CHAPTER 11
HIV

11.1 INTRODUCTION

Significant progress has been made over the last 3 decades in response to the human immunodeficiency virus (HIV) epidemic globally. However, addressing HIV remains an ongoing challenge, particularly in humanitarian contexts. Although a significant proportion of people affected by humanitarian emergencies are people at risk of or living with HIV, access to HIV prevention, treatment, and care is often not prioritized during emergencies. HIV transmission in humanitarian settings is complex and is dependent on the dynamic interaction of a variety of factors. This includes HIV prevalence and vulnerability of some groups within the population in the region of origin and that of the host population, the level of interaction between displaced and surrounding populations, the duration of displacement, and the location and extent of isolation of the displaced population (e.g., urban versus camp-based refugees). However, the characteristics that define a complex emergency, such as conflict, mass displacement,

loss of livelihood, food insecurity, social instability, lack of employment, infrastructural stress, and environmental destruction and powerlessness, can increase affected populations' vulnerability and risk to HIV. This increased vulnerability occurs by:

- Reducing access to HIV prevention, treatment, and care services due to the breakdown in health infrastructure
- Disrupting social support networks, increasing exposure to rape and sexual exploitation, increasing sex work, and increasing use of psychoactive substances, including injection drugs
- Exacerbating existing inequalities, stigmatization, and marginalization of key populations at risk of HIV and those living with HIV
- Increasing population movement to an area of higher HIV prevalence

In 2017, approximately 36.9 million people globally were living with HIV; nearly 59% were accessing antiretroviral therapy. About 1.7 million people living with HIV were affected by humanitarian emergencies in 2013, the most recent year for which we have data, including 174,000 children (age 0-14), 81,000 pregnant women, and 193,000 adolescents. Treatment coverage was low in emergency affected populations, but was generally similar to global treatment coverage at the time. In 2013, 63% of all people living with HIV had no access to antiretroviral therapy while 68% of people living with HIV affected by emergencies had no access to treatment. However, the coverage varied by sub-population; the largest treatment gap was in children affected by emergencies (83%), followed by adolescents (76%), adults (67%), and pregnant women (55%). Despite recent advancements in user-initiated interventions and mobile health tools, HIV services for key populations (see section 11.3.4) remain inadequate in most settings.

When planning HIV programming in humanitarian settings, sexual and reproductive health (SRH) Coordinators and health program managers together with HIV service providers and program managers must consider:

- The combined impact of humanitarian emergencies and HIV, including factors which may increase vulnerability to HIV
- Existing policy and practice in humanitarian response which aim to prevent the spread of HIV and mitigate its impact
- The availability and accessibility of prevention, care, and treatment services for people living with HIV, including interruption, restarting, or continuation of antiretroviral treatment, and opioid substitution therapy (OST) for people who inject drugs (PWID)
- The need to initiate antiretroviral therapy (ART) at least in people who have tested HIV positive for the first time presenting with advanced HIV disease progression according to national policies and guidelines
- Stigma and discrimination against people living with, at risk of, and affected by HIV
- The need to prevent and manage other sexually transmitted infections (STIs)

11.2 OBJECTIVES

The objective of this chapter is to assist SRH Coordinators, health program managers, and service providers to:

- Plan for and implement comprehensive HIV prevention, care, and treatment services as part of the humanitarian response
- Understand evidence-informed interventions and barriers to implementation
- Improve utilization and demand for HIV services

11.3 HIV PROGRAMMING

11.3.1. Preparedness

Disruption of HIV prevention and treatment services can have a significant impact on transmission risks, including mother-to-child transmission, and on the health of people living with HIV. To mitigate these risks, the inclusion of HIV and AIDS within preparedness efforts is key.

1. Include HIV in humanitarian action plans. The ability to address the needs of people living with HIV or affected by HIV in a timely manner is directly linked to the inclusion of these needs in the preparedness and contingency plans of both the HIV program and the general national disaster preparedness plans. In doing so, involve all relevant stakeholders, including organizations of people living with HIV, health workers from implementing agencies involved in HIV and SRH service delivery, and representatives from communities, women's groups, and key populations, as relevant. Protocols to conduct situation analysis and needs assessments adapted to the national context developed within the preparedness phase should include HIV.

2. Pre-position buffer stocks, redistribute supplies in areas with greater need, and provide support for transport and emergency procurement to ensure drug and commodities supply in humanitarian settings. In acute emergencies when no buffer stocks are in place, consider including HIV, prevention of mother-to-child transmission (PMTCT), and ART starter kits in global/regional emergency supplies for uninterrupted antiretrovirals (ARVs), HIV counseling and testing (HCT), and key prevention services/commodities access.

3. Provide leadership and support to ensure ARVs are included in the emergency response from the outset. Put HIV on health cluster/coordination meeting agendas and integrate HIV systematically into humanitarian assessments.

11.3.2 Minimum Initial Service Package implementation

The Minimum Initial Service Package (MISP) components related to HIV interventions at the onset of a humanitarian response focus on prevention of HIV transmission and reduction in morbidity and mortality due to HIV and other STIs. To reduce the transmission of HIV from the onset of the humanitarian response, the SRH Coordinator must work with health sector/cluster partners to:

- Establish safe and rational use of blood transfusion
- Ensure application of standard precautions
- Guarantee the availability of free lubricated male condoms and, where applicable (e.g., already used by the population), ensure provision of female condoms
- Support the provision of ARVs to continue treatment for people who were enrolled in an ART program prior to the emergency, including women who were enrolled in PMTCT programs
- Provide post-exposure prophylaxis (PEP) to survivors of sexual violence as appropriate and for occupational exposure
- Support the provision of co-trimoxazole prophylaxis for opportunistic infections for patients found to have HIV or already diagnosed with HIV
- Ensure the availability of syndromic diagnosis and treatment of STIs in health facilities

These priority interventions should be provided in all humanitarian emergencies regardless of the local HIV epidemiology. In contexts of high prevalence of injection drug use, access to sterile needles or syringes (and continuity of OST) should be provided, in line with the national policies.

This chapter describes approaches for SRH Coordinators, health program managers, and service providers to program for comprehensive HIV prevention, care, and treatment services as soon as the situation allows, building upon the MISP interventions. When planning for comprehensive HIV prevention, care, and treatment services, a needs assessment should be undertaken as a first step.

11.3.3 Needs assessment

SRH Coordinators, health program managers, and service providers must collect or estimate the relevant information for the setting they work in, in coordination with representatives of the Ministry of Health (MOH) and other sector/cluster actors. Various methods of data collection and study designs are available to assess HIV-related needs of displaced populations, from quantitative survey approaches to data monitoring and in-depth ethnographic studies to rapid cross-sectional qualitative studies. Joint assessment missions on HIV-related needs require consensus on objectives and priorities but also common standardized approaches and tools. It must be recognized that tools need to be adapted in each specific context. Experience has shown that a joint assessment

between government and non-governmental stakeholders has many advantages.

The assessment team should work with local non-governmental organizations (NGOs), community-based organizations (CBOs), and other key informants (such as displaced people, key populations) to gather information from local perspectives.

