action 2. Ensure that gender-based violence programmes take key populations at higher risk of exposure to HIV into account

- Advocate relevant actors, including national and local authorities, to include HIV prevention and response programmes in gender-based violence programmes, focussing on gender-based violence risk reduction for sex workers and their families.
- Facilitate rehabilitation and reintegration of groups vulnerable to violence.

Resource materials

-  Inter-Agency Standing Committee. *Guidelines for Gender-based Violence Interventions in Humanitarian Settings*. Geneva, Inter-Agency Standing Committee, 2005, available at http://www.humanitarianinfo.org/iasc/content/subsidi/tf_gender/gbv.asp.
-  Office of the United Nations High Commissioner for Refugees. *Handbook for the Protection of Women and Girls*. Geneva, Office of the United Nations High Commissioner for Refugees, 2008, available at <http://www.unhcr.org/protect/PROTECTION/47cfa9fe2.pdf>.
-  Office of the United Nations High Commissioner for Refugees. *Sexual and Gender-based Violence against Refugees, Returnees and Internally Displaced Persons: Guidelines for Prevention and Response*. Geneva, Office of the United Nations High Commissioner for Refugees, 2003, available at <http://www.unhcr.org/cgi-bin/texis/vtx/refworld/rwmain?docid=3edcd0661&page=search>.
-  World Health Organization. *Ethical and Safety Recommendations for Researching, Documenting and Monitoring Sexual Violence in Emergencies*. Geneva, World Health Organization, 2007, available at http://www.who.int/gender/documents/OMS_Ethics&Safety10Aug07.pdf.
-  International Rescue Committee, University of California, Los Angeles. *Clinical Care for Sexual Assault Survivors—a Multimedia Training Tool*, 2008, available at <http://clinicalcare.rhrc.org/>.

3.4. Food security, nutrition and livelihood support

Action sheet 3.4.1. Ensure food security, nutrition and livelihood support

Humanitarian crises disrupt people's food security. Furthermore, in high-prevalence countries the livelihoods of households and communities may have already been weakened by the impact of HIV and would therefore be more vulnerable to the impacts of humanitarian crises. Food insufficiency has been associated with high-risk sexual behaviour, in particular among women.

Food assistance and livelihood support make people, especially women and children, less vulnerable to HIV infection. Food assistance and restoring livelihoods should be seen as complementary actions to avoid food assistance dependency and to contribute to a sustainable livelihood strategy. Food assistance is part of a life-saving, short-term response to maintain and improve nutritional status and increase households' food security. At the same time, restoring basic household assets and local food production, promoting alternative income-generation activities compatible with the constraints faced by HIV-affected households and alleviating discrimination, even in the absence of food assistance, enables afflicted households to strengthen their livelihoods and provide a safety net for recovery.

Minimum initial response

Action 1. Target and distribute food assistance to HIV-affected communities and households

- Work with established community-based organizations and institutions that are already involved with HIV-affected individuals and families to provide appropriate food assistance.
- Map (in collaboration with other agencies) the needs, constraints and opportunities of identified vulnerable households while treating information confidentially.
- Register the recipients of food assistance, specifying the actual composition of households, including breakdowns by age and sex. Where registration is not feasible, distributions should be based on average family size and in accordance with national and regional demographic patterns.
- Select distribution sites as close as possible to the maximum number of households/communities.
- Consider smaller and more frequent rations, taking into consideration the nutrient requirement of people living with HIV (+10% or +20–30% according to whether asymptomatic or symptomatic), and reducing the quantities to be carried. Note that general food rations are not individualized. Thus, if there is a high prevalence of HIV but individual status is not known, all food rations for all families would have a higher kilocalorie amount. Food distribution linked to ART programmes should always take the higher nutrient needs into account.
- Ensure that the provision of food assistance to people living with HIV and HIV-affected households and families does not increase their stigmatization.

Action 2. Integrate HIV into existing food assistance and livelihood support programmes and food security, nutrition and livelihood support into HIV projects and activities

- Mainstream the needs of vulnerable households in food distribution and homestead food production support programmes in the following ways:
 - Ensure short distances to food distribution points.
 - Ensure smaller food packages and more frequent distribution so that affected people can carry them more easily.
 - Give preference to milled cereals and easy to prepare pulses (food must be prepared more frequently during the day for chronically ill people).
 - Allow for an alternative recipient if the head of the household is sick or otherwise unable to receive rations on behalf of the household.
 - Identify organizations of people living with HIV and solidarity networks and assess how they can be engaged with the programme.
 - Identify opportunities for livelihood diversification to address household-specific constraints and local opportunities.
- Include HIV sensitization and prevention awareness activities with large-scale food distribution activities wherever possible.

Action 3. Introduce specific measures to protect/adapt the livelihoods of HIV-affected households and support homestead food production

- Support dietary diversification, i.e. food choice, availability and access, processing and preparation, including attention to time-saving and labour-saving considerations.
- Provide tools, fertilizers and improved variety seeds (drought-resistant, more nutritious types of vegetables and fruits, adapted to the agro-ecological characteristics of the affected area).
- Give preference to appropriate labour-saving tools.
- Re-establish livestock and provide access to essential agricultural and livestock-keeping skills programmes.
- Promote the organization of people living with HIV and strengthen existing solidarity networks.
- Provide joint problem-solving training to local institutions (government and nongovernmental organizations) in high-prevalence areas.
- Where there are large numbers of vulnerable children and youth relative to the number of adults, implement skills-building programmes such as junior farmer fields and life school programmes that combine livelihood support with life skills education.

Expanded response

Action 1. Adapt agricultural methods and build capacity

- Train agricultural extension workers regarding the circumstances and needs of persons living with HIV in order to sensitize them.
- Introduce and expand the adoption of technologies, practices and organizational skills that reduce drudgery, increase labour efficiency and allow households to combine productive and reproductive tasks, strengthening solidarity networks.
- Provide essential livelihood skills-building programmes for local institutions and affected groups, in particular vulnerable youth.




Action 2. Provide appropriate relief inputs and training to vulnerable and affected households to restore/rebuild livelihoods

- Expand the implementation of interventions to protect and restore priority livelihood assets and for the livelihood diversification of households and communities
- Adapt and diversify livelihoods systems to mitigate the impact of HIV at the household level.

Action 3. Adapt food distribution rations for hyperendemic settings

- In high-prevalence settings, adjust/increase standard rations to address the specific dietary needs of people living with HIV within the affected population.

