Guidelines for HIV/AIDS interventions in emergency settings

IASC
Inter-Agency Standing Committee

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This document is still a draft version. Following field testing and evaluation, the final version will be delivered later this year.

Preface

The publication of these **Guidelines for HIV/AIDS interventions in emergency settings** responds to growing concerns, shared among UN organizations, community-based organizations, NGOs, and partnering entities, for the *particular vulnerability* of HIV-infected and HIV-affected individuals and groups during emergencies. In the introductory materials of the Guidelines, the case is made strongly that any emergency planning and response action must inevitably take into account the specific issues confronting this special group.

To understand better the complexity of responding to the needs of HIV-infected and HIV-affected individuals and groups in emergencies, it is illustrative to read the list of organizations that have contributed to this publication. They represent a broad range of mandates, strategies, foci, experiences, and approaches to crises and to HIV/AIDS, yet there is a shared vision of the greater successes attainable through a pooling of resources.

The Guidelines are offered in the same spirit of partnership and cooperation with which the participating organizations developed them.

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List of acronyms

AIDS	Acquired Immune Deficiency Syndrome
ARV	Antiretrovirals
BCC	Behaviour change communication
CAP	Consolidated Appeal process
CBR	Crude birth rate
CHAP	Common humanitarian action plan
CSO	Country support offices
EPI	Extended programme of immunization
HIV	Human immunodeficiency virus
HH	Household(s)
IDP	Internally displaced persons
MCH	Mother and child health
MISP	Minimum initial service package
MOH	Ministry of Health
NGO	Non governmental organizations
PEP	Post exposure prophylaxis
PTS	Parents teachers associations
PWLHA	People living with HIV/AIDS
RH	Reproductive health
SGBV	Sexual and gender based violence
STI	Sexually transmitted infections

Chapter 1. Introduction

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

In February 2000, the Working Group of the Inter-Agency Standing Committee[1] (IASC WG) created a Reference Group on HIV/AIDS in Emergency Settings, chaired by the World Health Organization. The Reference Group was dismantled when it fulfilled its mandate. Subsequently, recognizing a renewed interest in developing a more specific response to HIV/AIDS in emergency settings, as well as needing to ensure best practice and co-ordination, the Working Group of the Inter-Agency Standing Committee reactivated the Reference Group. The IASC Task Force[2] on HIV/AIDS in Emergency Settings (IASC TF) was formally established by the IASC Working Group in March 2002.

Upon its reactivation in March 2002, the Task Force began a revision of the "Guidelines for HIV/AIDS interventions in emergency settings."[3] These revised guidelines reflect an increasing awareness of the need to integrate HIV/AIDS epidemic response activities into all aspects of an emergency humanitarian response.

The Task Force is chaired by WHO and its membership includes the following organizations: Civil and Military Alliance (CMA), FAO, The International Centre for Migration and Health (ICMH), the International Committee of the Red Cross (ICRC), the International Council of Voluntary Agencies (ICVA), the International Federation of Red Cross & Red Crescent Societies (IFRC), the International Office for Migrations (IOM), OCHA, UNAIDS, UNDP, UNFPA, UNHCR, UNICEF and WFP. Several NGOs have participated in this work through ICVA.

The rationale for a specific HIV/AIDS intervention within complex emergencies: HIV/AIDS and crisis

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

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

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

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

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

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

Clearly, there is an urgent need to incorporate the HIV/AIDS response into the overall emergency response. Equally clearly, the impacts of HIV/AIDS will persist and expand beyond the crisis event itself, influencing the outcome of the response and shaping future prospects for rehabilitation and recovery. Increasingly, it is clear that, unless the HIV/AIDS response is part of the wider response, all efforts to address a major food and humanitarian crisis in high prevalence areas will be insufficient.

Purpose of the guidelines

The purpose of these guidelines is to enable governments and cooperating agencies, including UN Agencies and NGOs, to deliver the *minimum* required multi-sectoral response to HIV/AIDS during the early phase of emergency situations. As a general rule, this response should be integrated into existing plans and the use of local resources should be encouraged. A close and positive relationship with local authorities is fundamental to the success of the response and will allow strengthening of the local capacity for the future.The purpose of these guidelines is to enable governments and cooperating agencies, including UN Agencies and NGOs, to give the minimum required multi-sectorial response to HIV/AIDS during the early phase of emergency situations. As a general remark, activities developed to respond to a crisis should be integrated into existing ones and the use of local resources should be encouraged. The relationship with local authorities is paramount to the success of the response and will allow strengthening of the local capacity for the future.

Target audience

These guidelines were designed for use by authorities, personnel and organizations operating in emergency settings at international, national and local levels. The guidelines are applicable in any emergency setting, regardless of whether the prevalence of HIV/AIDS is high or low. For example, even in low prevalence settings, a breakdown in the health infrastructure can cause increased transmission of HIV/AIDS if health care workers do not follow universal precautions against blood-borne diseases.

Certainly the guidelines should be applied in emergency settings with high HIV/AIDS prevalence, where an integrated response is urgently needed in order to prevent the epidemic from having an even greater and more devastating impact.

Although HIV/AIDS is not given as high a priority in low prevalence settings, this does not mean that emergency response personnel in low-prevalence settings can be complacent. Even in low prevalence settings, advocacy is needed to raise awareness of the importance of integrating emergency responses and HIV/AIDS prevention and care programming in low prevalence settings, highlighting the points of vulnerability to transmission of HIV/AIDS exacerbated during emergencies. At the very least, key actors in any emergency response situation, along with the relevant authorities and existing response teams, should establish co-ordination mechanisms to decide the appropriate minimum response for their geographic area based on these guidelines and the existing response to the disease.

Description of chapters, sectors and the Matrix

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

The sectors are:

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

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

The Matrix, shown on pages 14 - 15, is divided into columns according to a specific phase of the emergency: emergency preparedness, minimum response and comprehensive response. These guidelines give emphasis to the *minimum* required actions needed in order to manage HIV/AIDS in the midst of an emergency. Each of the bullet points in the sectors in the minimum response column corresponds to an Action sheet that provides information on the minimum activities that should be undertaken to consider HIV/AIDS in the overall response to the crisis. It also shows the interaction between the different sectors.

Use of the companion CD-ROM

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

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

An emergency is an unexpected situation which arises after a natural or social occurrence and which threatens human life and well being; it demands immediate, appropriate and extraordinary action. Emergencies may be characterized by mass deaths, hunger, food insecurity, destruction of infrastructure, disruption of essential services, spread of epidemics, collapse of agricultural systems, formation of refugee populations, and increased social tensions. Emergencies often exceed the adjustment and response capacities of individuals, households, communities, local institutions, and governments. As a result, assistance is required to help people at all levels to cope with the consequences of an emergency.

Experience has demonstrated the mutually exacerbating effects that emergency situations and the HIV/AIDS epidemic have on one another. HIV/AIDS can spread quickly where there is poverty, powerlessness and social instability -- conditions common to emergencies. In general, emergency situations increase vulnerability to the HIV/AIDS epidemic, facilitate the spread of HIV, and aggravate the impact of HIV/AIDS on health and well being.

In emergency situations, ongoing HIV/AIDS prevention and care activities are apt to be disrupted or supplanted by other actions presumed to have greater priority. Thus, people have fewer options for protecting themselves at a time of high vulnerability.

Until recently, HIV/AIDS interventions were limited primarily to prevention and awareness raising. Such limited interventions were not seen as a priority during emergencies, especially during the acute phase, because HIV/AIDS was not viewed as a direct threat to life. Immediate response efforts focused instead on those people at risk of death from injury, starvation and other priorities related to the context.

Groups at risk: the rural poor

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

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

Groups at risk: women

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

Groups at risk: children

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

The role of international agencies

International agencies are important actors in emergency situations, providing a wide range of relief services, such as food aid, health care, technical assistance, and attention to refugees and other displaced populations. Until recently, UN work on HIV/AIDS has focused on the behavioural and epidemiological dimensions of the epidemic, and has concentrated on controlling HIV transmission and alleviating the health impacts.

However, new information suggests that people's decisions to engage in at-risk behaviours are strongly influenced by household food security. Thus, if the disease undermines people's livelihoods, the result can be a vicious circle hampering efforts to address the epidemic. It is therefore essential for humanitarian actors to understand the wider implications of HIV/AIDS in emergency situations, as well as the potential for emergency interventions to protecting and promote the livelihoods of households and communities affected by HIV/AIDS.

The implications of such an emergency response, one which incorporates HIV/AIDS into a larger effort, need to be understood by health agencies in order to provide an appropriate response to be incorporated in the overall emergency response. By definition, the impact of any crisis is determined by the event (here the epidemic) and the local context (in particular the existing social and livelihoods systems). In the case of HIV/AIDS, the impact will also vary according to the stage of the epidemic.

Since the present guidelines concentrate on addressing the *minimum* required actions to address HIV/AIDS issues in an emergency, emphasis is given herein to necessary and feasible interventions. However, emergency responses clearly should not be limited to the minimum required actions; more comprehensive actions need to occur as soon as possible to ensure appropriate

rehabilitation and recovery. In at-risk areas ("chronic vulnerable areas", drought-prone areas) where crises are known to be recurrent or of slow onset, prevention and emergency preparedness should be a priority. These two stages will eventually be the subjects of specific and complementary guidelines.