POPULATION CHARACTERISTICS

- Population information (demographic information of host and displaced populations), patterns of displacement, and numbers of people in different settings (rural, urban, migration)
- HIV and other STI prevalence (for both displaced and host populations). This can be found on the UNAIDS website, as well as with the National AIDS Control Program or from MOH surveillance sources
- Number of people living with HIV from the affected population whose HIV treatment services were disrupted (e.g., PMTCT and ART programs) and who are in need of continuation of ARV regimens
- The profile and number of populations whose essential HIV prevention services (such as condoms and lubricant, needles and syringes, OST) have been disrupted or are at risk of disruption
- Behavioral, structural, and environmental factors that might place vulnerable subgroups at increased risk of HIV transmission

HEALTH SERVICES CHARACTERISTICS

- Health facilities and health staff already available in the area (international, from the MOH, and from communities)
- Health facility and community-based staff, including pharmacists, with experience in HIV prevention, treatment, and care and training needs of staff
- Availability of condoms and condom-compatible lubricant
- Availability of sterile injection equipment for PWID and OST
- National ARV protocols for prevention (PEP), pre-exposure prophylaxis (PrEP), PMTCT, and treatment (ART) and available antiretrovirals
- Availability of laboratory services, including point of care rapid tests
- Availability of different types of HIV testing
- Existence of a reliable supply chain that can support sustainable access to HIV prevention, care, and treatment commodities (such as ARVs and condoms)
- Availability of food and nutrition support
- Availability of local organizations or peer networks and peer groups of people living with HIV or key populations or those that provide services to these populations in the local context

NATIONAL LEGISLATION AND POLICIES

SRH program managers and service providers must also be familiar with national legislation and policies related to HIV, assess how refugees and internally displaced persons (IDPs) are included, and if there are any gender, age, or other status-based restrictions. Examples include:

- Laws and/or policies on HIV testing, including pre- and post-test counseling. Are there mandatory testing laws? Specifications as to where testing can take place?
- Laws and/or policies related to condom distribution, PWID, and harm reduction services (especially OST and needle and syringe programs)
- Laws and/or policies regarding HIV transmission, sex work, or same-sex sexual relations
- Laws and/or policies regarding health care provider disclosure of HIV status
- Laws and/or policies governing provision of and access to ART and whether displaced (refugees/IDPs) are included in national HIV plans and policies

HIV EPIDEMIC CHARACTERISTICS

To have an impact on HIV prevalence, program efforts must be targeted appropriately. As a useful programming guide, the World Health Organization (WHO) and UNAIDS have categorized HIV epidemics in different countries broadly as low level, concentrated level, and generalized epidemics (see Table 11.1).

TABLE 11.1: HIV EPIDEMIC SCENARIOS

	EPIDEMIC SCENARIO	KNOW YOUR EPIDEMIC
Low level	HIV prevalence <1%: HIV prevalence has not reached significant levels in any sub-population. This suggests either that networks of risk are diffuse or that the virus has been introduced recently	Knowledge of risk behaviors, sexual networks, and other factors indicating the potential for HIV spread - such as rates of other STIs - is essential for prevention planning
Concentrated	HIV prevalence is high enough (5% or more) in one or more key populations, such as men having sex with men, people who inject drugs, transgender people, or sex workers and their clients, to maintain the epidemic in that sub-population. However the virus is not circulating in the general population, where the prevalence remains < 1%	The future course of this type of epidemic will be determined by • The size of the vulnerable sub-population(s) and the frequency and nature of interactions between them and the general population • The extent of tailored HIV programs provided by and for affected key populations • The degree to which key populations are able to self-mobilize (affected by stigmatization, and conversely by community empowerment)
Generalized	HIV prevalence is 1%-15% in pregnant women attending antenatal clinics, indicating that HIV prevalence is present among the general population at sufficient levels to enable sexual networking to drive the epidemic. In a population with more than 5% prevalence every sexually active person has potentially a high risk of infection and no sub-populations are considered "low-risk"	Social norms that lead to multiple sexual partner relations and/or norms and policies that prevent people from protecting themselves (for example, norms that decrease girls' access to education and information) are directly implicated in the epidemic dynamics and need to be addressed

An exceptional situation exists in the southern African region, where large numbers of people – over half of them girls and women, are living with HIV. In this hyperendemic scenario, HIV prevalence exceeds 15% in the adult population. These situations require exceptional effort and resources to mobilize entire communities to change sexual behaviors. In addition, responding to HIV epidemic effectively requires better geographic and population localization to ensure that effective and tailored combinations of prevention and treatment interventions are provided to people at risk of HIV, whether in generalized, concentrated or mixed epidemic contexts.

11.3.4 Principles of working with key populations and vulnerable groups

There are certain key populations who in almost all settings are disproportionately affected by HIV. These include gay men and other men who have sex with men (MSM), PWID, persons who engage in sex work, transgender people, and people in prisons and other closed settings. The disproportionate risks reflect both legal and social barriers that increase vulnerability and risk-associated behaviors among members of these populations.

In certain contexts, other groups also are particularly vulnerable to HIV infection, for example, adolescents, migrant workers, refugees, long-distance truck drivers, military personnel, and, in southern Africa, young women. These populations are not uniformly vulnerable or equally affected across different countries and epidemic settings. Countries should identify these additional populations specific to their settings and develop and tailor services accordingly. In many countries, inadequate coverage and poor quality of services for key populations and vulnerable groups undermine responses to HIV. All countries should consider the importance of reaching these groups, understanding their needs, empowering them and providing them with equitable, accessible, and acceptable services.

11.3.5 Programming considerations

HUMAN RESOURCES, TASK-SHARING, AND TASK-SHIFTING

Strong and effective health systems depend on having enough clinical staff, with the right skills, in the right place. But the number of available health workers remains

BOX 11.1: KEY POPULATION: MEN WHO HAVE SEX WITH MEN

Men who have sex with men (MSM) include all men who have same-sex relations, regardless of their self-identified sexual orientation (gay, bisexual, or heterosexual). Worldwide, MSM are estimated to be 24 times more likely to be infected with HIV than the general population, with HIV prevalence ranging from 14% to 18% across the Americas, Asia, and sub-Saharan Africa. HIV responses for MSM continue to be hampered by homophobia, discrimination, violence, and criminalization, all of which affect the physical and mental health of MSM and limit their access to services. Addressing homophobia, stigma, and discrimination is central to implementing evidence-informed and rights-based HIV prevention, care and treatment services.

Delivering a continuum of services in close partnership with communities of MSM increases access and reduces morbidity, mortality and onward transmission of HIV. Effective HIV programming for MSM includes:

- Community empowerment is central to all prevention efforts. Empowerment supports MSM to address structural constraints to their health, human rights and well-being, and improves access to services. Building capacity of MSM networks supports planning, implementation, scale-up, management, and monitoring of HIV programs with MSM
- Addressing violence is a most urgent and prioritized need of MSM. Protection from violence, discrimination, and other forms of human rights violation is necessary to ensure that HIV interventions can be implemented effectively
- Condom and lubricant provision is a core prevention intervention, which includes managing supplies, multi-level promotion, and creating an enabling environment to increase condom use
- Comprehensive healthcare services include HCT, PrEP and PEP, ART, treatment of STIs and other co-infections, addressing mental health and substance use issues including needle and syringe programs and OST for MSM who inject drugs
- Community-led services are an important method of service delivery. Men's health groups and organizations of MSM are essential partners in providing outreach, managing drop-in centers, and helping peers navigate health, justice, and social services. MSM participation and leadership builds trust, makes programs more comprehensive and responsive, and creates enabling environments for HIV prevention
- Integrated services enable treatment, care, and support for multiple co-morbidities (e.g., HIV, viral hepatitis, TB, STIs, and mental health conditions) and poor social situations (e.g., detention, lack of housing, and unemployment). Integrated services facilitate better communication and care and enable better outcomes for MSM clients