Resource materials

-  World Food Programme. *Food Assistance in the Context of HIV: Ration Design Guide*. Rome, World Food Programme, 2008, available at http://one.wfp.org/food_aid/doc/Brief_Ration_Design_Guide.pdf.
-  Food and Nutrition Technical Assistance Project, World Food Programme. *Food Assistance Programming in the Context of HIV*. Washington, DC, Food and Nutrition Technical Assistance Project, 2007, available at http://one.wfp.org/food_aid/doc/Food_Assistance_Context_of_HIV_sept_2007.pdf.
-  Food and Agriculture Organization of the United Nations. *Incorporating HIV/AIDS Considerations into Food Security and Livelihood Projects*. Rome, Food and Agriculture Organization of the United Nations, 2003, available at <http://www.fao.org/docrep/004/y5128e/y5128e00.htm>.
-  Food and Agriculture Organization of the United Nations, World Food Programme. *Getting Started! Running a Junior Farmer Field and Life School*. Rome, Food and Agriculture Organization of the United Nations, 2007, available at <http://www.fao.org/docrep/010/a1111e/a1111e00.htm>.
-  World Food Programme. *Technical Guidelines. HIV/AIDS Analysis: Integrating HIV/AIDS in Food Security and Vulnerability Analysis*. Rome, World Food Programme, 2008, available at http://documents.wfp.org/stellent/groups/public/documents/manual_guide_proced/wfp193482.pdf.
-  World Food Programme. *Emergency Food Security Assessments (EFSA)*. Rome, World Food Programme, 2009, available at <http://www.wfp.org/food-security/reports/EFSA>.
-  Food and Agriculture Organization of the United Nations, International Labour Organization. *The Livelihood Assessment Tool-kit: Analysing and Responding to the Impact of Disasters on the Livelihoods of People*. Rome, Food and Agriculture Organization of the United Nations, 2008, available at [http://www.reliefweb.int/rw/lib.nsf/db900sid/JBRN-7PCKH7/\\$file/fao_june08.pdf?openelement](http://www.reliefweb.int/rw/lib.nsf/db900sid/JBRN-7PCKH7/$file/fao_june08.pdf?openelement).

Action sheet 3.4.2. Provide nutritional support to people living with HIV

People living with HIV have particular needs in terms of nutrition. Good nutrition is essential for health and helps the body protect itself from infections by supporting the immune system. Access to a well-balanced diet for people living with HIV can be a major challenge, especially in emergencies, even with food assistance. An appropriate diet can also contribute to improving the medical outcomes of HIV-related illnesses, thus improving comfort and contributing to survival.

People suffering from HIV-related illnesses, including those who are on ART, often experience a range of problems that lead to malnutrition.

Nutritional support interventions include nutritional assessment, nutrition education, dietary counselling, prescription of targeted nutrition supplements, and linkages with food-based intervention programmes.

Minimal initial response

Action 1. Ensure adequate nutrition and care for vulnerable people living with HIV

- Provide supplementary feeding to those moderately malnourished and/or provide increased food rations to those at risk of malnutrition, including adults on ART and tuberculosis treatment, pregnant and lactating women and children under five years of age (see action sheet 3.2.6).
- Ensure that the basic micronutrient needs of people living with HIV are met, through a diversified diet, fortified foods or micronutrient supplements.
- For severely malnourished people living with HIV, therapeutic treatment should be provided to support nutrition rehabilitation alongside appropriate care. Depending on the condition of the person, in-patient care or community care can be provided using ready-to-use therapeutic foods, where available.
- Ensure a supply of water, hygiene and food safety when implementing therapeutic and supplementary feeding.
- If there are health facilities with the capacity to manage ART, health-care staff should be encouraged to provide an assessment of people's nutrition and dietary counselling as soon as feasible.

Table 3. Energy and micronutrient requirements of people living with HIV

Nutrient/population group	Recommendation*
Energy	
Asymptomatic HIV-positive adults	Increase of ~10%
Adults with symptomatic HIV-related infection or AIDS (including pregnant/lactating women)	Increase of ~20–30%
Asymptomatic HIV-positive children	Increase of ~10%
Children experiencing weight loss (regardless of HIV status)	Increase of ~50–100%
Children with severe acute malnutrition	No change from WHO guidelines
Protein	
All population groups	No change indicated to date in the relative proportion of protein, although absolute quantities would increase with increased energy intake (10–12% of total energy intake)
Fat	
Individuals who are HIV-negative or HIV-positive but not taking ARV drugs	No change indicated to date (>17% of total energy intake)

* Compared with the normal dietary requirements of WHO. Source: World Health Organization. *Nutrient Requirements for People Living with HIV/AIDS*. Geneva, World Health Organization, 2003.

Action 2. Respond to the specific needs of pregnant and lactating women living with HIV and their children

- Meet the increased nutritional requirements of pregnant and lactating women through supplementary feeding and the inclusion of fortified food items in the general food distribution ration. Micronutrient supplements may also be considered to address specific nutrient requirements.
- Provide infant feeding counselling and support to all HIV-positive pregnant and lactating mothers. Encouraging HIV-positive breastfeeding mothers to breastfeed exclusively for the first six months (see action sheet 3.2.5).

- Treat children (irrespective of HIV status) with severe acute malnutrition in the community or clinical (hospital) setting by providing therapeutic formula (in-patient only) or ready-to-use therapeutic foods (when available).
- Provide supplementary feeding, home-based or facility-based, for moderately malnourished children (irrespective of HIV status).
- Integrate monitoring of infants and young children for growth, weight gain and infections.

Expanded response

Action 1. Expand nutrition and care programmes for vulnerable people living with HIV

- Assess the food and nutritional needs of people living with HIV (i.e. assessment of individual people living with HIV in order to implement programmes for people living with HIV in general), taking into account factors affecting nutritional status (such as disease patterns and metabolic complications), dietary requirements, food access (income), food availability (markets) and consumption (habits). This should include risk screening of people living with HIV based on these food security indicators in order to provide appropriate care.
- Promote improved feeding practices among people living with HIV, including mitigating the side-effects of ART and dealing with poor appetite, nausea, mouth ulcers, etc., based on locally available foods and incorporate appropriate nutrition education and communication strategies.
- Conduct individual, group or household nutrition education and counselling (by trained health-care workers or peer groups) to prevent weight loss and promote nutritional recovery and to manage any nutritional complications of common opportunistic infections and symptoms.
- Integrate regular monitoring of nutritional well-being into clinical treatment and care activities.
- In high-prevalence areas, it may be necessary to increase resources for the management of severe malnutrition, taking into consideration:
 - The longer-term nature of institution-based treatment of HIV-positive children.
 - Increased costs of therapeutic foods/ready-to-use therapeutic foods.
 - Additional staff time.
 - Additional time and space for the caregiver to remain in the facility.

Action 2. Integrate nutritional support with other services



- Integrate supplementary feeding and nutrition education and rehabilitation programmes into health-care services, including mother-child care, PMTCT, tuberculosis treatment and ART, and available livelihood support systems.
- Distribute supplementary food rations through these programmes as well as through home-based care.
- Provide nutrition education training and capacity-building for home-based care providers.
- Use food and nutrition programmes to support the establishment of other community-based activities, including peer education and care programmes.