Prevention and preparedness

Prevention and preparedness focus on addressing the causes of the emergency with a view to avoiding its recurrence or reducing its impact, strengthening resilience of at-risk households and communities, and building up local capacity to address the crisis (including prepositioning of relief items to shorten the time of the response). These efforts are often linked to early warning systems, especially in natural disaster prone areas.

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

Comprehensive response

The rehabilitation and recovery phases of an emergency cycle permit a more comprehensive response, built upon the initial minimum response and enhancing coverage and sustainability. In the Matrix, presented below, the comprehensive response specifies the activities to be undertaken following the initial phase. The rehabilitation phase can last until the situation causing the emergency has returned to normal. During the comprehensive phase, it is important to coordinate activities with the local authorities and among the various actors providing services to the population.

Chapter 3:The Matrix

The Matrix is a tool which provides guidance on key actions for responding to HIV/AIDS in emergencies. The Matrix, shown on the following pages, is divided into three parts: Emergency Preparedness, Minimum Response, and Comprehensive Response.

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

Principles

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

Sectoral Response	Emergency Preparedness	Minimum Response (to be conducted even in the midst of emergency)	Comprehensive response
Co-ordination	• Determine co-ordination structures • Identify and list partners • Establish network of resource persons • Raise funds • Prepare contingency plans • Include HIV/AIDS in humanitarian action plans and train accordingly relief workers	1.1 Establish co-ordination mechanism	• Continue fundraising • Strengthen networks • Enhance information sharing • Build human capacity • Link emergency to development HIV action • Work with authorities • Assist government and non-state entities to promote and protect human rights[4]
Assessment and monitoring	• Conduct capacity and situation analysis • Develop indicators and tools • Involve local institutions and beneficiaries	2.1 Assess baseline data 2.2 Set up and manage a shared database 2.3 Monitor activities	• Maintain database • Monitor and evaluate all programmes • Assess data on prevalence, knowledge attitudes and practice, and impact of HIV/AIDS • Draw lessons from evaluations
Protection	• Review existing protection laws and policies • Promote human rights and best practices • Ensure that humanitarian activities minimize the risk of sexual violence, and exploitation, and HIV-related discrimination • Train uniformed forces and humanitarian workers on HIV/AIDS and sexual violence	3.1 Prevent and respond to sexual violence and exploitation 3.2 Protect orphans and separated children 3.3 Ensure access to condoms for peacekeepers, military and humanitarian staff	• Involve authorities to reduce HIV-related discrimination • Expand prevention and response to sexual violence and exploitation • Strengthen community based protection for orphans and separated children and young people • Institutionalize training for uniformed forces on HIV/AIDS, sexual violence and exploitation, and non-discrimination • Put in place HIV-related services for demobilized personnel
Water and Sanitation	• Train staff on HIV/AIDS, sexual violence, gender, and non-discrimination	4.1 Include HIV considerations in water/sanitation planning	• Establish water/sanitation management committees • Organize awareness campaigns on hygiene and sanitation, targeting people affected by HIV
Food Security and Nutrition	• Contingency planning/preposition supplies • Train staff on special needs of HIV/AIDS affected populations • Include information about nutritional care and support of PWLHA in community nutrition education programmes • Support food security of HIV/AIDS-affected households	5.1 Target food assistance to affected households and communities 5.2 Plan nutrition and food needs for population with high HIV prevalence 5.3 Promote appropriate care and feeding practices for PLWHA 5.4 Support and protect food security of HIV/AIDS affected & at risk households and communities 5.5 Distribute food aid to affected households and communities	• Develop strategy to protect long-term food security of HIV affected people • Develop strategies and target vulnerable groups for agricultural extension programmes • Collaborate with community and home based care programmes in providing nutritional support • Assist the government in fulfilling its obligation to respect the human right to food.

Shelter and Site Planning	• Ensure that potential sites safe • Train staff on HIV/AIDS, gender and non-discrimination	6.1 Establish safely designed sites	• Plan orderly movement of displaced
Health	• Map current services and practices • Plan and stock medical and RH supplies, • Adapt/develop protocols • Train health personnel • Plan quality assurance mechanisms • Train staff on the issue of SGBV and the link with HIV/AIDS • Train health staff on RH issues linked with emergencies and the use of RH kits • Assess current practices in the application of universal precautions	7.1 Ensure access to basic health care for the most vulnerable 7.2 Ensure a safe blood supply 7.3 Provide condoms 7.4 Institute syndromic STI treatment 7.5 Management of the consequences of SV 7.6 Ensure safe deliveries 7.7 Universal precautions	• Forecast longer-term needs; and secure regular supplies; and ensure appropriate training of the staff • Palliative care and home based care • Treatment of opportunistic infections • Provision of ARV treatment • Safe blood transfusion services • Ensure regular supplies, include condoms with other RH activities • Reassess condoms based on demand • Management of STI, including condoms • Comprehensive sexual violence programmes • Prevention and care for IDU • Voluntary counselling and testing • Reproductive health services for young people • Prevention of mother to child transmission • Enable/monitor/reinforce universal precautions in health care
Education	• Determine emergency education options for boys and girls • Train teachers on HIV/AIDS and sexual violence and exploitation	8.1 Ensure children's access to education	• Educate girls and boys (formal and non-formal) • Provide lifeskills-based HIV/AIDS education • Monitor and respond to sexual violence and exploitation in educational settings
Behaviour Communication Change and Information Education Communication	• Prepare culturally appropriate messages in local languages • Prepare a basic BCC/IEC strategy • Involve key beneficiaries • Conduct awareness campaigns • Store key documents outside potential emergency areas	9.1 Provide information on HIV/AIDS prevention and care	• Scale up BCC/IEC • Monitor and evaluate activities
HIV/AIDS in the workplace	• Review personnel policies regarding the management of PLWHA who work in humanitarian operations • Develop policies when there are none, aimed at minimising the potential for discrimination • Stock materials for post-exposure prophylaxis (PEP)	10.1 Prevent discrimination by HIV status in staff management 10.2 Provide post-exposure prophylaxis (PEP) available for humanitarian staff	• Build capacity of supporting groups for PLWHA and their families • Establish workplace policies to eliminate discrimination against PLWHA • Post-exposure prophylaxis for all humanitarian workers available on regular basis

Action sheet 1.1
Establish co-ordination mechanisms

Sector 1: Co-ordination
Phase: Minimum response

Background

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

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

It is therefore essential:

- to identify the different actors, and to ensure appropriate co-ordination
- to raise the awareness and motivation of decision-makers to improve projects, programmes and policies;
- to strengthen the capacity of institutions working in affected areas; and
- to ensure the dissemination of relevant information and facilitate provision of technical assistance to users.

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

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

Key actions

1. Setting up and strengthening co-ordination mechanisms

- Identify and ensure collaboration of existing regional, national and local co-ordination bodies (for HIV/ AIDS and for emergencies). This includes the Humanitarian co-ordinator and the Office for the Co-ordination of Humanitarian Affairs (OCHA); define and map the mandate and strengths of each stakeholder to avoid duplication and identify gaps.
- Identify an office or some central

point as the focal point for the co-ordination effort, and, appoint staff as needed; put in place record-keeping mechanisms and procedures to ensure all stakeholders are informed.

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

2. Raise awareness of decision makers and programme managers

- Organize information and advocacy seminars at central level.
- Promote the incorporation of HIV/AIDS in emergencies on the agenda of relevant co-ordination mechanisms at national level.
- Promote the creation of, and agreement upon, a strategic plan, taking into consideration the flexibility needed to adjust to the evolving imperatives of the emergency.
- Collaborate with media organizations to explain to donors and partners the links between HIV/AIDS and the emergency.

3. Raise awareness/train/support local institutions in affected HIV areas

- Field visit by representatives of relevant national co-ordinating bodies[5] to relevant administrative areas (preferably joint) to:
  - contact local authorities and key humanitarian actors and exchange information, and
  - initiate arrangements for a training and awareness raising workshop for local institutions.
- Joint training and awareness-raising workshop (total duration approximately 2 days, which can be adjusted according to time constraints);
- Follow-up activities
  - HIV/AIDS in emergencies included on the agenda of relevant local co-ordination mechanisms;
  - Simple reporting and information-sharing system set up at local level;
  - Complementary local needs assessments carried out to identify populations most at risk and priority areas for interventions;
  - Periodic support missions by representatives of relevant co-ordinating bodies at country level and/or national centre of expertise.

4. Information and technical assistance

- Ensure that appropriate support is provided to all stakeholders for strategic planning, assessment, monitoring and analysis in relation to HIV/AIDS in emergency-affected areas;
- Review, share, and discuss the existing information with relevant stakeholders,

and inform populations of the risks posed by HIV/AIDS;

- Regular and consistent reports made available to all stakeholders on how HIV/AIDS is being addressed throughout the humanitarian response. The focal point/co-ordination body is responsible for maintaining a network of communication between all stakeholders.
- Information, reference material and tools made available; national reference system and network set up to facilitate exchange of information and advice; central web page to store and facilitate access to display relevant information and resources, if appropriate.