HIV programs for MSM can face resistance and criticism from the broader community, especially where social, cultural, and religious attitudes stigmatize MSM. However, with funding and support, program implementers can increase acceptance of the MSM community and interventions. For example:

- Determine the size and characteristics of MSM communities among the affected population and involve them in designing and implementing targeted HIV prevention activities
- Promote understanding and acceptance of diverse sexual orientation and gender identities in public awareness campaigns to decrease homophobia
- Sensitize and build capacity for professionals, particularly health workers, law enforcement officials, social workers and community workers, to interact or work with MSM and apply rights-based approaches and evidence-informed practice
- Implement and enforce anti-discrimination and protective laws, to eliminate stigma, discrimination, and violence
- Monitor and report violence, in consultation with clients and with an understanding of legal risks, and establish redress mechanisms to provide justice
- Ensure health services are accessible, acceptable, patient-focused, and based on principles of medical ethics, avoidance of stigma, non-discrimination and the right to health

BOX 11.2: KEY POPULATION: PEOPLE WHO INJECT DRUGS

The United Nations Office on Drugs and Crime (UNODC) estimated that in 2014 worldwide around 11.7 million people had recently injected drugs; of these, 1.6 million were living with HIV (13.5%). Injecting drugs is highly prevalent in Eastern and South-Eastern Europe and 27% of PWID reside in East and South-East Asia. Rates of new HIV infection have been found to be 24 times higher amongst people who inject drugs than the general population. HIV is highly prevalent among PWID in South-West Asia, and Eastern and South-Eastern Europe, where respectively 27.9% and 22.9% of PWID are living with HIV. Sharing contaminated needles and syringes contributes to a third of new HIV infections outside sub-Saharan Africa. Women who inject drugs are particularly stigmatized and are vulnerable to violence and HIV. Insufficient coverage of harm-reduction programs in settings where unsafe injecting drug use is high, is of concern because of high risk for transmission of HIV and other infections such as viral hepatitis.

While sharing syringes and other equipment for drug injection is a well-known route of HIV transmission, injection drug use also contributes to the epidemic's spread beyond the circle of those who inject. Sexual partners of PWID are at risk through sexual transmission. Children born to mothers who contracted HIV through sharing needles or having sexual intercourse with a PWID may become infected as well. People who engage in sex work and MSM using stimulant drugs (cocaine, amphetamines) have also higher prevalence of sexual risk behaviors.

PWID may also have additional HIV transmission risks such as sex work and imprisonment. The criminalization of injection drug use can lead to social marginalization and limit access to health and HIV services, including HCT and ARV. All these can further fuel the epidemic.

HIV services for people who inject drugs should therefore focus on a harm reduction approach. The comprehensive package for the prevention, treatment, and care of HIV among people who inject drugs includes nine interventions ranked by order of priority as follows:

1) Needle and syringe programs

2) Opioid substitution therapy

3) HIV testing and counseling

4) Antiretroviral therapy

5) Prevention and treatment of sexually transmitted infections

6) Condom programs for people who inject drugs and their sexual partners

7) Targeted information, education, and communication for people who inject drugs and their sexual partners

8) Prevention, vaccination, diagnosis and treatment for viral hepatitis

9) Prevention, diagnosis, and treatment of tuberculosis

Provision of sterile needles and syringes reduces the risk of HIV transmission. Where possible, and depending on context, provision of other elements of harm reduction services, such as non-coercive opioid substitution therapy (methadone or buprenorphine) for people dependent on opioids, naloxone for overdose prevention, and psychosocial support could be considered. In addition, PMTCT services for women who inject drugs and for sexual partners of PWID as part of SRH programming should be considered. Quality condoms should always be provided.

In most cases, service providers lack experience, skills, and competency to provide good quality services to people who inject drugs. In such cases, training for service providers on HIV-related services for PWID should be considered. Peer-led community outreach is an effective way for reaching PWID who are not in contact with health and HIV prevention services. More specifically:

- Determine the size and characteristics of PWID among the affected population and involve them in designing and implementing targeted HIV prevention and treatment activities.
- Create demand and offer access to sterile injection equipment through needle and syringe programs
- Create demand and offer access to OST and other evidence-based drug dependence services
- Create demand and offer access to HCT and ART
- Create demand and offer access to condoms, STIs prevention and treatment, and SRH services
- Address and mitigate stigma and discrimination

In addition, Naloxone should be provided in the community to prevent death due to the overdose of opiates.

BOX 11.3: KEY POPULATION: PEOPLE WHO ENGAGE IN SEX WORK

The exchange of sexual services for money or goods is present in all communities and is often prevalent in emergency-affected populations. This includes persons who do not consider themselves sex workers but who lack other forms of income and offer sexual services to support themselves and their dependents during humanitarian situations. Thus, as well as ensuring security and access to food and support for vulnerable people, it is of utmost importance to provide non-stigmatizing HIV and SRH services for all persons providing sexual services within humanitarian settings. People who engage in sex work and their families benefit from support mechanisms, including the provision of assistance and incentives as well as legal, economic, and social services to reduce dependency on sex work for survival.

Globally, people who engage in sex work experience 10 times higher prevalence of HIV than the general population, with an average 12% rate of HIV infection. There are numerous reasons for this risk, including multiple sexual partners, vulnerability to sexual violence, unsafe working conditions, barriers to the negotiation of consistent condom use, and lack of access to health services. Stigma, discrimination, violence, and criminalization of sex work limit access to services and ability to reduce risk. For example, police may harass people who engage in sex work and use possession of condoms as evidence of sex work. Violence, alcohol and drug use in some settings also increase the vulnerability and risk face by this key population.

A number of interventions have been identified for reducing HIV within the context of sex work:

- Community empowerment is central to reducing risk for people who engage in sex work and other key populations. It enables effective planning, implementation and monitoring of all aspects of HIV and STI prevention, treatment and care. Building capacity of sex worker networks supports implementation and scale up of interventions that are tailored for local sex worker communities

- Addressing violence against people who engage in sex work is a priority, often of greater immediate concern than preventing HIV. HIV programs need to include protection from violence, discrimination, abuse, and other human rights violations, including by some State actors

- Condom and lubricant programming is a key intervention for ensuring adequate provision of male and female condoms and lubricants, including in community settings

- Clinical and support services need to be rights-based and people-focused, ensuring voluntary and informed consent and avoidance of any coercion and/or judgmental attitudes of providers. Voluntary services include HCT, PrEP and PEP, ART, treatment of STIs and co-infections, such as TB and viral hepatitis, including hepatitis B virus vaccination, and additional services for SRH, harm reduction for people who engage in sex work who inject drugs, post-rape care, and mental health services. In locations with high STI prevalence and limited health services, periodic presumptive treatment for STIs may be offered to people who engage in sex work for limited time periods. Uptake of all services is dependent upon people who engage in sex work being adequately informed and empowered to make their own choices about accepting treatment and support