Action 3. Strengthen the capacity of people living with HIV and those on ART to provide for their nutritional needs

Where the diet is predominantly plant-source based and includes few fortified foods or animal-source foods, it may be necessary to provide a complementary food supplement, such as a micronutrient powder or a lipid-based nutrient supplement of 20 g/d (125 kcal), to ensure that people living with HIV, including those on ART, consume the recommended daily intake of specific nutrients, in particular micronutrients, essential fatty acids and essential amino acids (micronutrients in the case of micronutrient powder and all three in the case of lipid-based nutrient supplements).

- Introduce diversified homestead food production for essential nutrients, access to fresh food and diversified diets for people living with HIV.
- Provide gender- and age-sensitive training courses for professional and family care providers on nutrition education (encouraging the use of local resources and good agricultural practices) in order to ensure healthy, diversified and well-balanced diets for people living with HIV.

Resource materials

-  Office of the United Nations High Commissioner for Refugees, United Nations Children's Fund, World Food Programme, World Health Organization. *Food and Nutrition Needs in Emergencies*. Rome, Food and Agriculture Organization of the United Nations, 2003, available at http://www.who.int/nutrition/publications/en/nut_needs_emergencies_text.pdf.
-  World Health Organization. *Guiding Principles on Feeding Non-breastfed Children 6–24 Months of Age*. Geneva, World Health Organization, 2005, available at http://www.who.int/child_adolescent_health/documents/9241593431/en/index.html.
-  Office of the United Nations High Commissioner for Refugees, World Food Programme. *Integration of HIV Activities with Food and Nutrition Support in Refugee Settings: Specific Programme Strategies*. Geneva, Office of the United Nations High Commissioner for Refugees, World Food Programme, 2004, available at <http://www.unhcr.org/protect/PROTECTION/4215c7dd2.pdf>.
-  Food and Agriculture Organization of the United Nations, World Health Organization. *Living Well with HIV/AIDS: a Manual on Nutritional Care and Support for People Living with HIV/AIDS*. Rome, Food and Agriculture Organization of the United Nations, 2002, available at <http://www.who.int/nutrition/publications/hiv aids/Y416800/en/index.html>.

3.5. Education

Action sheet 3.5.1. Promote access to relevant and protective education for all children and young people

Education is an essential intervention in humanitarian crises settings. It provides protection through a safe and stable learning environment and restores a sense of normalcy, dignity and hope by offering structured, relevant and supportive activities. Access to good-quality educational opportunities is also widely recognized as a means of reducing HIV vulnerability among children and young people. Children and young people who have access to education are also more likely to delay the onset of sexual activity and avoid alcohol and substance use. In addition, education can provide life-saving knowledge, skills and services to children and young people who maybe vulnerable to or at risk of HIV infection, provide additional protection for those who are already infected and affected, and raise awareness in the larger community. Even in times of emergency, it is important to advocate for the inclusion of HIV in the national curricula. It should be ensured that education is part of the emergency preparedness plan.

All education responses in an emergency should be in line with and contribute to the INEE (Inter-Agency Network for Education in Emergencies) Minimum Standards for Education in Emergencies, Chronic Crises and Early Reconstruction and to the work of the IASC Global Education Cluster.

Minimum initial response

Action 1. Ensure that young people, including those affected by HIV, participate in the planning, implementation and evaluation of education programmes

- Include all young people (girls and boys) in all stages of education programme planning, including initial assessments, implementation, monitoring and evaluation. Involve existing youth clubs and associations of local groups of young people living with HIV and peer educators and/or establish focus group discussions with young people to help develop education programming.

Action 2. Provide all children and young people with free access to formal and non-formal education

Use the INEE Minimum Standards for Education in Emergencies, Chronic Crises and Early Reconstruction for equal access to education, to:

- Ensure that no learners are excluded because of HIV-related stigma and discrimination.
- Set up education and protection monitoring and support mechanisms (with education staff, care providers and the community) in order to identify and support (both in financial and psychosocial terms) children and young people at risk. Reach out to out-of-school young people with opportunities for learning knowledge and skills related to HIV and STI prevention, protection from sexual exploitation and violence, and sexual and reproductive health rights.

Action 3. Provide needs- and outcomes-based participatory life-skills-based HIV education

Use the INEE Minimum Standards for Education in Emergencies, Chronic Crises and Early Reconstruction, and teacher management and education, to:

- Review existing curricula for gender sensitivity, appropriateness and inclusiveness with regard to HIV prevention, care and support and ensure that all education activities are directed towards knowledge, attitudes and skills with regard to identified risk behaviours.
- Include in teaching and learning HIV content and life skills building with respect to vulnerability reduction (gender-based and sociocultural drivers of HIV infection, stigma and gender-based violence, and increased vulnerabilities during emergencies), risk reduction (identified risk behaviours, such as injecting drug use, unsafe sex and access to services) and increasing opportunities (health promotion, social and emotional learning for connectedness and vocational training for entrepreneurship).
- Focus on interactive teaching and learning of information and skills, with an emphasis on reflective skills for analysing information, personal skills for goal setting and coping, and interpersonal skills for positive relationships with regard to HIV risk and vulnerability reduction.
- Train teachers on learner-centred and gender-sensitive approaches to help them understand girls' and boys' learning needs and enhance their skills and competencies to contextualize the subject and content. Enable them

to give learners the opportunity to develop their own understanding of HIV with regard to HIV prevention, care and support, including increased vulnerabilities and risks during situations of emergencies and displacements, and on psychosocial and peer support.

- Identify children and young people involved in behaviours that place them at higher risk of exposure to HIV (such as girls, young injecting drug users, young people involved in sex work and young men who have sex with men) and provide them with targeted information, skills building, livelihood skills, support and services (see action sheet 3.2.8).

Action 4. Provide enabling and protective learning environments for all children and young people

Use the *INEE Minimum Standards for Education in Emergencies, Chronic Crises and Early Reconstruction* for ensuring enabling and protective learning environments and:

- Ensure the establishment and enforcement of school policies, regulations and codes of conduct related to discrimination based on HIV status, violence and abuse in schools, which put learners at risk of HIV, with the full participation of children, parent/teacher associations and the larger community.
- Provide healthy learning environments and ensure access to safe water in order to help HIV-infected learners and teachers remain at school, provide safe and sex-separate latrines to protect against sexual violence and provide safe spaces where young people can meet and discuss issues around HIV.
- Ensure that teachers and senior education personnel (head teachers, inspectors) are aware of and enforce codes of conduct, understand how to address all forms of violence and abuse in school and promote inclusion and protection, particularly with regard to girls and young women, children and young people affected by HIV, as well as other additional needs.