Key resources

Guidelines on how to integrate HIV/AIDS in the Consolidated Appeals Process. (Document attached 46)

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

Food security and HIV/AIDS: an update. www.fao.org/DOCREP/MEETING/006/Y9066e/Y9066e00.HTM (Doc 2)

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

Weblinks:
www.unaids.org
www.reliefweb.int

Chapter 4. The guidelines

Action Sheet 2.1
Assess baseline data

Sector 2: Assessment and Monitoring
Phase: Minimum Response

Background

A variety of factors influence the transmission of HIV in emergency settings, including:

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

In addition to these, culturally-related factors pertaining to the setting must be considered, as well as the maturity of the epidemic in both host and displaced populations. There are many challenges in assessing baseline data in emergencies primarily due to limited data; often proxy indicators must be used.

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

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

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

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

Key Actions

1. HIV/AIDS Rapid Risk and Vulnerability Assessment

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

2. HIV/AIDS Surveillance

Existing baseline data may include:

- Voluntary blood donor testing.
- Trends of AIDS case surveillance reporting, new TB cases
- Incidence (new cases/1,000 persons/ month) and trends of STI disaggregated by syndrome (male urethral discharge, genital ulcer disease, syphilis at antenatal clinics).
- Percent and trends of hospital bed occupancy of persons between 18-39 years of age.

Data may already exist for:

- Sentinel surveillance of pregnant women (proxy for general population).
- Sentinel surveillance of high-risk subgroups (STI patients, intravenous drug users, and commercial sex workers).
- Voluntary testing and counselling.
- Prevention of mother to child transmission.
- Behavioural surveillance surveys.

Challenges to surveillance reporting include:

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

3. Other Key Baseline Data

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

4. Feedback

5. Also see monitoring activities (Action sheet 2.3) and shared database (Action sheet 2.2).

▸ Key Resources

UNHCR/WHO/UNFPA. Inter-agency field manual. Reproductive health in refugee situations. Geneva, 1999. Chapter 9.
www.unhcr.ch/cgi (Doc. 24)

WHO. Guidelines for sexually transmitted infections surveillance: WHO, 1999.
www.who.int/emc-documents/STIs/whocdscsredc993c.html (Doc 14)

UNAIDS/WHO. Guidelines for second generation HIV surveillance. Geneva: UNAIDS/WHO, 2000: 1-48. (Doc 18)

Demographic and Health Surveys at:
www.measuredhs.com

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

Chapter 4. The guidelines

Action Sheet 2.2: Set-up and manage a shared database

Sector 2 : Assessment and Monitoring
Phase: Minimum Response

Background

Each sector needs to have a lead agency whose responsibility is to co-ordinate and communicate with other organizations and governments involved in the emergency response. One component of this co-ordination is the setting up of a shared and standardized database of information. A database facilitates comparisons between various locations as well as the aggregation and interpretation of information from the lowest level (clinics and camps) to the highest level (country or regional level).

Key Actions

- Make inventory of existing data collection forms and systems to examine possible linkage with HIV/AIDS information system.
- Develop standardized forms; types of forms may vary according to available programmes, but include the following:
  - Health information system including confidential clinical AIDS case reporting, STI by syndrome, gender-based violence, and death reporting components.
  - Blood screening (HIV and syphilis).
  - Orphan programmes.
  - Protection cases.

  Depending upon the situation and programmes in place, forms and systems for:
  - Sentinel surveillance (antenatal and high risk).
  - Surveys: behavioural surveillance, nutrition, others.
  - Voluntary counselling and testing .
  - Prevention of mother to child transmission.
  - Supplemental and therapeutic feeding programmes.
- Develop standardized case definitions; as above.
- Achieve consensus with partners and actors on the items above, together with the harmonizing of existing government forms, if applicable.
- Provide housing of shared database with open access to users.
- Training.
  - Various sector workers involved in reporting, collecting and analysing data.
  - Designated “data specialist” to deal manage hardware and software with computer aspects of data.
- Feedback at all levels.
  - Participating organizations, governments.
  - Sector workers.
  - Affected population.
- Also see Assess baseline data (Action sheet 2.1) and Monitoring activities (Action sheet 2.3).

Key resources

UNHCR/WHO/UNFPA. Inter-agency field manual. Reproductive health in refugee situations. Geneva, 1999. Chapter 9.
www.unhcr.ch/cgi-bin/texis/vtx/home/opendoc.pdf (Doc 24 Chap. 9)

WHO. Guidelines for sexually transmitted infections surveillance: WHO, 1999. A–add URL from WHO website (Doc 14)

UNAIDS/WHO. Guidelines for second generation HIV surveillance. Geneva: UNAIDS/WHO, 2000: 1-48. (Doc 18)

www.unaids.org

Chapter 4. The guidelines

Action Sheet 2.3: Monitor activities

Sector 2: Assessment and Monitoring
Phase: Minimum Response

Background

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

Key actions

1. Basic Indicators for Minimum Response

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

For example, male condom supply and utilization:

- Short-term Process Indicators:

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

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

Y condoms x 3 months

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

Distribution of condoms:

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

Number of condoms/sexually active male/month

Benchmark: minimum: 12 condoms/sexually active male/month [6]

- Midterm Outcome Indicators:

STI incidence by syndrome over time:

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

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

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

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

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

B2. Consensus on above indicators with harmonization of existing government indicators, if applicable.

B3. Training

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

B4. Feedback

B5. Also see Assess baseline data (Action sheet 2.1) and Set-up and manage a shared database (Action sheet 2.2).

Key Resources

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

UNHCR. Prevention and response to sexual and gender-based violence in refugee situations. Inter-agency lessons learned 2001, Geneva. (Doc 19)

UNHCR/WHO/UNFPA. Inter-agency field manual. Reproductive health in refugee situations. Geneva, 1999. Chapter 9.
www.unhcr.ch/cgi- (Doc 24)

WHO. Guidelines for the management of sexually transmitted infections. 2001. (Doc 15)

Chapter 4. The guidelines

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

Sector 3: Protection
Phase: Minimum response

Background

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

Sexual and gender based violence infringes the fundamental human rights of adults and children, affecting their integral development as individuals and that of their communities. Sexual and gender-based violence intensifies in conflict and post-conflict situations, adding to the risks faced by refugees, returnees and internally displaced persons. In response, humanitarian workers and peacekeepers have begun to actively direct the attention of the international community to strengthening and enhancing the protection of women and children in situations of humanitarian crisis.

Sexual and gender based violence, through the increase in sexual activity, increases the possibilities and the likelihood of the spread of HIV/AIDS.

Key actions

Prevention of and response to the complex problems of sexual and gender based violence require inter-agency, interdisciplinary, and multi-sectoral collaboration. Key characteristics of effective prevention and response include:

- full engagement and involvement of the community. Equal participation of women and men in all stages of planning, implementation, monitoring and evaluation;
- incorporation of relevant messages in integrated information and communication strategy (see Sector 9);
- multi-sectoral action;
- inter-disciplinary and inter-organizational cooperation; and
- collaboration, communication and co-ordination.

During an emergency, it is essential to make sure that information and access to specific services for victims of violence are set up as a minimum response. (See paragraphs 6, 7 and 8.)

1. Identify and engage key stakeholders.
Begin the process by mapping the relevant actors and inviting stakeholders to a discussion meeting. It is recommended that these discussions be highly participatory, with representatives of both sexes. Examples of key stakeholders include: UN Agencies, NGOs, refugee groups, health-care providers, CSOs, host government authorities, and community leaders.

2. Develop a common understanding of SGBV and agree on the scope of action.

It is important that all actors in each setting reach a common understanding of sexual and gender-based violence concepts and agree on standard reporting mechanisms. This step will facilitate the adoption of a coherent approach among stakeholders allowing for the establishment of appropriate prevention and response mechanisms and facilitating the information sharing process.

3. Conduct a situation analysis.

Gather information to gain an understanding of needs, problems, services available, and community strengths and weaknesses. Understanding the dynamics of the community will allow appropriate planning.

4. Establish guiding principles.

The guiding principles for all actors are:

- Ensure the physical safety of the survivor(s)
- Guarantee confidentiality
- Respect the wishes, the rights and the dignity of the survivor(s)

5. Design a collaborative action plan.

Convene a second stakeholder's meeting to discuss the findings from the situation analysis. All participants should share information to reach a better understanding of the needs, problems, services available, and refugee community strengths and weaknesses concerning SGBV.

Develop a problem list and plans for addressing the problems. As the different interventions are developed and as the inter-relations between one intervention and another are identified, it may be necessary to prioritize problems if resources are severely limited.

Establish an inter-sectoral and inter-agency programme monitoring and evaluation plan. This includes goals, objectives, indicators, data and information gathering, and analysis reporting.

6. Build mechanisms for reporting, referrals and co-ordination.

Common systems must be agreed upon for referrals for health care, counselling, security and legal needs. Co-ordination involves sharing information on incidents of SGBV, discussing and resolving problems of prevention and response activities among actors and stakeholders, and developing common monitoring and evaluating tools.

With this in mind:

- Establish and continuously review methods for reporting and referrals among and between different actors. Referral networks should work with no delays and obstacles, focusing on providing prompt and appropriate services to survivors.
- Share written information – bearing in mind the confidentiality principles – especially the monitoring and evaluation reports and incident data, among actors and key stakeholders.
- Convene regular meetings of key actors and stakeholders. The designated "Lead Agency" is responsible for encouraging participation, facilitating meetings and developing other methods of co-ordination and information sharing.

7. Promote awareness of gender rights among beneficiaries.

Beneficiaries must be informed of and educated on their fundamental human rights for protection. Women's committees, health clinics, and food distribution points are all possible intervention points for providing information regarding SGBV, as well as alerting the reporting and referral systems for victims.