- Provision of community-led services increases reach and delivery of services acceptable to people who engage in sex work by peers within community settings. A community-led approach to planning, delivering and monitoring services makes programs more effective and sustainable, with delivery via outreach, mobile clinics and safe spaces (drop-in centers), and peer navigation through health, social, and justice systems to maximize uptake and ensure sex workers' rights are upheld. Interventions can also address the "demand" side of sex work - working to change the behavior of clients - to reduce violence against people who engage in sex work and reduce demand for unprotected paid sex. Humanitarian staff, peacekeepers, civil police, and members of the general population can be clients of sex workers in humanitarian settings

- Interventions to protect against discrimination and violence, and other rights violations faced by people who engage in sex work, and to enhance sex workers' right to social, health, and financial services are critical. These may need to be linked to protection or gender-based violence sectors

- Health services should be made available, accessible and acceptable to people who engage in sex work based on the principles of avoidance of stigma, non-discrimination and the right to health

- Advocacy with community leaders is useful for increasing awareness and acceptance of the importance of providing services for people who engage in sex work

Finally, any efforts to stop human trafficking and sexual exploitation of children need to work in harmony with sex worker communities and HIV, protection, or gender-based violence programs. Blind sweep "raid and rescue" operations disregard sex workers' rights and make both sex work and trafficking more hidden, increasing the risk of HIV and violence. Sex worker communities are excellent allies for anti-trafficking efforts and need to be consulted and involved. Often people who engage in sex work themselves will know if individuals are being forced or coerced into providing sexual services or are under age 18 years (sexually exploited children).

inadequate in many settings with a high burden of HIV and this is accentuated in emergency settings. Universal access to HIV services will not be possible without strengthened health systems, including a significant expansion of the health workforce. Against this background, the need for a plan to strengthen and expand the health workforce in the context of HIV becomes clear. Given increasing numbers of patients, shortages of trained medical personnel, and financial constraints, treatment must be provided more efficiently.

Scaling-up HIV prevention, treatment, and care programs cannot only rely on formally trained health care professionals, as these are insufficient to respond to the needs. Rather, programs must also involve management and support staff from outside the clinical health sector who can free up time for health care providers to perform clinical work. Task-sharing and task-shifting (in which physicians, nurses, dentists, and other health professionals delegate health care responsibilities and relevant knowledge to others, including trained community health workers (CHWs) and community-led care and support, can make more efficient use of existing human resources and ease bottlenecks in service delivery without compromising patient outcomes. Sharing of responsibility may also involve the delegation of some clearly delineated tasks to newly created cadres of health workers who receive specific competency-based training.

Task-sharing is the process of enabling a range of lay and trained healthcare professionals - such as nurses, midwives, clinical officers, and community health workers - to provide clinical tasks and procedures safely that would otherwise be restricted to higher level cadres. Task-sharing emphasizes a knowledge base requirement for delegated roles and responsibilities and underscores the involvement of health professionals' collaboration when providing care.

The World Health Organization defines task-shifting as the process whereby specific tasks are transferred, when appropriate, to health workers with less training and fewer qualifications. Community health workers, including people living with HIV, can safely and effectively provide specific HIV services, both in a health facility and in the community. Unlike informal and opportunistic task shifting/sharing, deliberate strategies are accompanied by training, certification, support, and supervision.

TRAINING

It is essential that capacity to implement good quality HIV programs exists to ensure good quality HIV services are provided. However, capacity can differ from context to context. In addition, the nature of an emergency may require expansion of specific skills and competencies among health providers (e.g., how to respond to sexual violence, or how to effectively manage HIV commodities). For this reason, it is important to include a basic assessment of capacity gaps as part of the needs assessment and program planning. Based on identified capacity and skill gaps, training can be conducted, focusing on different target audiences, such as:

- Health care providers in clinics or health posts
- Health sector managers in implementing agencies
- Community health workers and peer-outreach workers
- Others depending on identified needs and gaps

Wherever possible, use existing training manuals or materials and utilize local expertise.

PROVISION OF SERVICES IN DIFFERENT CONTEXTS AND SETTINGS

Over 60% of the world's refugees and IDPs live in urban environments. Unlike a refugee/displaced persons camp, cities allow refugees to live anonymously, make money, and build a better future. But they also present dangers. Refugees may be vulnerable to exploitation, arrest or detention, and can be forced to compete with the poorest local workers for the worst jobs. Large numbers of refugee women, children, and older people in urban areas, are confronted with a range of protection risks, including the threat of arrest and detention, refoulement, harassment, exploitation, discrimination, inadequate and overcrowded shelter, as well as vulnerability to sexual and gender-based violence (GBV), HIV, substance use disorders and human trafficking.

In urban contexts, particular efforts must be made to reach refugees and IDPs, as there are often no records and such persons often do not receive direct material support or services from host governments or humanitarian agencies. Service providers experience challenges reaching refugees and IDPs within urban settings and such persons often have little opportunity to voice their concerns. Furthermore,

refugees in urban areas often face numerous disadvantages compared with low income city dwellers, such as lack of community support systems, language barriers, exclusion from social security systems or health insurance schemes, and insufficient disposable income. Stigma and discrimination may also reduce access to already overstretched government health services.

In countries where nationals have subsidized or free health services, the first priority would be the integration of refugee health services with the national health system, with the aim of assuring the same access for urban refugees as those available to nationals. This would particularly apply to primary health services and SRH-specific services such as contraception services, antenatal and postnatal care, emergency obstetric care, and HIV/STI and GBV management. If this privilege is not granted by the host government, there is the need to set up alternative services and develop an advocacy strategy.

Informal protective community-led services and peer networks must also become a cornerstone of urban protection. These peer networks can be among refugees, for instance in the form of support groups, including for GBV survivors, elders, lesbian, gay, bisexual, transgender, queer, questioning, intersex, and asexual (LGBTQIA) people, people who engage in sex work, people with disabilities (PWD), people who inject drugs, people in prisons, and people living with HIV. Key populations can be encouraged to mobilize and form local networks to work collectively. Where possible, provide community drop-in centers where services can be provided, and people can meet and initiate community action. Engage local organizations that have expertise working in a particular neighborhood or geographic area that is seeing an influx of refugees; others may have expertise working with urban subpopulations, including vulnerable groups like LGBTQIA people, people who engage with sex work, homeless persons, and people living with HIV.

11.3.6 Implementing comprehensive services for HIV prevention and care

Once the conditions allow, scaling up should occur from the initial minimum HIV package to comprehensive HIV prevention, care, and treatment services. SRH Coordinators, health program managers, and service providers, should review the findings of the situational needs assessment and implement comprehensive HIV services, according to available services and the security condition. Continuum of HIV care refers to a comprehensive package of HIV prevention, testing, treatment, and care services provided for people at risk of acquiring HIV and people living with HIV and their families.

HIV AWARENESS

Public information campaigns should be conducted to raise community awareness about how HIV is and is not transmitted and promote the rights of people living with HIV, the benefits of knowing one's HIV status, and the availability of services for HIV prevention, testing, care, and support. Information about safe disclosure is also critical. People, and in particular women and girls who may be at risk of violence, must have informed choice about to whom they disclose, for whom they disclose,

BOX 11.4: KEY POPULATION: TRANSGENDER PEOPLE

Transgender people are rarely identifiable in national surveillance systems, and there is limited understanding of the global burden of HIV and other STIs among transgender populations. Data are only available from middle and high-income countries and indicate that transgender women, in particular, are at disproportionate risk for HIV infection, 49 times higher than the general population. A meta-analysis published in 2013 found an HIV prevalence rate of 17.7% among 7,197 transgender women from low- and middle-income countries.