Action 5. Facilitate access to essential HIV health for learners and staff





- Use the Focus Resources on Effective School Health (FRESH) framework to ensure links and referrals to specific health and social services.
- Work with local communities and health and protection actors to ensure that learners, teachers and staff affected by HIV have access to basic psychosocial support and essential health and nutritional services, including HIV, STI and sexual and reproductive health services and access to condoms.
- Refer boys and girls who have been sexually abused to post-rape care, including PEP (see action sheet 3.2.3).

Expanded response

Action 1. Refer affected children and young people to specialist services

- Facilitate access for children, young people and staff to youth-friendly, gender-responsive HIV and reproductive health services, including access to condoms and STI diagnosis and treatment.
- Refer pregnant girls to PMTCT services.
- Mobilize community members in high-prevalence areas to provide assistance with domestic and school work and to provide psychosocial support to HIV-affected children and young people, including child-headed households.

Resource materials

-  Inter-Agency Network for Education in Emergencies. *Minimum Standards for Education in Emergencies, Chronic Crises, and Early Reconstruction*. Paris, Inter-Agency Network for Education in Emergencies, 2004, available at http://www.unicef.org/violencestudy/pdf/min_standards_education_emergencies.pdf
-  Inter-Agency Network for Education in Emergencies. *INEE Minimum Standards Toolkit: HIV/AIDS*. New York, Inter-Agency Network for Education in Emergencies, 2008, available at www.ineesite.org/uploads/documents/store/doc_1_INEE_toolkit_-_HIV_AIDS.pdf.
-  United Nations Educational, Scientific and Cultural Organization, Office of the United Nations High Commissioner for Refugees. *Educational Responses to HIV and AIDS for Refugees and Internally Displaced Persons: Discussion Paper for Decision-makers*. Paris, United Nations Educational, Scientific and Cultural Organization, 2007, available at <http://unesdoc.unesco.org/images/0014/001493/149356e.pdf>.
-  UNAIDS, Inter-Agency Task Team on Education. *Toolkit for Mainstreaming HIV and AIDS in the Education Sector: Guidelines for Development Cooperation Agencies*. Paris, United Nations Educational, Scientific and Cultural Organization, 2008, available at <http://unesdoc.unesco.org/images/0015/001566/156673e.pdf>.

3.6. Shelter

Action sheet 3.6.1. Integrate HIV in shelter activities

Well-selected and planned sites with adequate shelter and infrastructure are essential in the early stages of a humanitarian crisis—they can save lives and reduce suffering and stigmatization. Initial decisions on the location and layout of sites, including self-settled camps, can have long-term effects on the protection of settlers and on the delivery of humanitarian assistance. The factors that need to be taken into consideration when designing a camp or shelter include, among others, gender, vulnerabilities, climatic condition, cultural habits, religious practice, soil mechanics and environmental impacts.

In addition, it is important to take into account the fact that people living with HIV and their families may lack the resources or capacity to build, rent or secure their own shelter—proper site planning must therefore include support for them, in order that they are not excluded.

Statutory and customary laws may deny women and children equal property rights, thus affecting their livelihoods.

Minimum initial response

Action 1. Select sites that are safe and secure

- Select and design sites that provide prompt and safe access to communal services (e.g. health facilities, food distribution and water points, markets, schools, latrines, places of worship, social services, fuel resources and recreation activities) and ensure proper lighting of those areas. Apply the same considerations for urban settings.
- Consider the specific needs of vulnerable children and youth, child-headed and one-parent-headed households and those chronically ill, including people living with HIV, in a gender-sensitive manner, when assembling shelters.
- Involve people affected by displacement in decisions regarding shelter and site planning, including those particularly vulnerable to HIV. Consult women about privacy and security, including safe access to communal services. Ensure that site selection minimizes any risks and opportunities for women and children to be recruited into sex work.
- Pay special attention in transit centres to the vulnerability of separated children, including girls, and female-headed households and put in place protection measures and specific safe places inside the centre.

Action 2. Integrate HIV prevention messages into shelter programmes




- Ensure that basic information and education on HIV, including on modes of transmission, methods of prevention and access to services, are provided in shelter programmes.

Expanded response

Action 1. Allocate shelter and land in a non-discriminatory manner

- Map the diversity (age, sex and ethnicity) of the affected population in order to address the needs of each group as appropriate.
- Assist the local authority in establishing a multisectoral team comprising specialists in water and sanitation, health, nutrition, shelter and camp coordination and camp management and a cross-section of the community.
- Assist the specialists and the cross-section of the community to include all adults in shelter assessment, planning and implementation and to address the needs of diverse groups (age, sex and ethnicity).
- Include people living with HIV and vulnerable groups (in generalized epidemics) in shelter assessments, while taking care not to increase stigma and discrimination against people living with HIV, their families and groups at risk.
- Ensure that shelter distribution and land allocation occur in a gender-sensitive and non-discriminatory manner, without preferences, and that people known to be living with HIV have equal access.
- Ensure that women and children are treated fairly in terms of assignment of land and occupancy rights, irrespective of whether the planned shelters are to be temporary or permanent.

Resource materials

-  Global Protection Cluster Working Group. *Handbook for the Protection of Internally Displaced Persons*, provisional release, shelter section. Geneva, Global Protection Cluster Working Group, 2008, available at http://www.humanitarianreform.org/humanitarianreform/Portals/1/cluster%20approach%20page/clusters%20pages/Protection/Protection%20Handbook/IDP%20Handbook_Complete_FINAL%20Jan%202008.pdf.
-  Sphere Project. *Humanitarian Charter and Minimum Standards in Disaster Response: the Sphere Handbook*, revised version. Geneva, Sphere Project, 2004, available at http://www.sphereproject.org/dmdocuments/handbook/hdbkpdf/hdbk_full.pdf .
-  Office of the United Nations High Commissioner for Refugees. *UNHCR Handbook on Emergencies*, 3rd ed. Geneva, Office of the United Nations High Commissioner for Refugees, 2007, available at http://www.the-ecentre.net/resources/e_library/doc/han_Em.pdf.

3.7. Camp coordination and camp management

Action sheet 3.7.1. Integrate HIV in camp coordination and camp management

Large numbers of people are often displaced in humanitarian crises. Many of these people are able to stay within their own countries, but others are forced to flee to become refugees in other countries. Displaced people may spend a long time, sometimes years, living in camp situations, sometimes after a shorter period of time in transit centres.

Mainstreaming HIV into camp coordination and camp management can help to prevent the transmission of HIV and can assist in upholding the human rights of people living with HIV.