8. Ensure the necessary health care services for victims of SGBV.

Health care services must be ready to respond compassionately to people who have been raped, sexually assaulted, or sexually abused. The health co-ordinator should ensure that health care providers (doctors, medical assistants, nurses, etc.) are trained to provide appropriate care and have the necessary equipment and supplies. Female health care providers should be trained as a priority, but a lack of trained female health workers should not prevent the service providing care for survivors of rape. (See Action Sheet 7.5.)

▸ Key resources

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

How To Guide: Crisis Intervention Teams: Responding to Sexual Violence in Ngara Tanzania. UNHCR, January 1997. (Doc 42)

How to Guide: Building a Team Approach to Prevent and Respond to Sexual Violence in Kigoma-Tanzania. UNHCR December 1998.

How to Guide: Monitoring and Evaluation of Sexual Gender Violence Programmes. UNHCR April 2000. (Doc 41)

Clinical Management of Survivors of Rape (draft for field-testing). WHO and UNHCR, June 2002. (Doc 50)

Sexual and Gender-based Violence: Inter-agency Lessons Learned Conference Proceedings. UNHCR March 2001. (Doc 19)

Refugee Children, Guidelines on Protection and Care. UNHCR 1994. (Doc 25)

Guidelines on the Protection of Refugee Women. UNHCR 1991. (Doc 22)

Action Sheet 3.2: Protection of orphaned and separated children

Sector 3: Protection
Phase: Minimum response

Background

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

Key actions

- Work to prevent separation of orphaned and separated children through training of humanitarian workers, and sensitization of parents to limit risk of separation (for example, by putting name and address on children's clothing).
- Provide boys and girls who are demobilized from child soldiering with basic HIV education, screening and treatment for sexually transmitted infections.
- Provide immediate care and attention to separated children with special attention to unaccompanied children. Ensure that safe spaces are provided by child protection agencies, that children are registered and that food, shelter and support are available.
- Trace and reunite children with parents or relatives, avoiding adoption at the peak of the emergency.
- Arrange temporary or permanent fostering if parents or relatives cannot be found.
- In camp settings, provide extra protection to child and female headed households, for example by grouping them in the centre rather than the periphery of the camp, or ensuring that they are placed in a social group that will provide them with appropriate protection.
- Provide psychosocial support to orphaned and separated children and their caregivers.
- Provide access to appropriate reproductive health services for orphaned and separated children.
- Establish child friendly spaces where children can meet, play, access basic health and nutrition needs and learn in school or out of school setting.
- Set-up schools and playgrounds.

Key resources

UNICEF. Actions for Children Affected by Armed Conflict, May 2002. (Doc 38)

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

UNHCR, OHCRC, UNICEF, Save the Children. Action for the rights of children. October 2002. (Doc 27)

Working with separated children. Field Guide, Training Manual and Training Exercises. Save the Children, London, Uppard, S., Petty, C. and Tamplin, M. 1998.
www.savechildren.org.uk/onlinepubs/guide/sepchildpubs.html

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

Sector 3: Protection

Phase: Minimum Response

Background

Peacekeepers and national uniformed services are highly vulnerable to sexually transmitted infections (STI) due to their work environment, mobility, age and other facilitating factors that expose them to higher risk of HIV/AIDS infection. In particular, military personnel, constitute a population at special risk of exposure to STI, including HIV/AIDS. In peacetime, STI rates among armed forces personnel are generally 2 to 5 times higher than in civilian populations; in time of conflict the difference can be much greater.

Condoms offer effective protection against the sexual transmission of HIV if they are used consistently and correctly. Sustainable condom programming identifies key activities required to ensure successful and effective procurement, promotion, and delivery of condoms. However, in emergency settings there is an immediate need to make condoms freely available to those at risk.

Key actions

1. Needs assessment

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

- Before assessing the condom needs of uniformed services personnel, it is advisable to contact the medical division (if it exists and is accessible) of the armed forces to determine what if anything is being done about HIV/AIDS prevention. This collaboration will facilitate a more realistic needs assessment.
- Some peacekeeping missions have a medical officer and/or may have a focal point or adviser on HIV/AIDS; therefore contact with these people is essential.
- Try to ascertain the number of uniformed service and/or peacekeeping personnel present in the region.
- There is no international scale of issue for condoms. Five male condoms and two to three female condoms (if available) per person per week is supported by agencies specializing in reproductive health for planning purposes.[7]

2. Procurement

Given the often-harsh conditions in which they will be distributed, good quality condoms are essential. Good quality also ensures effectiveness in preventing the spread of STI. Condoms can be gotten from donors, intermediary suppliers, or directly from manufacturers.

Therefore:

- Procurement officers or their equivalent should ensure that each shipment of condoms they receive have been quality tested.
- Condoms that satisfy the requirements of the WHO Specification can be gotten from UNFPA, IPPF or WHO.[8]

3. Distribution of condoms

- Assess the main constraints (and opportunities) pertaining to access to condoms.
- These could include religious or cultural beliefs which restrict or ban the use of condoms.
- Opportunities could include putting condoms into survival kits for armed or peacekeeping forces.
- Contact (if feasible) the medical contingent personnel of both the armed forces and peacekeeping forces to determine whether collaboration on condom distribution is possible. Condoms could be distributed along with other necessary supplies to members of both forces.
- Identify other avenues for distribution, for example, through NGO partners or by targeting establishments frequented by uniformed services (bars and/or brothels).
- Condom packaging should display culturally appropriate instructions (for example, pictorial information) on how to use condoms and how to dispose of them safely. (See Document 9: The male condom, technical update.)

4. Monitoring and evaluation

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

5. The UNAIDS Awareness Card strategy

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

▸ Key resources

Manual of reproductive health kits from UNFPA. (Doc 43)

Male Condom programming Fact sheets, UNAIDS, WHO, WHO/RHT/FPP/98.15 UNAIDS/98.12. (Doc 9)

The Female Condom, A guide for planning and programming, UNAIDS, WHO, WHO/RHR/00.8 UNAIDS/00.12E. (Doc 11)

Chapter 4. The guidelines

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

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

Sector 4: Water, Sanitation and Hygiene Promotion

Phase: Minimum response

Background

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

Key actions

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

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

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

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

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

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

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

- Facilitate access to water and sanitation for families with chronically ill family members; people living with HIV/AIDS may have difficulty obtaining water due to stigmatization and discrimination, limited energy to wait in queues, or insufficient strength to transport heavy water containers.

- Design water systems to take into account that children and older people frequently fetch water; make sure that pump handles are not too high, that pumping is not too difficult, and that the walls of the well are not too high. This is especially important where the task of fetching water falls increasingly on children and the elderly as a consequence of HIV/AIDS.

- Facilitate access to extra water for caretakers of people living with HIV/AIDS, who may need more greater than usual quantities water, to wash sheets and blankets of chronically ill family members and to bathe the sick more frequently.

- Include appropriate water and sanitation facilities in health centres and education sites, and provide hygiene education in emergency education programmes.

- Make extra efforts to ensure that the voices of people living with HIV/AIDS are heard either directly or indirectly by representation; infected people and their families can be inadvertently of intentionally excluded from community-based water decision making.

Key resources

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

International Federation of the Red Cross and Red Crescent Societies. Water and Sanitation Kit. (Doc6)

Chapter 4. The guidelines

Action sheet 5.1: Target food assistance to affected households and communities

Sector 5: Food security and nutrition
Phase: Minimum Response

Background

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

Key actions

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

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

- Ensure that food assistance, when provided to PLWHA and HIV/AIDS affected families, does not increase stigmatization or make non-affected vulnerable families feel excluded.
  - Work should be done with established community-based organizations that are already involved with HIV/AIDS-affected individuals and families.
  - Whenever possible, sensitization and prevention awareness activities should be linked whenever possible to large-scale distribution activities.

- In emergencies, certain individuals may be more at risk than others. These are often the same people whose food insecurity is exacerbated by HIV/AIDS, and may include:
  - female, child and elderly headed households;
  - orphan hosting families;
  - families caring for chronically ill person(s).

- Increase the number and types of sites where food is provided. Such sites could include: scale of targeted activities both as a means to provide additional resources to meet special needs of HIV/AIDS affected households should be considered, such as schools;, orphanages;, churches;, hospitals;, MCH clinics, and HBC programmes.

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

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

These proxy indicators include:

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

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

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

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

▸ Key resources

WFP Southern Africa Implementation Strategy. (Doc 23)
www.wfprelogs.org/bulletins/rep_programme.asp

Programming in the era of AIDS: WFP's response to HIV/AIDS, January 2003.
www.wfp.org/eb (Doc 31)

Food Security, Food Aid and HIV/AIDS: WFP Guidance Note. (Doc 39)

Frequently Asked Questions on Food Security, Food Aid and HIV/AIDS. (Doc 34)

Information Sheet on Nutrition, Food Security and HIV/AIDS. (Doc 32)

Background Paper on HIV/AIDS and Orphans: Issues and challenges for WFP. (Doc 29)

Food and Education: WFP's Role in Improving Access to Education for Orphans and Vulnerable Children in Sub-Saharan Africa. (Doc 35)

Food Security, Food Aid and HIV/AIDS: Project Ideas to Address the HIV/AIDS Crisis. (Doc 30)

WFP Food Distribution Guidelines, 2003 (Provisional version) (Doc 28)
UNHCR. 1997. Commodity Distribution; a Practical Guide for Field Staff. UNHCR, Geneva.
www.unhcr.ch/ (Doc 26)

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

Sector 5: Food security and nutrition
Phase: Minimum Response

Background

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

- preventing increases in malnutrition;
- preventing excess mortality.