Transgender populations are distinct from MSM and often have different vulnerabilities and health needs (such as hormone therapy) and require gender sensitive services. Transphobia and a lack of gender-congruent identity documents may limit their ability to access health care. Healthcare workers providing HIV services may require sensitization to ensure they provide gender-affirming services for adult and adolescent transgender people, free from transphobia.

A "syndemic" (synergistic epidemic) of multiple, co-occurring health problems markedly affects transgender people, especially transgender women, including high rates of violence, victimization, substance use, sexual abuse and assault, and depression with suicidal ideation and attempts. This syndemic is associated with structural and social inequalities, including stigma and discrimination, lack of identity documents that match gender expression, unemployment, low-paid sex work, homelessness, and lack of access to health services, included gender-affirming care. Transgender women who seek psychological affirmation of their gender from partners may be more willing to have sex without condoms and many partners of transgender women are at high risk of HIV.

Many transgender people use feminizing or masculinizing hormones to physically align with their gender identity. Many prioritize hormone therapy; this may be an entry point into HIV testing and care. Uncertainty remains over how hormonal contraceptives, particularly in large doses, affect HIV acquisition and transmission. Ethinyl estradiol - the estrogen commonly used in oral contraceptives - has well-characterized drug interactions with some ARV drugs; these contraceptives are widely used by transgender women. Data are lacking on drug interactions between ARVs and 17-β estradiol – a drug commonly used for hormone replacement therapy. Testosterone and ARVs may be co-administered. However testosterone suppresses estrogen, resulting in vaginal atrophy (thinning and drying of the vaginal lining). Although data are unavailable, this raises concerns about the impact on HIV acquisition among transgender men.

Some considerations for programming include:

- Acknowledge and build upon the strengths, competencies, and capacities of transgender people, especially their ability to express their views and articulate what services they need. Partner with community-led organizations of transgender people, building upon their experience and credibility with transgender people
- Involve transgender people meaningfully in the planning, design, monitoring, implementation, and evaluation of services suited to their needs in local contexts
- Fully utilize existing infrastructure and services, such as services for adolescents that have been demonstrated to be appropriate and effective, and add components for reaching and providing services to young transgender people
- Ensure that there is sufficient capacity amongst professionals, particularly health workers, law enforcement officials, social workers and community workers, to interact or work with transgender people and apply rights-based and gender-sensitive approaches and evidence informed practice
- Adequate supplies of condoms and lubricant should be made available, emphasizing the need to ensure use of lubricant. Behavior change interventions can be delivered via internet, social marketing, drop-in centers, and outreach to venues (e.g., nightclubs, sex venues)
- HIV clinical services for transgender people include HCT, PrEP and PEP, ART, treatment for STIs and other co-morbidities including tuberculosis and viral hepatitis, including the hepatitis B virus vaccination where immunization coverage is incomplete. Further services include for mental health issues, harm reduction for transgender people who inject drugs, and further drug and alcohol programs. Transgender people should receive adequate SRH services including contraception. Transgender women should be counseled about the risks of using oral hormonal contraceptives for feminization treatment
- Violence against transgender people should be prevented and addressed in partnership with trans-led organizations. All violence should be monitored and reported, and redress mechanisms established to provide justice

BOX 11.5: KEY POPULATION: PRISONERS

People in prisons are 5 to 10 times at higher risk for HIV. In addition to HIV risk behaviors, such as unsafe sexual activities and sharing injection equipment or body piercing equipment, factors related to the prison infrastructure and prison management, including health also contribute to vulnerability to HIV, tuberculosis, and other health related risks in prisons. These factors include overcrowding, violence, poor prison conditions, corruption, denial, stigma, lack of protection for vulnerable prisoners, lack of training for prison staff, isolation, and poor medical and social services.

In such contexts, effective HIV response requires addressing HIV prevention and treatment needs of those in need to ensure widest possible access to high quality services. A comprehensive package of 15 interventions for HIV in prisons includes:

1) Information, education, and communication (IEC)

2) Condom programs

3) Prevention of sexual violence

4) Drug dependence treatment, including OST

5) Needle and syringe programs

6) Prevention of transmission through medical or dental services

7) Prevention of transmission through tattooing, piercing, and other forms of skin penetration

8) Post-exposure prophylaxis

9) HIV testing and counseling

10) HIV treatment, care, and support

11) Prevention, diagnosis, and treatment of tuberculosis

12) PMTCT

13) Prevention and treatment of STIs

14) Vaccination, diagnosis, and treatment of viral hepatitis

15) Protection of staff from occupational hazards

BOX 11.6: ESSENTIAL MESSAGES

- HIV, the virus that causes AIDS, can spread through unprotected sexual contact (vaginal, anal, and oral sex without a condom) with someone who is infected with HIV, transfusions of HIV infected blood, reusing needles, syringes and other skin penetration equipment contaminated with HIV, and from a woman living with HIV to her child during pregnancy, childbirth, or breastfeeding
- Everyone must know about HIV and AIDS and how to prevent HIV transmission, because HIV is not curable, only preventable and treatable
- There is effective antiretroviral treatment for HIV and also for certain opportunistic infections (AIDS-defining conditions). Although ART is not a cure, it can control HIV and prolong life if taken lifelong
- Having an STI (e.g., chlamydia, gonorrhea, syphilis) increases one's risk of transmitting or acquiring HIV
- The risk of infection through sexual intercourse can be reduced by using barrier protection, such as condoms, correctly every time, maintaining a mutually monogamous relationship with an uninfected partner, abstaining from sexual intercourse, or using oral pre-exposure prophylaxis
- Everyone who may have been exposed to HIV should consult a qualified health worker for voluntary, informed HIV testing and counseling to protect their health
- Pregnant women should access HIV testing and counseling. If infected, they will be offered appropriate medication to reduce the risk of transmitting the infection to their infant during pregnancy delivery or breastfeeding
- Stigma, discrimination, wrong information, and negative attitudes towards people living with HIV and key populations increase the potential for suffering and for HIV to spread. Discrimination against people living with HIV is a human rights violation

and when, where, and how they disclose. People living with HIV and affected communities should be involved in the formulation, implementation and monitoring of such campaigns.

Communication efforts in the early humanitarian response focus on informing people where they can access basic HIV services. As soon as possible, review the findings of the initial assessment, to tailor communications toward local populations affected by HIV, for example:

- What level of knowledge and common misconceptions about HIV do people have?
- What common practices put people at risk of HIV transmission?
- What elements of the new situation increase the risk of HIV transmission?
- What are the common attitudes and beliefs regarding people living with HIV and key populations?

Public information and health service-based campaigns can increase awareness about HIV, STIs, and other SRH issues within newly formed communities of refugees and IDPs. In addition, design and tailor specific communications campaigns to:

- Target key populations and other people vulnerable to HIV transmission. Displaced people face increased risks because protective community systems and health services are interrupted, sexual networks change, youth may initiate sexual activity earlier, drug use may change and people may initiate sex work as means of livelihood
- Reduce stigmatizing attitudes and discriminatory behavior against people living with HIV and key populations and assure care and support for them

Community-led programs, such as community drop-in centers and peer outreach, are effective ways to motivate people to practice safer behaviors and access services. A variety of community groups can be involved and mobilized including networks of people living with HIV, LGBTQIA people, sex workers, people who inject drugs, and people with disabilities. Support can also be sought from community and religious leaders, health clubs at schools, post-HIV test clubs, and Stop-AIDS associations in the police and military. Associations of people living with HIV and other community groups can be powerful catalysts for change of individual and community-wide attitudes.