Camp coordination and camp management are expected to focus on establishing governance, coordinating all types of services, including for HIV prevention, care, treatment and support, and ensuring that community participation and mobilization mechanisms are in place.

Minimum initial response

Action 1. Establish HIV-sensitive camp governance mechanisms and services

- Ensure that personal HIV information is not included in the registration process.
- Ensure that culturally and linguistically appropriate messages on HIV prevention, stigma and discrimination and on AIDS treatment are integrated into meetings and community radio programmes (see action sheet 3.1.1).
- Advocate for the provision of basic assistance to people living with HIV who are chronically ill, including adequate shelter, nutritional support and health care (see action sheet 3.4.2).

Action 2. Mainstream HIV into camp coordination and camp management

- Facilitate and support HIV mainstreaming into the initial participatory needs assessment in order to ensure that the needs of people living with HIV are reflected.
- Ensure that all persons involved with community security sign the code of conduct for humanitarian staff (see action sheets 3.3.1 and 3.3.3). Provide basic HIV information and workplace training to all camp coordination staff.

Expanded response

Action 1. Assess the situation of the affected camp population and plan appropriate programmes






- Review data on current HIV epidemiological trends, including prevalence in the country/areas of origin and destination areas.
- Obtain a comprehensive profile of the population and assess the current vulnerabilities to HIV among internally displaced persons and refugees in the camp. Pay special attention to the situation of female-headed households, separated children and orphans, as well as young adults and adolescents, and ensure that this analysis is incorporated into security provisions within the camps.
- Include a mapping of hot spots in the host community that may be related to HIV risk behaviours as part of vulnerability assessments.

Action 2. Expand camp governance mechanisms that protect people against HIV infection and promote the rights of people living with HIV

- Establish appropriate links with local national AIDS programmes and district AIDS authorities. In settings of high HIV prevalence, establish HIV camp committees with representatives of all agencies, the government, nongovernmental organizations and the community. Promote the active participation of people living with HIV.
- Integrate HIV prevention into all service delivery points (e.g. health centres, food distribution sites and community and social centres) and inform staff on where to refer people living with HIV who require treatment, care and support services.

- Sensitize local staff on health issues, particularly HIV prevention, standard precautions and AIDS treatment and care needs.
- Ensure that chronically ill persons, and in particular people living with HIV, receive support to access all essential services, including health services, food and nutrition, and have an adequate livelihood and protection.

Resource materials

-  Norwegian Refugee Council, Camp Management Project. *Camp Management Toolkit*. Oslo, Norwegian Refugee Council, 2008, available at http://www.nrc.no/arch/_img/9295458.pdf.
-  Office of the United Nations High Commissioner for Refugees. *UNHCR Handbook on Emergencies*, 3rd ed. Geneva, Office of the United Nations High Commissioner for Refugees, 2007, available at http://www.the-ecentre.net/resources/e_library/doc/han_Em.pdf.
-  Office of the United Nations High Commissioner for Refugees. *The UNHCR Tool for Participatory Assessment in Operations*. Geneva, Office of the United Nations High Commissioner for Refugees, 2006, available at <http://www.unhcr.org/publ/PUBL/450e963f2.html>.
-  Inter-Agency Standing Committee. *Gender Handbook in Humanitarian Action*, camp coordination and camp management section. Geneva, Inter-Agency Standing Committee, 2006, available at http://www.humanitarianinfo.org/iasc/pageloader.aspx?page=content-subsidi-tf_gender-genderH.
-  Sphere Project. *Humanitarian Charter and Minimum Standards in Disaster Response: the Sphere Handbook*, revised version. Geneva, Sphere Project, 2004, available at http://www.sphereproject.org/dmdocuments/handbook/hdbkpdf/hdbk_full.pdf.

3.8. Water, sanitation and hygiene

Action sheet 3.8.1. Integrate HIV in water, sanitation and hygiene programmes

An integrated approach to water, sanitation and hygiene is essential because hygiene promotion is critical in combating diarrhoeal disease, to which people living with HIV are particularly vulnerable. Water points can be a breeding ground for malaria, and because the risk of contracting malaria is greater for people living with HIV, malaria reduction approaches should be included as part of this integrated approach. People living with HIV and their carers may have difficulty accessing water and sanitation facilities due to discrimination, inappropriate design and limited energy or strength to wait in queues or to transport heavy water containers.

When integrating the needs of people living with HIV and their carers in water, sanitation and hygiene programming, particular attention must be paid to physical, health and safety aspects. Specific measures may need to be implemented in order to ensure sufficient and appropriate quantity, quality, design and location of water, sanitation and hygiene facilities and materials. Access to water points and toilets needs to be made acceptable and safe for all users in order to ensure equity of access and protection from sexual violence.

The actions identified for people living with HIV may be relevant for other groups with special needs and therefore it is important to identify and plan for the whole population so that the needs of other groups are not overlooked.

Minimum initial response

Action 1. Ensure people living with HIV and their carers have access to an appropriate and sufficient quantity and quality of water and sanitation services

- Provide jerry cans and buckets that are easy to carry and of a size that people living with HIV, children and the elderly can easily handle.
- Make water hand pumps easy to reach and use so that people living with HIV, children and the elderly can use them. If there are wells, ensure that the walls of the wells are not too high for children, people living with HIV and the elderly to access water.
- Provide individual bedpans and washbasins for use in the home for people who are chronically ill.
- Provide information and support for people living with HIV and carers, with clear instructions on how to care for chronically ill persons in an emergency setting and how to access additional hygiene materials where available.
- Facilitate access to water and sanitation for families with chronically ill members—people living with HIV may have difficulty obtaining water, owing to stigmatization and discrimination, limited energy to wait in queues or insufficient strength to transport heavy water containers.

Action 2. Ensure that water, sanitation and hygiene programmes minimize the risks of violence against vulnerable groups, including people living with HIV

- Ensure that the design of all water and sanitation facilities affords safe access for all users.

Action 3. Integrate HIV prevention messages into water, sanitation and hygiene programmes to help to dispel misconceptions about HIV and about people living with HIV

- Include people living with HIV and carers as animators and in user and maintenance groups.
- Include HIV and the particular circumstances of and care required by people living with HIV in hygiene education initiatives.
- Identify and address myths and misconceptions about HIV, about AIDS and about the contamination of water with HIV. Counter discrimination of people living with HIV through opportunities presented by water, sanitation and hygiene programming.
- Provide hygiene promoters with information on services and referral systems for HIV, gender-based violence and sexual exploitation (see action sheet 3.4.3).