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

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

Therefore, in order for emergency operations to achieve their goals when targeting populations with high prevalence of HIV/AIDS, it becomes even more critical to plan food baskets that accurately reflect the nutritional and dietary needs of the population.

People living with HIV/AIDS (PLWHA) may have special dietary and nutritional needs. Adequate intake of energy, protein, and micronutrients is essential for coping with the HIV virus and fighting off opportunistic infections. The WHO Expert Consultation on Nutrient Requirements for PLWHA (May, 2003) recommended that an increase of 10% in energy requirements is needed to maintain body weight and physical activity in asymptomatic HIV-infected adults. This proportion can rise to 20-30% for symptomatic adults and to as high as 50-100% for children with acute weight loss and infection. Available data at the time of the consultation did not permit specific recommendations above and beyond the recommended daily allowance (RDA) for protein or fat requirements; however; adequate consumption of both protein and fat is very important for people living with HIV/AIDS.[9]

There is also evidence that nearly all vitamins and minerals affect the immune system or are affected by infection. Although there is much research still to be done on the specific roles of micronutrients in HIV infection, studies have shown that micronutrients such as selenium, vitamin A, iron, zinc, are associated with positive outcomes, such as slowing disease progression, reducing mortality due to HIV/opportunistic infections, and reducing the incidence of low birth weight among pregnant women with HIV. The special nutritional needs of PLWHA should be considered when planning rations, and suggested actions are presented in the next section.

Key actions

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

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

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

Normal Population	Population with High HIV/AIDS Prevalence
Temperature If the temperature is below 20°C, adjust energy requirements upward by 100 kcal for every 5° below 20°C.	
Health or Nutritional Status of the population If either of these is extremely poor, adjust the energy requirements upward by 100–200 kcal.	**A high prevalence of HIV/AIDS may be justification for adjusting the energy requirements of a population upward. Consult with a nutritionist (UNICEF, WHO, WFP) to determine if such an adjustment is desirable.**
Demographic distribution of the population If the demographic distribution is not normal, there may be a need to adjust the energy requirements upwards or downwards.	**HIV/AIDS can have significant effects on the demographic composition of a population that may need to be considered when planning rations. Annex 1[10] of the Food and Nutrition Needs of the Inter-agency Guidelines provides a breakdown of the energy requirements of specific population subgroups by age and sex that can be used to adjust requirements.**
Activity levels If the population is engaging in medium to heavy activities, there may be a need to adjust the energy requirements higher.	**Activity levels are often under-estimated in non-refugee situations. Underestimates may have even more detrimental effects in a population with higher basic physiological needs.**

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

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

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

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

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

Practical Example: Humanitarian assistance works: The Southern Africa Emergency 2002-2003

The effects of HIV/AIDS on food insecurity have been particularly visible during the Southern Africa Crisis. Three of the six countries targeted by the crisis response had adult HIV prevalence rates exceeding 30%, and all six countries have rates in excess of 12%. As part of the regional response, a reference ration was adopted providing 2198 kcals, 12% from protein and 17% from fat. During the process of calculating the energy requirements, it was agreed to adjust the ration upward from 2100 kcals to 2200 kcals in recognition of the high prevalence of HIV. The ration also included 100 g of fortified blended food in recognition of the importance of vitamins, minerals, and protein in fighting off opportunistic infections. Fortification of maize meal with micronutrients was also pursued in the context of a large milling exercise as a key element to address the HIV/AIDS dimension of the emergency.

Humanitarian assistance works! The crisis in southern Africa is evolving and so is the response. A food crisis has been averted, thanks to the timely response of the UN, governments, donors and NGO partners. However, the region is still in crisis. Southern Africa still has the highest adult prevalence rates of HIV/AIDS in the world, undermining the coping and recovery mechanisms of people. A concerted, radical and long term response is required to tackle this challenge.

Southern Africa Reference ration

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

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

Key resources

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

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

UNHCR/UNICEF/WFP/WHO. 2003. Food and Nutrition Needs in Emergencies. (Doc 21)

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

Chapter 4. The guidelines

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

Sector 5: Food security and nutrition
Phase: Minimum Response

Background

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

In developing countries, care for PLWHA is provided largely through family members and community-based organizations that working through volunteer networks. In emergency situations, this support is needed more than ever, but these care systems are often disrupted. Efforts should be made to rehabilitate them as feasible, strengthening them through on the job training and support, and to promote new ones.

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

Key actions

- Identify local institutions and individuals (health centres, schools, agricultural extension workers, social workers) operating in the area (government and NGOs) as well as relevant information materials.
- Rapid assessment by local staff (NGO staff, including confessional, health workers, extension agents) in existing care systems for chronically sick patients, the effects of the crisis on these systems, coping strategies, training needs, and information gaps.
- Adaptation of generic existing "nutritional care" guidelines to local needs and possibilities.
- Capacity building of relevant local staff, who in turn will, be able to inform and assist caregivers and community workers/social mobilizers on:
  - special eating needs of PLWHA
  - coping with the complications of HIV/AIDS
  - taking care of PLWHA
  - herbal treatments and remedies
- Strengthening of community-based care networks:
  - identification and capacity-building of community volunteers;
  - incorporation of nutritional care for PLWHA into the programmes of relevant local institutions (health, education, nutrition, rehabilitation);
  - establishment of a reference and support system for community-based care systems.

Key resources

Living well with HIV/AIDS: a manual on nutritional care and support for people living with HIV/AIDS. FAO/WHO, 2002 (Doc. 2)

Chapter 4. The guidelines

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

Sector 5: Food Security and Nutrition
Phase: Minimum Response

Background

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

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

Key actions

- Review existing food and agriculture needs assessments in order to identify the most food insecure population groups, their main constraints and coping strategies, with particular attention to gender issues.

- Gain an understanding[11] of the specific constraints and strategies of HIV/AIDS affected households and communities. These constraints include labour constraints, loss of knowledge, trends in food consumption, care needs, and gender dimensions.[12]

- Identify possible food and agriculture emergency relief interventions:
  - agriculture production, including conservation farming, home or community gardening, small livestock breeding;
  - small scale food-processing which can strengthen resilience of these groups and provide alternatives to at-risk behaviours.

- Provide appropriate inputs, training and technical assistance to local institutions (especially NGOs) to protect and promote household food security while ensuring and facilitating basic reproductive tasks and increasing security.

- Ensure the participation of youth, including girls, young women, orphans, and demobilized child soldiers, in training and education activities supporting food production, home economics, and nutrition education.

- Identification of entry point(s) for linking minimum response interventions with long-term food security, and livelihoods policies, and programmes at local and national levels.

Key resources

Guidelines for integrating HIV/AIDS concerns in agricultural emergency interventions (draft).

Guidelines for emergency needs assessment. (draft)

Link to websites:
www.fantaproject.org/focus/hiv_aids.shtm

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

Sector 5: Food Security and Nutrition
Phase: Minimum Response

Background

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

General food distributions

In emergencies with large-scale food needs, the best way to provide nutritional support to the large number of HIV/AIDS infected and affected persons is through general food distributions. The distribution modality is a function of the beneficiary registration process chosen. This will have significant implications for the actual ration size received by the beneficiaries.

Key actions

- Review operational strategies with partners to determine the best possible options, taking into account both the needs of the people as well as the practicalities of large-scale registration activities. Demographic profiles, particularly in areas affected by HIV/AIDS, are helpful in ensuring that distribution methods are to guide modalities that are fair to families with high dependency ratios.

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

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

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

Emergency School Feeding Programme

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

Key actions

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

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

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

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

- they do not require cooking and utensils, though eating does require a minimum of clean water and sanitation facilities;
- they do not disrupt classes; substantial quantities can be eaten throughout the day under teacher supervision;
- they can be phased out as soon as enrolment rates return to normal, without harmful impacts on the overall education system; and
- they can be supplanted by longer-term recovery programmes, without compromising critical sustainability requirements.

Alternatives to school feeding for orphans and other vulnerable children

Background

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

Key actions

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

- Interventions aimed at improving the welfare of orphans must not exclude children whose parents are still alive though ailing.

• Reaching vulnerable children before they become orphaned, (for example through school feeding), can help keep them in school and away from harm.

• When specifically targeting orphans outside an institutional programme such as school feeding, food assistance should be provided to an entire household rather than solely just to the orphans being cared for in that household. This will prevents food rations intended for one person from being shared by an entire family. Such material assistance for extended and foster families can ease the collective burden of caring for orphans, and resulting in more families being willing to take in orphans.

Home-Based Care

Background

The support for supporting of home-based care programmes in emergency situations is essential because:

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

Key actions

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

Issues to consider:

• The choice of supplemental food products;
• The important role played by volunteers in communities hard hit by the HIV/AIDS pandemic by providing critical services and psychosocial support to the chronically ill and their families. Food aid agencies can choose to provide food rations to volunteers, helping them offset the need to find food elsewhere, and freeing up their time to serve their communities;
• However, it is important to make certain that such aid does not create dependency and thus undermine the very spirit associated with volunteerism;
• Careful targeting and close collaboration with community-based organizations; and local;
• NGOs are key to ensuring successful activities in this area.