BOX 11.7: POPULATIONS AT-RISK: YOUNG PEOPLE AND ADOLESCENTS

Young people (10–24 years), including adolescents (10–19 years), continue to be vulnerable, both socially and economically, to HIV infection. This is particularly true for adolescents, especially girls, who live in generalized HIV epidemic settings or who are members of key young population groups.

Adolescents often have poor access to and uptake of services, which increases adolescents' vulnerability to and risk of contracting HIV. For those under 18 years of age, policy and legal barriers related to age of consent often prevent access to a range of health services, including for HIV and SRH services. Such barriers also limit adolescents' ability to exercise their right to informed and independent decision-making.

Adolescents and youth, including those from key populations, should have access to tailored and age-appropriate and rights-based information and services. There should be meaningful participation of young people in the design, implementation, monitoring and evaluation of policies and programs. This includes:

- **Provision of rights-based and gender-transformative comprehensive sexuality education**
- **Access to comprehensive adolescent SRH services, including for HIV, other STIs, and contraception**
- **Ensuring that sufficient and accurate information about reproductive health and rights is provided**
- **Creating peer education and support programs**
- **Providing adolescents with treatment, care, and support**
- **Supporting adolescents living with HIV to make informed decisions about if, when and to whom to disclose their HIV status**
- **Supporting adolescents with treatment adherence and the transition from pediatric to adult services**

BOX 11.8: POPULATIONS AT-RISK: PEOPLE WITH DISABILITIES AND THE ELDERLY

Access to HIV prevention, treatment, and care should be recognized as an essential component of realizing the universal right to health. However, people with different types of disabilities (such as hearing, visual, physical, and intellectual disabilities) and the elderly may face difficulties accessing health services. HIV service planning should promote accessibility of services for these groups.

Key factors associated with HIV, such as lack of education and social marginalization, are more common for both men and women with disabilities which may increase their vulnerability to HIV. This is due to the lack of appropriate access to HIV prevention, information, and services, and the high rate of sexual and gender-based violence against persons with disabilities of all ages.

Key considerations include:

- People with disabilities have equal or greater exposure to all known risk factors for HIV
- Include people with disabilities and the elderly in HIV training groups so they can get involved in prevention and outreach initiatives themselves
- Sensitize educators, outreach workers, clinical, and social services staff on disability
- Ensure prevention programs reach people with disabilities, for example, HIV and life skills programming targeting young people should incorporate the specific concerns of young people with disabilities in school and those that are not
- Identify local disability organizations and involve them in all phases of prevention efforts
- Ensure measures to improve accessibility of health services is inclusive of those with disabilities. Such measures should also safeguard the privacy of the clients during communication of sensitive information
- Ensure all public education materials and initiatives are accessible to and inclusive of children and adults with different abilities and disabilities, by involving them directly in the selection of content and format (e.g., sign language, braille, digital or audio versions, simple language, simplified graphic information, etc.), testing, and adaptation of materials
- In awareness-raising campaigns involving the media, it is important that images reflect the target population for the messages and should therefore not exclude people with disabilities

BOX 11.9: POPULATIONS AT RISK: UNIFORMED PERSONNEL

Military and other uniformed personnel are often at high risk of HIV and STIs mainly due to their work environment, mobility, age, and other factors influencing exposure. One important factor leading to increased vulnerability to HIV in uniformed services is the practice of posting personnel far from their accustomed communities and families for varying periods of time. As well as freeing them from traditional social controls, it removes them from contact with spouses or regular sexual partners and can lead to increased risk-taking behaviors.

Key considerations for programming include:

- Peer education can be an effective tool in educating uniformed and prison services about HIV prevention, care, and treatment
- Involve police, military, and other uniformed personnel in the planning, design, monitoring, implementation, and evaluation of HIV prevention services suited to their needs in local contexts
- Facilitate access to voluntary confidential counseling and testing for police, military, and other uniformed personnel
- Condoms should be made widely available at all military, prison, and police sites, for example through condom dispensers placed in washrooms, clinics, HCT centers and/or offices and transport and dispatch offices
- HIV awareness training should be provided for all prison, military, and police personnel prior to deployment
- Ensure that HIV prevention services to police, military, and other uniformed personnel is linked with prevention services for clients of people who engage in sex work
- Crisis management plans and disaster management plans should include guidance on universal precautions to reduce the transmission of HIV in medical emergencies and in responses to accidents

HIV PREVENTION

HIV prevention programs are interventions that aim to halt the transmission of HIV and thus protect individuals and communities. HIV prevention programs may focus on preventing sexual, blood-borne, or maternal-to-child transmission of HIV. A combination of interventions works best, including biomedical approaches, behavior change communication, and removing structural barriers to prevention.

Health staff, program managers, and service providers need to understand the HIV epidemic characteristics in the settings in which they work and the knowledge and behaviors of the local population in order to tailor HIV programming. In humanitarian settings, people may engage in behaviors that place them at higher risk of HIV, even if they do not self-identify as being at risk. Adolescent girls and young women may have multiple SRH and HIV vulnerabilities and thus HIV prevention needs to be placed in the context of comprehensive SRH education and services.

Although key populations and populations at risk have unique characteristics and require tailored approaches, the following elements should be considered across all HIV programs and their applicability determined depending on context and resources.

- Involve community groups from the start in program design, implementation and monitoring. Community-led programs are most effective if community networks can be mobilized
- Provide HIV prevention information to enhance community awareness of HIV
- Tailor combination HIV prevention programs by including different interventions depending on local HIV geographic population vulnerabilities
- Decentralize HIV services and incorporate community-led approaches to service delivery to increase accessibility and acceptability. Peer-based outreach, mobile services, and drop-in centers are useful for reaching those with limited access to public health facilities
- Promote consistent and correct use of male and female condoms as well as condom compatible lubricants and ensure their availability, affordability, and reliable supply
- As part of a combination prevention approach, offer voluntary oral PrEP, such as that containing tenofovir disoproxil fumarate (TDF) for populations at substantial risk of HIV infection
- Make PEP available to all eligible people on a voluntary basis as soon as possible after exposure to HIV
- Promote voluntary medical male circumcision (VMMC) as an additional strategy for the prevention of heterosexually acquired HIV infection in men, particularly in settings with hyperendemic or generalized HIV epidemics and low prevalence of male circumcision
- Train health and social workers to provide high quality, client-friendly, HIV-related services to people living with HIV and their partners and families, including syndromic management of STIs, family planning counseling and contraceptive services, HIV counseling and testing, PMTCT, pediatric testing and treatment, and treatment for tuberculosis (TB) and AIDS
- Address structural barriers including policies, legislation, and customary practices that discriminate against and prevent access to and utilization of appropriate HIV prevention, treatment, and care services by different groups. This should include the creation of safe spaces tailored to each group where people can comfortably meet and seek information and referrals for care and support

BOX 11.10: DEFINITIONS OF PMTCT AND EMTCT OF HIV AND SYPHILIS

Preventing mother-to-child transmission (PMTCT) of HIV and syphilis is a multi-pronged strategy.