Expanded response

Action 1. Assess and monitor the impact of water, sanitation and hygiene programmatic response on HIV vulnerability

- Obtain feedback from vulnerable groups and improve facilities as appropriate.
- Make extra efforts to ensure that the voices of people living with HIV are heard either directly or indirectly by representation. HIV-positive people and their families can be inadvertently or intentionally excluded from community-based decision-making on issues related to water.
- Establish a feedback mechanism that includes a system for making complaints.
- Appoint a knowledgeable person comfortable dealing with sensitive issues to look after people living with HIV-related complaints.






Action 2. Expand HIV education for water, sanitation and hygiene programme staff and provide comprehensive hygiene education to people living with HIV and their carers

- Train water source and sanitation facility maintenance personnel in HIV prevention and care in order to strengthen the integration of HIV prevention messages in water, sanitation and hygiene programmes.
- Provide hygiene education for the families of people living with HIV and caregivers, with clear instructions on how to wash and where to dispose of waste when providing care to chronically ill persons.

Action 3. Ensure that people living with HIV and their carers have access to an appropriate and sufficient quantity and quality of water and sanitation services in high-prevalence settings

- Take into account that people living with HIV may require more time and privacy to bathe: this may call for an increased ratio of facilities per person.
- Consider the need for increased and more private means to wash clothing and hygiene items in areas where there are large numbers of people living with HIV. This includes facilitating access to extra water for caregivers of people living with HIV for washing sheets and blankets and bathing the sick.
- 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.

Resource materials

-  Jones H, Reed B. *Water and Sanitation for Disabled People and other Vulnerable Groups: Designing Services to Improve Accessibility*. UK, Loughborough University, 2005.
-  Sphere Project. *Humanitarian Charter and Minimum Standards in Disaster Response: the Sphere Handbook*, revised version. Geneva, Sphere Project, 2004, available at http://www.sphereproject.org/dmdocuments/handbook/hdbkpdf/hdbk_full.pdf.
-  UN Habitat. *HIV/AIDS Checklist for Water and Sanitation Projects*. Nairobi, UN Habitat, 2006, available at <http://www.unhabitat.org/pmss/getPage.asp?page=bookView&book=2068>.
-  Walden VM, O'Reilly M, Yetter M. *Humanitarian Programmes and HIV and AIDS: a Practical Approach to Mainstreaming*. Oxford, Oxfam, 2007, available at <http://publications.oxfam.org.uk/oxfam/display.asp?K=9780855985622>.
-  USAID, Hygiene Improvement Programme. *Programming Guidance for Integrating Water, Sanitation, and Hygiene Improvement into HIV/AIDS Programs to Reduce Diarrhea Morbidity*. Washington, DC, USAID, 2008, available at <http://www.hip.watsan.net/page/2458>.

3.9. HIV in the workplace programme

Action sheet 3.9.1. Implement HIV in workplace programmes

Comprehensive programmes that address HIV in the workplace are an important part of the global response to HIV. The workplace provides an opportunity to extend access to HIV prevention, treatment, care and support. In addition, workplace policies set standards for the protection of workers' rights and help to combat stigma and discrimination related to HIV status.

All humanitarian agencies have a responsibility to ensure that their activities do not inadvertently contribute to the HIV epidemic. Staff who are working in humanitarian settings have a responsibility, both to their colleagues and to the people they are assisting, to provide humanitarian assistance free from sexual exploitation and abuse. The statement of commitment on eliminating sexual exploitation and abuse by UN and non-UN personnel affirms that preventing sexual exploitation and abuse and protecting the most vulnerable people are both individual and organizational responsibilities.¹¹ Some humanitarian agencies may have their own codes of conduct related to sexual exploitation and abuse—these should be strictly enforced.

Minimum initial response

Action 1. Provide HIV information and education

- Provide newly deployed staff (including contractors and transport staff) with information on HIV prevention, including how to access voluntary counselling and testing, treatment and support.
- Seek opportunities to provide newly recruited humanitarian staff with minimal HIV awareness and workplace training and education as soon as feasible.
- Inform all staff of existing codes of conduct and zero tolerance policies concerning sexual exploitation and abuse of beneficiaries.
- Ensure that uniformed personnel have access to information on HIV prevention and that they abide by existing codes of conduct and zero tolerance policies concerning sexual exploitation and abuse of beneficiaries.

Action 2. Provide condoms, PEP kits and access to other services to staff

- Make condoms (male and female) available to all staff, in a discreet and affordable way, through the workplace or in partnership with local providers.
- Inform all staff of the protocol governing PEP, where and how to access PEP kits, the name of the PEP kit custodian at their duty station and what to do if it is necessary to use the PEP kit (whom to inform and what follow-up actions to take).
- Ensure that clinical care and HIV counselling are available in the event of occupational or non-occupational exposure to HIV.
- Provide staff with first-aid kits and information on standard precautions, including the use of gloves and sterilized equipment, to prevent the transmission of HIV in the event of accidents.
- Maintain confidentiality regarding the HIV status of staff. All staff members should be aware that no one has to share information on their HIV status and that they do not need to inform their supervisors if they do not wish to.
- Encourage all humanitarian agencies to ensure appropriate treatment, care and support of staff members living with HIV who are in need of such services.

Expanded response

Action 1. Expand HIV in workplace programmes





- Put in place regular refresher courses on gender-sensitive information on HIV prevention, care and protection of rights for all staff, including uniformed personnel.

¹¹ The requirements of the *Secretary-General's Bulletin on Special Measures for Protection from Sexual Exploitation and Abuse* are to be followed by all United Nations employees and employees of United Nations implementing partners. <http://www.unhcr.org/405ac6614.html>

Action 2. Support partners in setting up and implementing HIV in workplace policies and programmes

- Build the capacity of partners and provide training.

Resource materials

-  United Nations. *UN Cares: the UN System-wide Workplace Programme on HIV* (see Minimum Standards, Fact Sheets and Tool Kit and the UN Learning Strategy on HIV/AIDS for guidance on learning sessions). Geneva, UNAIDS, available at www.uncares.org.
-  *Code of Good Practice for NGOs Responding to HIV/AIDS*, available at www.hivcode.org.
-  International Labour Organization. *The ILO Code of Practice on HIV/AIDS and the World of Work: an Education and Training Manual*. Geneva, International Labour Organization, 2001, available at http://data.unaids.org/HRM/hiv-workplace_ilo-code_en.pdf.
-  UNAIDS. *Peer Education Kit for Uniformed Services: Implementing HIV/AIDS/STI Peer Education for Uniformed Services*. Geneva, UNAIDS, 2003, available at http://data.unaids.org/publications/IRC-pub05/jc927-engaginguniservices-peered_en.pdf.

Chapter 4. Monitoring and evaluation

This chapter describes the principles of monitoring and evaluating interventions to address HIV in humanitarian situations. It proposes a set of indicators that, if collected systematically across sectors and agencies, can help to gauge the degree to which the set objectives of the multisectoral response are achieved.