Key resources

WFP Southern Africa Implementation Strategy (Doc 33)
www.wfprelogs.org/bulletins/rep_programme.asp

Programming in the Era of AIDS: WFP's Response to HIV/AIDS, January 2003. Available on WFP's WEB site:
www.wfp.org/eb (Doc 31)

Information Sheet on Nutrition, Food Security and HIV/AIDS. (Doc 32)

Background Paper on HIV/AIDS and Orphans: Issues and challenges for WFP. (Doc 29)

Food and Education: WFP's Role in Improving Access to Education for Orphans and Vulnerable Children in Sub-Saharan Africa. (Doc 35)

Food Security, Food Aid and HIV/AIDS: Project Ideas to Address the HIV/AIDS Crisis. (Doc 30)

WFP Food Distribution Guidelines, 2003. (Provisional version) (Doc 28)

UNHCR. 1997. Commodity Distribution; a Practical Guide for Field Staff. UNHCR, Geneva.[9] www.unhcr.ch/ (Doc 26)

Action sheet 6.1: Establish safely designed sites

Sector 6: Shelter and Site Planning
Phase: Minimum response

Background

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

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

Key actions

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

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

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

and protection suitability of potential water sources, vulnerable environmental areas, seasonal variations, and endemic diseases.
- Complete an assessment report that includes all the above information.
- Make the findings of the assessment available to other sectors, national and local authorities, participating agencies and female and male representatives from the affected population.

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

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

Key areas points to take into account for site planning and shelter:

- Place families with chronically ill family members and child headed households closer to facilities.
- Take note of the distance to the water supply. It should be no further than 500 metres from any shelter to the water point.
- Use different toilet blocks for women and men. Develop individual family toilet blocks for families. (A maximum of 20 people per toilet and not more than 50 metres from the dwellings.)
- Take note of the distance to the health facility.
- Take note of distances to other communal services such as markets, places of worship, community centres, wood lots, recreational areas, graveyards, and solid waste disposal areas.
- Ensure security and protection.
- Support groups that are unable to build their own shelters.
- Train women and adolescents to participate in building activities.

Key resources

Handbook for emergencies – United Nations High Commissioner for Refugees 1999. Part 3, Chapter 12, Page 132. (Doc 39)

Humanitarian Charter and Minimum Standards in Disaster Response – The Sphere Project 2000. Part 2, Chapter 4, Page 171. (Doc 7)

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

Sector 7: Health
Phase: Minimum Response

Background

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

Key actions

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

Assessment of availability and capacity

The following should be included:

- an analysis of the buildings providing health services (those which are physically still in place);
- the number of the facilities functioning per population;
- a list of number and qualifications of medical staff in each facility (doctors, medical assistants, nurses);
- a list of health staff working in the local villages and in refugee and /or internally displaced persons (IDP) camps;
- an assessment of the range of services provided (care, diagnostic facilities, EPI, MCH) and their quality;
- identification of a reference hospital for referral of severe cases and laboratory confirmation as needed;.
- an assessment of the availability of drugs and medical equipment.

Assessment of accessibility of health services (based also on above information)

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

Reasons might include:

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

Analysis of the public health situation

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

Current concerns include:

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

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

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

Identify the most vulnerable

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

Provision of health services at different levels

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

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

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

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

Key resources

Handbook for emergencies UNHCR. (Doc 39)

Action sheet 7.2: Ensuring a safe blood supply

Sector: Health
Phase: Minimum response

Background

The efficacy of HIV transmission through transfusion of infected blood is close to 100%. Finding ways to ensure the safety of blood transfusion in emergency situations is extremely important.

Key actions

- Avoid unnecessary use of blood
  - Transfuse only in life-threatening circumstances and when no other alternative is possible. (See references: The Clinical Use of Blood Handbook. WHO 2001.)
  - Use blood substitutes whenever possible: simple crystalloids (physiological saline solutions for intravenous administration) and colloids. (See references: The Clinical Use of Blood Handbook. WHO 2001.)

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

Selection of safe donors can be promoted by giving clear information to potential donors on when it is appropriate or inappropriate to give blood, and by using a donor questionnaire. Blood from voluntary, non-remunerated donors is safer than blood from paid donors.

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

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

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

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

▼ Implementation

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

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

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

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

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

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

Item Description	Usual or preferred presentation	Recommended quantity	Remarks
Perishable items: must be stored at 2°C to 8°C			
Anti-A blood group reagent, monoclonal	5 ml vials	20 x 5 ml	
Anti-B blood group reagent, monoclonal	5 ml vials	20 x 5 ml	
Anti-D blood group reagent (Saline/ monoclonal)	5 ml vials	20 x 5 ml	
HIV 1+2 Simple/rapid tests	100 tests	12 x 100	
HBsAg simple/rapid tests	100 tests	12 x 100	
HCV simple/rapid tests	100 tests	12 x 100	
Phosphate buffered (normal) saline	1 L	12 L	
Consumables: non-perishable			
Single blood collection bags, CPD-A1 (needle must be in-built preventing re-use)	200 pieces	6 x 200 pieces	Size will differ depending on usual practice for the area 250/350/450 ml
Transfusion set, blood, sterile, with fixed vein needle 18Gx1.5" with inline filter and injection port	100 sets	12 x 100 sets	
IV catheter, 20Gx1/4¼", sterile, disposable, with wing	50 pieces	10 x 50 pieces	
IV catheter, 22Gx1", sterile, disposable, with wing	50 pieces	10 x 50 pieces	
IV catheter, 23Gx3/4¾ ", sterile, disposable, with wing	50 pieces	5 x 50 pieces	
Vacutainer tube 10ml, siliconized	100 tubes	12 x 100 tubes	
Pasteur pipettes with integral bulb, disposable plastic non-sterile, 3 ml graduated in 0.5 ml	500 pipettes	5 x 500 pipettes	
Blood lancets, sterile, disposable	200	10 x 200	
Gauze swab, 8-ply, 10x10cm	100 swabs	50 x 100 swabs	
Plaster, surgical, Tenso, 6x2cm	1000 pieces	5 x 1000 pieces	
Plaster, Albuplast, 9.14x5cm	6 pieces	10 x 6 pieces	
Markers, fine point, permanent black glassware etc.	10 markers	5 x 10 markers	
Impregnated medicated swabs, chlorhexidine or isopropanol	100 pieces	20 x 100	
Test tubes, round bottom, polystyrene, 75 x 10 mm	100 tubes	50 x 100 tubes	
Microscope slides, 25x75mm, glass	50	100 x 50 slides	
Syringe 5ml, hypo, disposable	100 syringes	12 x 100	
Needle, hypo, disposable, 21Gx1.5", Luer, sterile	100 needles	12 x 100	
Needle, hypo, disposable, 23Gx1", Luer, sterile	100 needles	5 x 100	
Haemoglobin Colour Scale	Starter kit Re-fills	5 x starter kits 50 x re-fills	
Glove operation latex, disposable, sterile, anatomically shaped, size 6.5 and 7.5	50 pairs	5 x 50 pairs	
Sharps container, disposable, 2 litre capacity		50	
Waste bags, 15 L, black plastic	100 a roll	4 x 100	
Sodium chloride 0.9%, 1 L + set vacutainer for IV human use	20 Vacutainers	200 x 20	Bulk item; appx. weight 4000 Kg
Recommended stationery			
Blood donor forms		1200	
Labels for blood bags		1500	
Laboratory register, hard-back, A4		10	
Transfusion request forms		1000	
One-off items – (If above are re-ordered, these should not be repeated.)			
Sphygmomanometer		5	
Surgical scissors		10	
Tourniquets, arm, adjustable		10	
Domestic body weighing scale, range 0 – 150 Kg		2	
Spring balance for weighing donated blood, range 250 – 600 gm		12	
Test tube racks, 30 holes, plastic		4	
Insulated cool box, 10 L		2	

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

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

www.who.int/bct/index.htm

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

The Clinical Use of Blood in Obstetrics, Paediatrics, Surgery & Anaesthesia, Trauma & Burns. Module and Handbook. WHO 2002, CD-ROM.

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

Aide-Mémoire on Blood Safety for National Blood Programmes. Information sheet. May 2002 WHO/BCT/02.03Arabic/Chinese/English/French/Portuguese/Russian/ (Doc 40)

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

Safe Blood and Blood Products. Distance Learning Materials containing five modules:
Introductory module: guidelines and principles for safe blood transfusion practice
Module 1: safe blood donation
Module 2: screening for HIV and other infectious agents
Module 3: blood group serology
Trainer's guide WHO 2001. 631 pp. Chinese/English/French/ Portuguese/ Russian/Spanish

Chapter 4. The guidelines

Action sheet 7.3: Provide condoms and establish condom supplies

Sector 7: Health
Phase: Minimum Response

Background

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

Key actions

Supply

Male and female condoms should be considered an essential item in emergency relief supplies. They should be on the checklist of every agency responsible for providing relief supplies, from the World Food Programme and UNHCR, to small NGOs. Decisions should be made as to whether it is better to pre-package condoms with other items such as emergency medical or food supplies, or to package them separately but deliver them to the field at the same time and using through the same channels as other relief supplies. This will depends in part on the quantity of condoms to be sent to the field.