1) Help women of reproductive age avoid HIV and other STIs

2) Prevent unintended pregnancies

3) Provide ARV prophylaxis during pregnancy, delivery, and breastfeeding

4) Provide care, treatment and support to mothers and their families

5) Provide penicillin as needed

eMTCT stands for elimination of mother-to-child transmission.

BOX 11.11: KEY MESSAGE

MANDATORY HIV TESTING SHOULD NEVER BE SUPPORTED.

THIS COMPRISES A VIOLATION OF A PERSON'S RIGHTS.

HIV counseling and testing

Voluntary HIV counseling and testing describes a process initiated by an individual who wants to learn her or his HIV status. HCT is not a priority intervention at the onset of a humanitarian response because it is not an immediately lifesaving intervention. However, as soon as the situation allows it is important to offer HCT for people who want to know their serostatus. HCT services are standard practice to improve the health and well-being of individuals and as an entry point to appropriate care and treatment services. Provide counseling to prepare clients for their test result and to encourage behavior change, whatever the test outcome.

BOX 11.12: THE 5 Cs

HCT should be voluntary and adhere to the 5 Cs:

- Consent
- Confidentiality
- Counseling
- Correct test results
- Connection to care, treatment, and prevention services

Quality assurance of both testing and counseling is essential.

Provider-initiated HIV testing and counseling

Evidence suggests that many opportunities to diagnose HIV in clinical settings are being missed, even in places with serious HIV epidemics. While expanded access to client-initiated HIV testing and counseling is still necessary to increase coverage of HIV testing and counseling, provider-initiated counseling and testing (PICT) can increase uptake of HIV testing, improve access to health services for people living with HIV, and may create new opportunities for HIV prevention. PICT involves the healthcare provider specifically recommending an HIV test to patients attending health facilities; individuals must specifically decline the HIV test after receiving pre-test information if they do not want the test to be performed.

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

- TB clinics
- STI services
- Antenatal, childbirth, and post-partum health services
- Medical inpatient and outpatient facilities

In low level and concentrated epidemics, healthcare providers should not initiate HCT to every patient attending a health facility, since most people will be at low risk. In such settings, the priority should be to ensure that HCT is recommended to all adults, adolescents, and children who present to health facilities with signs and symptoms suggestive of underlying HIV infection, including TB, and to children known to have been perinatally exposed to HIV. HCT facilities should be made available in stabilized humanitarian settings, either through established services, or mobile clinics.

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

BOX 11.13: QUALITY HCT SERVICES

Whether client- or provider-initiated, the following program components ensure quality HCT services:

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

BOX 11.14: RETESTING PRIOR TO ENROLLMENT IN CARE

It is a priority to retest all people who are diagnosed to be HIV positive prior to enrollment in HIV care and/or treatment in order to verify their serostatus. Failure to do this may lead, in rare cases, to people being diagnosed incorrectly, with potentially serious adverse long-term consequences.

Retesting a person diagnosed to be HIV positive to verify the diagnosis should include:

- Retesting of a new specimen for each newly diagnosed individual, preferably conducted by a different provider using the same testing algorithm, prior to initiation of ART
- Retesting that is preferably conducted at a different site, ideally the site where the decision about ART initiation will be made

Antiretroviral drugs for HIV prevention

ARV drugs play a key role in HIV prevention, including prevention of mother-to-child transmission, reducing the transmission of HIV to serodiscordant sexual partners (PrEP), and preventing the acquisition of HIV when a person is exposed (PEP). People living with HIV taking ART who achieve optimal viral suppression are extremely unlikely to pass HIV to sexual partners. It is important to plan the provision of essential ARV and ART programs. Providing HIV-related services to populations in humanitarian settings is a difficult yet critical undertaking, which is firmly rooted in international human rights laws. As with all HIV and AIDS policies and programs, ART must be linked to a prevention, care, and support program and not be implemented as a parallel intervention but rather as an integrated program linked to other services (e.g., health, nutrition, education, social services and water and sanitation). Where ART is available it is important that counseling covers the risks and benefits of ART and the importance of adherence to the treatment schedule.

Post-exposure prophylaxis

SRH Coordinators, health program managers, and service providers must ensure that the prompt (within 72 hours) administration of PEP to reduce the likelihood of HIV transmission is included in protocols for the following two situations:

- ***Services for sexual violence survivors:*** In order to prevent and manage possible health consequences of sexual violence, and rape in particular, survivors must have access to clinical care, including supportive counseling and emergency contraception (within 120 hours). This care also includes the provision of PEP (within 72 hours)
- ***Occupational exposure:*** Despite universal precautions put in place and adhered to in healthcare settings, occupational exposure to blood and body fluids potentially infected with HIV may occur, for example through a needle stick injury. Ensure PEP is available in these settings as part of a comprehensive universal precautions package that reduces the likelihood of HIV transmission after such an exposure

The recommended PEP regimen is a 28-day combination therapy. While a two-drug PEP regimen is effective, three drugs are preferred.

BOX 11.15: KEY RECOMMENDATION

ART SHOULD BE INITIATED IN ALL PREGNANT AND BREASTFEEDING WOMEN LIVING WITH HIV REGARDLESS OF CLINICAL STAGE AND AT ANY CD4 CELL COUNT AND CONTINUED LIFELONG.

Prevention of mother-to-child transmission

In the absence of ART, the probability of HIV transmission from an HIV-positive woman to her infant during pregnancy, labor, delivery, or breastfeeding range from 15% to 45%. This can be reduced to below 5% with effective interventions during the periods of pregnancy, labor, delivery, and breastfeeding. These interventions primarily involve ART for the woman and a short course of ARV drugs for the infant. Access to ART should be provided as part of the MISP in all settings during the acute emergency. Extended PMTCT services should be incorporated into comprehensive maternal and newborn health (MNH) services when the acute phase is over.

Although most attention is paid to the medical intervention, the WHO PMTCT framework outlines a comprehensive PMTCT program following four prongs:

- Help women of reproductive age avoid HIV and other STIs
- Prevent unintended pregnancies
- Provide ARV prophylaxis during pregnancy, delivery, and breastfeeding
- Provide care, treatment and support to mothers and their families.

HIV testing and counseling

In many countries, offering HIV testing in antenatal care (ANC) as part of PMTCT has led to substantial decreases in new pediatric HIV infections and increased ART coverage for women. Testing of partners and retesting of pregnant women in late pregnancy or during breastfeeding has been less widely implemented and should be prioritized in high prevalence settings. PICT should be provided for all women on their first ANC visit. Testing can be provided by lay providers who are trained and supervised. Male partners should be strongly encouraged to get tested and couples counseling should be made available. In high prevalence settings, retesting is recommended in the third trimester or during labor or shortly after delivery, because of the high risk of acquiring HIV infection during pregnancy.

Antiretroviral prophylaxis

Mothers known to be HIV-positive should be provided with lifelong ART or ARV prophylaxis throughout pregnancy and breastfeeding. ART should be initiated immediately in women who test positive for the first time in pregnancy. Ideally, pregnant HIV positive women should be initiated on lifelong treatment, but in the absence of this option the national protocol should be observed. Key to ensuring support within families is involving partners in programs for PMTCT and providing couples counseling and ongoing follow up. Table 11.2 outlines preferred and alternative first-line ART regimens for HIV-positive pregnant and breastfeeding women.