The information collected will help AIDS programme planners and managers, as well as humanitarian actors, to monitor whether:

- HIV preparedness is in place for an emergency situation.
- The required HIV interventions (both for the minimum initial response and expanded response package) are in place during a humanitarian crisis.
- The needs of key populations at higher risk of exposure to HIV and other vulnerable groups are adequately addressed.
- The desired coverage and impact of the intervention is achieved.

In the coordination chapter, mechanisms are described that serve to ensure that HIV responses are planned and implemented coherently. Monitoring and evaluation of coordination should/may include monitoring:

As part of HIV preparedness:

- Whether HIV has been integrated into national emergency preparedness/contingency planning and disaster preparedness.
- Whether long-term national AIDS planning/national strategic plans address HIV contingency planning and emergency preparedness (especially in countries with recurring natural disasters).
- Whether national strategy plans include populations of humanitarian concern—those directly and indirectly affected by humanitarian crises.

As part of the minimum initial response:

- Whether an interagency coordination mechanism has been established in a crisis.
- Whether key sectors have nominated HIV focal points within the overall interagency coordination mechanism.
- Whether HIV is included in humanitarian planning processes (flash appeals, consolidated appeals, common humanitarian action plans, etc.).
- Whether emergency funding for HIV is available from humanitarian funding mechanisms such as the CERF or pooled funds.

As the situation stabilizes and/or as soon as possible (expanded response):

- Whether predictable funding for HIV to address the HIV needs of those affected by humanitarian crises is available from national budgets and other sources such as the Global Fund, the US President's Emergency Plan for AIDS Relief (PEPFAR), etc.

A review of planning and resource mobilization documents (proposals and national strategic plans) can help to monitor how well HIV is integrated both in humanitarian funding and in long-term funding and plans.

As for HIV programming, groups of agencies, or individual agencies, working in one sector, or at a specific location, may well decide on their own monitoring plans and additional indicators, for example to assess progress with the implementation of a specific activity or to record the number of medical or food items distributed. However, core indicators should be selected from existing and already agreed-upon indicator sets.

Depending on the phase of the crisis, different types of data will be accessible, from a variety of sources. In the acute phase, no primary data may be available, as affected populations will not yet have been accessed and services may have been disrupted. Planning may have to rely on secondary data from before the crisis and on population and needs estimates. As a next step, questions on HIV should then be integrated into (and be part of) rapid assessments, or HIV-specific assessments if they are carried out.

As soon as specific services are provided, programme output and coverage data will become available. Such information might cover activities, services and/or vulnerable groups.

As part of the expanded response, larger evaluations—including population-based surveys—may be undertaken, or post-crisis reviews of the HIV response conducted.

Overview of indicators

Table 4 describes the core indicators and types of information required during humanitarian situations (the minimum initial response and the expanded response). Indicators can be expressed as yes/no variables, absolute numbers (e.g. the number of items distributed) or percentages/proportions (e.g. the percentage of the population reached). Although most indicators can be calculated from routine programme data, coverage indicators may need projections and estimates. If a situation poses particular challenges for the estimation of denominators, reporting can be done using absolute numbers.

Estimating the size of a population can be difficult, but there are methods for size estimation that can provide a reasonable estimate. The most frequently applied methods include: (i) census or enumeration methods; (ii) multiplier methods (e.g. using a known number such as the number of households affected and multiplying this number by the expected average number of persons per household); and (iii) population-based surveys.

Minimum initial response

The difficulties and challenges of operating in a crisis may mean that data collection has to be done in a different way, depending on the environment. Interventions may be redirected to other locations and population groups and data transmission may be more difficult.

Data, including on HIV and relevant services, should gradually become available from nongovernmental organizations and local administration records, as well as from rapid assessments. Projections and participatory techniques may be used to assess needs and establish denominators. For example, the number of HIV-positive displaced mothers can be estimated using the number of internally displaced persons, the prevalent fertility rate and the HIV prevalence in the area or the origin of the displaced. In case of cross-border movements, secondary data sources may already be available across the border. If refugees move from country X into country Y, there may be data from country X on HIV prevalence and fertility rates that can be used for planning interventions and projecting needs.

If real-time evaluations of the humanitarian responses are planned, the humanitarian country team and UNAIDS country staff should ensure that HIV elements are integrated from the onset.

Expanded response

After minimum monitoring mechanisms have been put in place, it is critical that the initial lessons learned are drawn upon and that the remaining information gaps are addressed. There may be scope to refine the existing tools and methods, reach areas and populations previously not accessed and conduct more sophisticated data collection efforts, such as population-based surveys, to re-assess the situation. Information on hidden and at-risk population groups, which tend to be neglected in sector-specific assessments, may also be collected at this stage, if this has not yet been done.







As soon as possible, the country should re-establish routine systems to monitor agreed/standard indicators on HIV prevention, treatment, care and support services using the established protocols. At this stage, structured reviews or impact evaluations of the HIV humanitarian response may also be carried out.

Table 4. Possible HIV humanitarian indicators

Sector	Preparedness	Minimum initial response	Expanded response
<p>HIV awareness-raising and community support</p>	<ul style="list-style-type: none"> • Are there stocks of information materials on prevention, human rights and access to treatment and care? (y/n) • Have the locations and contacts of the most affected communities been mapped? (y/n) • Has there been mapping of key populations are higher risk of HIV exposure? (y/n) 	<ul style="list-style-type: none"> • Is an information and community support strategy in place? (y/n) • Number/percentage of affected population reached with HIV messages and materials • Number of information, education and communication materials distributed 	<ul style="list-style-type: none"> • Number/percentage of specific key populations are higher risk of exposure reached by HIV messages and materials • Are affected communities included in planning and decision-making? (y/n)
<p>Health</p>	<ul style="list-style-type: none"> • Are there national protocols available on: (i) standard precautions, (ii) blood safety, (iii) waste management? (y/n) • Are national protocols available on the use of ARV drugs for (i) ART, (ii) PMTCT, (iii) PEP? (y/n) • Are national protocols on the clinical management of rape available? (y/n) • Percentage of clinical staff trained on the clinical management of rape • Percentage of clinical staff trained on HIV care and treatment • In the crisis affected area is there a six-month supply of: <ul style="list-style-type: none"> – Male condoms? (y/n) – Female condoms? (y/n) – ARV drugs for PEP? (y/n) – ARV drugs for PMTCT? (y/n) – ARV drugs for ART (where applicable)? (y/n) • Is a PMTCT programme in place? (y/n) 	<ul style="list-style-type: none"> • Percentage of health facilities which: <ul style="list-style-type: none"> – Apply standard precautions – Provide safe blood transfusions – Provide clinical management to rape survivors (including PEP and emergency contraception) – Provide STI management – Provide PMTCT services at delivery to pregnant women known to be HIV-positive – Provide continuation of ART to those already on treatment • Number of condoms distributed: (i) male and (ii) female • Percentage of people living with HIV already on ART who are receiving continuation therapy • Percentage of pregnant people living with HIV offered PMTCT services • Percentage of people offered PEP within 72 hours of possible exposure • Number of injecting drug users receiving sterile injecting equipment 	<ul style="list-style-type: none"> • Percentage or number of persons seeking voluntary counselling and testing who are tested and receive results • Number of people living with HIV in need of ART able to start such therapy • Number of pregnant women offered PMTCT services • Percentage of health centres providing integrated HIV and tuberculosis services • Number of community health workers actively supporting the provision of home-based care • Number of households receiving support to provide home-based care
<p>Protection</p>	<ul style="list-style-type: none"> • Is there of legislation on non-discrimination and confidentiality regarding HIV status? (y/n) • Is there a mechanism to document HIV-related human rights violations? (y/n) • Percentage of humanitarian workers trained on human rights/protection issues related to HIV 	<ul style="list-style-type: none"> • Do displaced people living with HIV have equal access to HIV services as surrounding populations? (y/n) • Are reports of mandatory HIV testing followed up on? (y/n) • Is there a confidential gender-based violence reporting mechanism in place? (y/n) • Number of HIV-related human rights violations reported and followed up on • Is a mechanism for monitoring and reporting of sexual exploitation and abuse at the workplace in place and is it functioning? (y/n) 	<ul style="list-style-type: none"> • Is there development of a full assessment of the human rights situation for people living with HIV? (y/n) • Number of humanitarian staff trained on HIV protection, including children's rights • Do interagency gender-based violence and HIV strategies exist? (y/n)