Distribution

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

Instructions

Culturally appropriate instructions -- for example, pictorial representations on how to use condoms and how to dispose of them safely[13] -- should be included with the consignments. The public should be informed of how and where to obtain condoms through whatever communication channels are available, for example, radio and posters.

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

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

Procurement and quality

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

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

Calculating condom supplies

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

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

Calculations for condom supplies for a population of 10,000 for 3 months[14]:

Male condoms for 3 months

Assume:
20% of the population are sexually active males.
Therefore:
20% x 10,000 persons = 2,000 males
Assume:
20% will use condoms.
Therefore:
20% x 2,000 = 400 users of condoms
Assume:
Each user needs 12 condoms each month, over 3 months.
Therefore:
400 x 12 x 3 months = **14,400 male condoms**
Assume:
20% wastage (2,880 condoms)
Therefore:
TOTAL = 14,400 + 2,880 = **17,280 (or 120 gross)**
Safe sex leaflets: 400

Female condoms for 3 months

Assume:
25% of the population are sexually active women.
Therefore:
25% x 10,000 persons = 2,500 women
Assume:
1% will use condoms.
Therefore:
1% x 2,500 = 25 users of condoms
Assume:
Each user needs 6 condoms each month, over 3 months.
Therefore:
25 x 6 x 3 months = **450 female condoms**
Assume:
20% wastage (90 female condoms)
Therefore:
TOTAL = 450 + 90 = **540 (or 3.8 gross)**
Safe sex leaflets: 25
Female condom use leaflets: 25

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

Key resources

Reproductive health in Refugee situations, an inter-agency field manual, chapters 2 and 5. (Doc 24)

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

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

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

Action sheet 7.4: Establish syndromic STI treatment

Sector 7: Health
Phase: Minimum response

Background

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

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

Comprehensive management of STI involves:

- reducing the incidence of STI, by preventing transmission through the promotion of safer sex, making condoms widely available, and
- reducing the prevalence of curable STI through early and effective case finding, treatment, partner notification, and surveillance and monitoring.

Key actions

Early and effective case management

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

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

Syndromic treatment

Provide guidelines for case management, including case definition and management. Treatment of symptomatic cases should be standardized on the basis of syndromes and should not depend on laboratory analysis. If possible, the national treatment protocol should be used. If a national treatment protocol is not immediately available, a standard WHO protocol should be used at the first encounter, using the most effective drugs (for example, antibiotics to which no

antimicrobial resistance is known. (See Key resources.) As soon as possible thereafter, introduce locally adapted treatment protocols.

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

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

▼ Condoms
Patients should be told to use condoms for the duration of their treatment and should be provided with sufficient free condoms for this purpose. The use of condoms should be explained and an instruction leaflet given. The continued use of condoms and other options to prevent re-infection should be discussed as well.

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

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

Key resources

Trained health personnel able to:

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

Sample calculation of supplies to treat 10,000 people for 3 months[15]

Assume:
50% of the affected population are adults
Therefore:
50% of 10,000 = 5,000
Assume:
5% of the adults have an STI
Therefore:
5% x 5,000 = 250 persons
Assume:
20% have genital ulcers
Therefore:
20% x 250 persons = 50
Assume:
50% have urethral discharge
Therefore:
50% x 250 persons = 125
Assume:
30% have vaginitis
Therefore:
30% x 250 persons = 7
Assume:
10% will be treated for cervicitis
Therefore: 10% x 250 persons = 25

Genital ulcers (treat for syphilis and chancroid)	
Benzathine Benzyl-penicillin 2.4 units, 1 dose	50
Syringes, disposable, 5ml	50
Needles, disposable, 21G	100
Water for injection 10ml	50
Cotton wool, absorbent, not sterile, 100g	3
Chlorhexidine sol. 5%, 1 liter	3
Erythromycin 500mg tablets (4/day x 7 days)	1,400
Urethral discharge (treat for gonorrhoea and chlamydia)	
Ciprofloxacin 500mg (single dose)	125
Doxycycline 100mg tablets (2/day x 7 days)	1,750
Vaginitis (treat for candidiasis and trichomonas)	
Metronidazole 250mg tablets (2 g single dose or 500mg 2/day x 7 days)	2,000
Clotrimazole 500 mg pessaries (single dose)	100
Cervicitis (treat for gonorrhoea and chlamydia)	
Ciprofloxacin 500mg1 (single dose)	20
Doxycycline 100mg tablets (2/day x 7 days)	280
For pregnant women:	
Cefixime 400mg tablets (single dose)	20
Erythromycin 500mg tablets (4/day x 7 days)	560
Condom distribution	
Condoms (20 gross)	3,000
Safe Sex Leaflets	100
Poster for syndromic diagnosis of STI	1
Safety box, for used syringes and needles – Capacity 5L	4
Envelope, plastic, 10 x 15 cm – pack of 100 (for drugs/tabs distribution)	10

Key resources

Guidelines for the Management of Sexually Transmitted Infections, WHO/HIV_AIDS/ 2001.01.
www.who.int/docstore/hiv/STIManagemntguidelines/who_hiv_aids_ 2001.01 (Doc 15)

Guidelines for Sexually Transmitted Infections Surveillance WHO/CDS/CSR/ EDC/99.3. (Doc 14)

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

Manual of Reproductive Health Kits for Crisis Situations, 2nd edition, UNFPA, New York 2003, Kit 5.
(Doc 43)

Inter-Agency Field Manual for reproductive health in refugee situations, Chapter 5.
(Doc 24)

Action Sheet 7.5: Manage the consequences of sexual violence

Sector 7: Health
Phase: Minimum Response

Background

Health care services must be ready to respond compassionately to people who have been raped. The health co-ordinator should ensure that health care providers (doctors, medical assistants, nurses, and others) are trained to provide appropriate care and have the necessary equipment and supplies. Female health care providers should be trained as a priority, but a lack of trained female health workers should not prevent the service providing care for survivors of rape.

Key actions

▼ Examination

A medical examination should be done only with the rape survivor's consent. It should be compassionate, confidential, and complete, as described in Step 5 of the manual *"Clinical Management of Survivors of Rape, Developing protocols for use with refugees and internally displaced persons."*

▼ Treatment

Give compassionate and confidential treatment as follows:

- treatment and referral for life threatening complications;
- treatment or preventive treatment for STI;
- emergency contraception;
- care of wounds;
- supportive counselling;
- referral to social support and psychosocial counselling services.

▼ Collecting minimum forensic evidence

Forensic evidence should only be collected and released to the authorities only with the survivor's consent.

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

Key resources

Checklist of supplies needed to manage survivors of rape

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

"Clinical Management of Survivors of Rape, Developing protocols for use with refugees and internally displaced persons" (Doc50)

For more information on prevention and response to sexual violence and exploitation, also see: Action sheet 3.1: Protection/ Minimum Response: Prevent and Respond to Sexual Violence and Exploitation,

Action sheet 7.6: Ensure safe deliveries

Sector 7: Health

Phase: Minimum Response

Background

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

Key actions

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

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

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

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

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

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

- Establishing a referral system to manage obstetric emergencies.

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

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

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

▼ As soon as feasible, organize comprehensive services for antenatal, delivery, and postpartum care.

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

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

▸ Key resources

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

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

Assume:
Population of 10,000
CBR = 4%/year (40 live births/1,000 population)
Therefore:
Total live births per year:
10,000 x 0.04 = 400
Total live births per three month period:
(10,000 x 0.04) /4 = 100
More examples of estimations link (page 112 IA FM)

Checklist for Safe Motherhood Services

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

Reproductive Health in Refugee Situations, an Inter-Agency Field Manual, Chapters 3 and 7. (Doc 24)

Reproductive Health Kits for Emergency Situations, Kit 2, 6, 8, 9, 10, 11, 12 (Doc 43)

For more information on safe delivery, see:
WHO Safe Motherhood documents
- Links to websites
- NEHK (DOC. 16)

Action Sheet 7.7: Universal precautions

Sector 7: Health
Phase: Minimum Response

Background

Because people working under pressure are more likely to have work-related accidents and to cut corners in sterilization techniques, infection control measures adopted during crises must be practical to implement and enforce. **Universal precautions** are a simple, standard set of procedures to be used in the care of all patients at all times in order to minimize the risk of transmission of blood-borne pathogens. These procedures are essential in preventing the transmission of HIV from patient to patient, from health worker to patient and from patient to health worker.

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

Key actions

▼ During the first meeting of Health Co-ordinators, emphasize the importance of universal precautions in deterring the spread of HIV/AIDS within the health care setting.

Provide clear treatment protocols and guidelines, reducing unnecessary procedures as much as possible. For example:

- Wherever possible, intravenous and intra-muscular treatments should be replaced by oral medicines.
- Blood transfusions should be reduced to an absolute minimum; volume replacement solutions are preferable.

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

▼ Provide sufficient facilities for frequent hand washing in health care settings. Hands should be washed with soap and water, especially after any contact with body fluids or wounds.

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

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

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

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

▼ Safe handling and disposal of sharp objects

All sharps should be handled with extremely care. They should never be passed directly from one person to another, and their use should be kept to a minimum. Do not recap used needles by hand; do not remove used needles from disposable syringes by hand; and do not bend, break, or otherwise manipulate used needles by hand. Place used disposable syringes and needles, scalpel blades, and other sharp items in puncture-resistant containers for disposal. Puncture-resistant containers must be readily available, close at hand, and out of reach of children. Sharp objects should never be thrown into ordinary waste bins or bags, onto rubbish heaps or into waste pits or latrines.