Sector	Preparedness	Minimum initial response	Expanded response
Food security, nutrition and livelihood support	<ul style="list-style-type: none"> Number/percentage of nutrition, food assistance and agricultural programme staff trained on HIV considerations and mitigation strategies Are there estimates of HIV-affected households potentially in need of food assistance, nutrition and livelihood support? (y/n) Are there estimates of the number of persons in need of dietary support? (y/n) 	<ul style="list-style-type: none"> Number/percentage of HIV-affected households receiving food assistance, nutrition and livelihood support Is HIV integrated in existing food assistance, nutrition and livelihood programmes? (y/n) 	<ul style="list-style-type: none"> Number of affected groups provided with nutrition and livelihood skills programmes Is there an interagency strategy to integrate HIV into food, nutrition and livelihood support? (y/n)
Education	<ul style="list-style-type: none"> Is HIV integrated within formal and non-formal education? (y/n) Number/percentage of teachers and auxiliary staff trained in life-skills-based HIV education Are there adequate stocks of key HIV and life skills educational materials and curricula? (y/n) 	<ul style="list-style-type: none"> Number/percentage of schools operating in affected areas providing life-skills-based HIV education Do children affected by HIV have equal access to formal and non-formal education? (y/n) 	<ul style="list-style-type: none"> Number of young people trained to provide psychosocial support to younger children affected by HIV Number of children affected by both HIV and humanitarian crises receiving psychosocial support
Shelter	<ul style="list-style-type: none"> Are there assessments of potential sites to determine vulnerability to HIV and the potential to accommodate the special needs of persons of people living with HIV? (y/n) 	<ul style="list-style-type: none"> Number/percentage of HIV-affected population with access to appropriate shelter 	<ul style="list-style-type: none"> Are all people living with HIV receiving adequate covered space as per the Sphere guidelines? (y/n)
Camp coordination and camp management	<ul style="list-style-type: none"> Are there assessments of potential sites to determine vulnerability to HIV and the potential to accommodate the special needs of people living with HIV? (y/n) 	<ul style="list-style-type: none"> Number/proportion of camps with visible, non-discriminatory HIV prevention messages 	<ul style="list-style-type: none"> Number/percentage of camps with HIV coordination committees
Water, sanitation and hygiene	<ul style="list-style-type: none"> Number/percentage of water, sanitation and hygiene programme staff trained in HIV considerations 	<ul style="list-style-type: none"> Number/percentage of HIV-affected population with access to safe water and sanitation facilities Are HIV prevention messages integrated into water, sanitation and hygiene programmes? (y/n) 	<ul style="list-style-type: none"> Is there a feedback mechanism to assess the appropriateness of water, sanitation and hygiene services? (y/n)
HIV in the workplace	<ul style="list-style-type: none"> Is there a workplace HIV policy in place? (y/n) Number of personnel and facilities trained in HIV in the workplace, including code of conduct Number of (i) condoms, (ii) deployment kits/medical kits, including PEP kits, and (iii) HIV information materials pre-positioned 	<ul style="list-style-type: none"> Number/percentage of field offices where PEP starter kits are available to humanitarian agencies for same-day access Is there a mechanism for monitoring and reporting of sexual exploitation and abuse at the workplace, in place and is it functioning? (y/n) Number of condoms and information materials distributed to staff 	<ul style="list-style-type: none"> Is the HIV workplace policy regularly reviewed/updated? (y/n) Is there a HIV staff support group? (y/n) Number and percentage of humanitarian workers who have completed training on HIV in the workplace and on the code of conduct

Resource materials

-  UNAIDS et al. *A Framework for Monitoring and Evaluating HIV Prevention Programmes for Most-at-risk Populations*. Geneva, UNAIDS, 2007, available at http://data.unaids.org/pub/Manual/2007/20070420_me_of_prevention_in_most_at_risk_populations_en.pdf.
-  UNAIDS. *Monitoring the Declaration of Commitment on HIV/AIDS: Guidelines on Construction of Core Indicators: 2008 Reporting*. Geneva, UNAIDS, 2007, available at http://data.unaids.org/pub/Manual/2007/20070411_ungass_core_indicators_manual_en.pdf.
-  UNAIDS. *Country Response Information System: CRIS Operations Guide*. UNAIDS, Geneva, available at http://data.unaids.org/pub/BaseDocument/2007/cris_cog_en.pdf.
-  World Health Organization et al. *Guide to Monitoring and Evaluating National HIV/AIDS Prevention Programmes for Young People*. Geneva, World Health Organization, 2005, available at <http://www.who.int/hiv/pub/epidemiology/napyoungpeople.pdf>.
-  UNAIDS, IMPACT, Family Health International. *Estimating the Size of Populations at Risk for HIV*. Geneva, Family Health International, 2003, available at http://data.unaids.org/Publications/External-Documents/EstimatingPopSizes_en.pdf.
-  Global Health Cluster. *Health Cluster Guide*. Refer to checklist of health services by level of care in Health Resources Availability Mapping System—HeRAMS, available at <http://onerresponse.info/GlobalClusters/Health>.



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