▼ Safe decontamination of instruments (cleaning, disinfecting and sterilizing)

Pressure-steam sterilizers are used for cleaning medical instruments between use on different patients. If sterilization is not available, or for instruments that are heat sensitive, the instruments must be cleaned and high-level disinfected (HLD). HIV is inactivated by boiling for 20 minutes or by soaking in chemical solutions, such as a five percent solution of chlorine bleach or a two percent glutaraldehyde solution, for 20 minutes.

▼ Safe disposal of contaminated waste

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

It should be recognized that people (including small children) struggling to survive will scavenge; thus, safe disposal is a vitally important consideration. All waste materials should be burnt and those that still pose a threat, such as sharps, should be buried in a deep pit (at least 30 feet from a water source).

▼ Monitoring

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

▼ Treating injuries at work

See Action sheet 10.3 on post-exposure prophylaxis (PEP) for humanitarian staff.

Key resources needed for universal precautions

▼ Trained staff

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

▼ Supplies

The following supplies are recommended as a minimum to prevent the transmission of blood-borne viruses such as HIV. To estimate the quantity of supplies needed, please consult the New Emergency Health Kit 98.
www.who.int/medicines/library/par/new-emergency-health-kit/nehk98_en.pdf (Doc 16)

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

▼ Further information

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

The infection prevention course of Engender Health on www.engenderhealth.org/ip/ (DOC 52)

Interagency Field Manual for Reproductive Health in Refugee Situations, chapter 2. (Doc 24)

Chapter 4. The guidelines

Action sheet 8.1: Ensure children's access to education

Sector 8: Education
Phase: Minimum phase

Background

Traditionally, education was not seen as a central part of humanitarian actions, which tended to focus more on direct life saving interventions. However, in recent years, the central importance of education has been increasingly appreciated, with education emphasized in consolidated appeals and emergency programmes as an integrated important part of any emergency the response.

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

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

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

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

Key actions

- Keep children, particularly those at the primary school level, in school or create new schooling venues when schools do not exist.
- Protect places where children gather for education from recruitment by armed groups and from sexual exploitation. Communities should ensure that teachers are not abusing children and that schools are not seen as sites for the recruitment of children into fighting forces.
- Link humanitarian services (such as special food packages for families tied to attendance) with schools in order to increase attendance levels, to promote a culture that values education, and to promote schools as vital community institutions, not merely a place where children go.

- Monitor drop-out to determine if and why children are leaving school.
- If children are dropping out of school because of lack of food, school feeding should be provided. Assistance with school fees, materials, and uniforms should be provided as necessary to facilitate children's access to schools.
- Provide psychosocial support to teachers who are coping with their own psychosocial issues as well as those of their students. Such support may help reduce negative or destructive coping behaviours.
- Brief teachers on the code of conduct which prohibits sex with children. When teacher training takes place, include discussion of the code of conduct.
- Try to accommodate children who cannot attend school all day because they are caring for an ailing parent or have been orphaned; one solution may be to offer shorter schooling hours at different times of the day.
- Consider the addition of school gardens and home economics activities.
- Provide materials to assist teachers (for example, "School in a box" and recreation kits that include HIV/AIDS life skills materials).

Key resources

Inter Agency Network on Education in Emergencies (INEE):
www.ineesite.org

Global Information Networks in Education:
www.ginie.org

UNICEF Life skills website:
www.unicef.org/programme/lifeskill/index.html

Stepping Stones training package on gender HIV, communication and relationship skills:
www.steppingstonesfeedback.org

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

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

Sector 9: BCC
Phase: Minimum response

Background

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

Key actions

Assemble a communications team.

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

Assess

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

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

Communications Plan

A communications plan for emergency situations focuses on finding a way to communicate to and with the most vulnerable groups. Thus, general awareness and long-term social changes would need to be temporarily suspended in favour of targeted interventions, until some degree of stability has been achieved. These tasks require that emergency staff:

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

8 FACTS ON HIV/AIDS

1. A virus called HIV causes AIDS. HIV damages the body's defense system, making it difficult to fight illnesses, and eventually causing death. A person who has HIV can pass it on to others even though he or she appears healthy. There is no cure for AIDS, so preventing infection in the first place is the only way to stay AIDS-free.

2. The HIV virus is found in the following fluids: blood, semen (including pre-ejaculated fluid), vaginal secretions, and breast milk. The virus is most frequently transmitted sexually. Women get sexually transmitted infections (STI), including HIV, from men twice as easily as men get them from women. Girls and young women are at high risk to get STI because their organs are not mature and are easily attacked by germs.

3. People who have STI are at greater risk of being infected with HIV and of transmitting their infection to others. Common signs of an STI include pain during urination, pain in the abdomen or during sexual intercourse, discharge from the penis or vagina, and genital sores. Some people with STI experience few or no symptoms. People with any of these signs should seek prompt treatment; they should avoid sexual intercourse or practice safer sex (non-penetrative sex or

sex using a condom), and inform their partners.

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

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

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

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

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

Monitor

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

Key resources

UNICEF. The Right to Know Project. 2002.

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

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

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

UNHCR (1995) Reproductive Health in Refugee Situations: An Inter-Agency Field Manual. (Doc 24)

CDC or WHO. Instruction sheets on condom use. (Doc 49)

Websites:
www.jhuccp.org
www.fhi.org
www.aed.org
www.synergy.org
www.communit.com

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

Sector 10: HIV/AIDS in the workplace
Phase: Minimum Response

Background

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

Discrimination has an impact on workplace safety.

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

Better understanding of HIV/AIDS

Workplace information and education programmes are essential to combat the spread of the epidemic and to foster greater tolerance for workers with HIV/AIDS. Effective education can significantly reduce HIV-related anxiety and stigmatization, minimize disruption in the workplace, and bring about attitudinal and behavioural change. Better awareness on how to prevent getting HIV infection will contribute to decreasing stigmatization of those infected.

Related action
Ensure provision of basic materials on HIV/AIDS and the means of transmission (handouts), through the workplace medical service or in informal meetings.

Understanding of human rights

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

Related action
Ensure provision of basic materials on human rights and HIV/AIDS, through the staff association, or through unofficial staff meetings.

Confidentiality

There is no justification for asking job applicants or workers to disclose HIV-related personal information. Nor should co-workers be obliged to reveal

such personal information about fellow workers. Awareness of this confidentiality is important in empowering the workers and the staff associations in their dialogue with management.

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

Social dialogue

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

Related action
Ensure the HIV/AIDS is adequately addressed in meetings between employers and workers.

Liaison and advocacy

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

Key resources

UNAIDS/WHO/UNHCR Guidelines on HIV/AIDS Interventions in Emergencies, 1996 (currently being revised). (Doc 20)

The ILO Code of Practice on HIV/AIDS. (Doc 3)

Peer education guide on HIV/AIDS. (currently in draft format with UNAIDS)

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

Sector 10: HIV/AIDS in the workplace
Phase: Minimum response

Background[16]

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

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

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

How it is done

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

Key actions

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

Managing Occupational Exposure to HIV

- First Aid should be given immediately after the injury: wounds and skin sites exposed to blood or body fluids should be washed with soap and water, and mucous membranes flushed with water.

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

Key resources

PEP should commence as soon as possible after the incident, ideally within two to four hours. There is no time limit in most country recommendations, however. Prophylaxis is sometimes given empirically up to 2 weeks in the case of severe exposure when the delay has been unavoidable. Combination therapy is recommended, as it is believed to be more effective than a single agent. Dual or triple drug therapy is recommended.

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

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

If a third drug is to be added:

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

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

Human resources, infrastructure and supplies needed

Institutional guidelines for PEP should be in place. HIV testing, counselling, and antiretrovirals must be available. It is crucial that effective universal precautions are in place and that an uninterrupted supply of protective materials (gloves, sharp boxes) is available, and that safe disposal of hazardous material occurs. An infection control specialist, staff counsellor, and health care worker trained in HIV/AIDS

care are beneficial into ensuring that PEP is provided.

Recommendations for Postexposure Prophylaxis CDC MMWR. (Doc 4)

WHO. Guidance Modules on Antiretroviral Treatments. Module 7: Treatments following exposure to HIV. Module 9: Ethical, societal issues relating to antiretroviral treatments. (Doc 12)

PEP preventive treatment, starter kit (Power point presentation). (Doc 44)

Post exposure preventive treatment starter kits, Guidelines. (Doc 45)

AIDS and HIV infection, information for UN employees and families. (Doc 10)

Endnotes

Chapter 1

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

[2] The name was changed from Reference Group to Task Force in 2003.

[3] These guidelines had been produced in 1996 by UNHCR, UNAIDS, and WHO.

Chapter 4

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

[5] Co-ordination of emergency response and Co-ordination of HIV/AIDS-related programmes and projects.

[6] See Action sheet. 7.3 for condom calculation.

[7] See Action sheet 7.3 for condom calculation.

[8] See Manual of reproductive health kits from UNFPA.

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

[10] P. 43, in Food and Nutrition needs in emergencies.

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

[12] This should be systematically incorporated into emergency food and agriculture needs assessments in high HIV/AIDS prevalence areas.

[13] An example of instructions on condom use are given in "The male condom: UNAIDS technical update."

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

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

[16] This document is adapted from WHO/TSH Document on PEP.