Where a woman who is known to be living with HIV presents for antenatal, delivery, or post-partum care, actively pursue the opportunity to prevent transmission of HIV to her infant. For the implementation of a prevention of mother-to-child transmission program the following must be established:

- ANC services
- Provider-initiated HIV testing and counseling
- Continuous availability of ARVs according to PMTCT protocols
- MNH care including safe delivery care
- Counseling on infant feeding
- Early infant diagnosis

Adapt monitoring systems by introducing patient passports as portable patient records. In acute emergencies when routine monitoring systems cannot be used, temporarily use a simplified paper-based facility record and develop a group of key indicators for humanitarian settings. This should be implemented as part of an approach that addresses other medical issues beyond HIV to help eliminate identification of HIV status and related stigma.

BOX 11.16: KEY RECOMMENDATION

MOTHERS LIVING WITH HIV SHOULD BREASTFEED FOR AT LEAST 12 MONTHS AND MAY CONTINUE BREASTFEEDING FOR UP TO 24 MONTHS OR LONGER (SIMILAR TO THE GENERAL POPULATION) WHILE BEING FULLY SUPPORTED FOR ART ADHERENCE.

Infant feeding

The risk of infants acquiring HIV through breastfeeding from mothers living with HIV must be balanced against the higher risk of death among non-breastfed infants from causes such as malnutrition, diarrhea, and pneumonia. Evidence on HIV transmission has shown that exclusive breastfeeding for up to 6 months is associated with a 3- to 4-fold decreased risk of transmission of HIV compared to non-exclusive breastfeeding. The WHO recommends

TABLE 11.2 PREFERRED AND ALTERNATIVE FIRST-LINE ART REGIMENS

FIRST-LINE ART	PREFERRED FIRST-LINE REGIMEN	ALTERNATIVE FIRST-LINE REGIMENS[X,Y]
Adults	TDF + 3TC (or FTC) + EFV	AZT + 3TC + EFV (or NVP) TDF + 3TC (or FTC) + DTG* TDF + 3TC (or FTC) + EFV400*,**,*** TDF + 3TC (or FTC) + NVP
Pregnant/breastfeeding women	TDF + 3TC (or FTC) + EFV	AZT + 3TC + EFV (or NVP) TDF + 3TC (or FTC) + NVP
Adolescents	TDF + 3TC (or FTC) + EFV	AZT + 3TC + EFV (or NVP) TDF (or ABC) + 3TC (or FTC) + DTG*,** TDF (or ABC) + 3TC (or FTC) + EFV400*,**,*** TDF (or ABC) + 3TC (or FTC) + NVP
Children 3 years to less than 10 years	ABC + 3TC + EFV	ABC + 3TC + NVP AZT + 3TC + EFV (or NVP) TDF + 3TC (or FTC) + EFV (or NVP)
Children less than 3 years	ABC (or AZT) + 3TC + LPV/r	ABC (or AZT) + 3TC + NVP

* Safety and efficacy data on use of DTG and EFV400 in pregnant women, people with HIV/TB coinfection and children and adolescents younger than 12 years of age are not yet available

** Conditional recommendation, moderate quality evidence. Refer to full guideline for more detail

*** EFV at lower dose (400 mg/day)

3TC lamivudine, ***ABC*** abacavir, ***ATV*** atazanavir, ***AZT*** zidovudine, ***DRV*** darunavir, ***DTG*** dolutegravir, ***EFV*** efavirenz

FTC emtricitabine, ***LPV*** lopinavir, ***NVP*** nevirapine, ***r*** ritonavir, ***TDF*** tenofovir

[X] For adults and adolescents d4T should be discontinued as an option in first-line treatment

[Y] ABC or boosted protease inhibitors (PIs) (ATV/r, DRV/r, LPV/r) can be used in special circumstances

that mothers living with HIV should breastfeed for at least 12 months and may continue breastfeeding for up to 24 months or longer (similar to the general population) while being fully supported for ART adherence.

Staff working in this area should coordinate within the health sector/cluster and with national health authorities to promote a single infant feeding practice across communities as the standard of care.

The provision of ARVs to pregnant and breastfeeding women living with HIV and their infant is strongly recommended and the health sector/cluster should strive to introduce or continue them (see antiretroviral prophylaxis above). However, the absence of ARVs does not change the recommendations regarding breastfeeding.

ART reduces the risk of postnatal HIV transmission in the context of mixed feeding. Although exclusive breastfeeding is recommended, practicing mixed feeding is not a reason to stop breastfeeding in the presence of ARV drugs. Shorter durations of breastfeeding of less than 12 months are better than never initiating breastfeeding at all. In settings where health services provide and support lifelong ART, including adherence counseling, and promote and support breastfeeding among women living with HIV, the duration of breastfeeding should not be restricted.

BOX 11.17: PREVENTING HIV INFECTION IN INFANTS AND YOUNG CHILDREN

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

- **Primary prevention of HIV infection**
- **Prevention of unintended pregnancies among women living with HIV**
- **Prevention of HIV transmission from mothers living with HIV to their infants**
- **Care, treatment, and support for mothers living with HIV, their children and families**

In comprehensive SRH programs, all 4 components must be implemented in order to reach the overall goal of improving maternal and child health in the context of HIV.

Oral pre-exposure prophylaxis

Oral PrEP is the use of antiretroviral drugs before HIV exposure by people who are not infected with HIV in order to block the acquisition of HIV. It is recommended that PrEP containing TDF should be offered as one prevention choice for people at substantial risk of HIV infection in combination with other HIV prevention approaches. "Substantial risk" of HIV infection is provisionally defined as HIV incidence around 3 per 100 person-years or higher in the absence of PrEP. HIV incidence higher than 3 per 100 person-years has been identified among some groups of MSM, transgender women, and heterosexual men and women who have sexual partners with undiagnosed or untreated HIV infection.

The WHO recommends PrEP be used as part of a package of combination prevention interventions that includes HIV testing, condom use, as well as screening and treatment of STIs. For this reason, appropriate messaging and counseling to potential users will be essential for successful and optimal use of PrEP. In addition, provision of PrEP needs to be consistent with the prevailing national guidelines.

11.3.7 Implementing comprehensive care for people living with HIV

ANTIRETROVIRAL THERAPY FOR PEOPLE LIVING WITH HIV

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

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

Plan for comprehensive HIV testing and counseling and ART programs as soon as possible. Before initiating ART services, it is important, together with the representatives of the MOH and/or the health sector/cluster, to consider the following questions:

PROGRAMMATIC EXAMPLE 11.1: INTEGRATING SRH AND HIV PROGRAMMING IN A HUMANITARIAN CONTEXT

ORGANIZATION: International Rescue Committee (IRC)

LOCATION: Uganda

INTRODUCTION: In Uganda, the International Rescue Committee is responding to the South Sudanese refugee crisis while also continuing to serve the host population and vulnerable communities. IRC provides primary health care support, including comprehensive sexual reproductive health (SRH) services, in the newly established settlement in Yumbe district through 2 health facilities that serve over 100,000 refugees. Additionally, the IRC supports 8 health facilities in Adjumani district (with a refugee population of over 86,000) and 3 health facilities in Kiryandongo district (with a refugee population of over 60,000 refugees) with delivery of SRH services.

PROJECT DESCRIPTION: According to UNAIDS, 360 new HIV infections occur per week in Uganda among adolescent girls and young women aged 15–24 years. In all efforts, HIV programming is integrated within comprehensive sexual and reproductive health work, ensuring care, treatment, and support for HIV positive patients. The IRC offers HIV counseling and testing (HCT) in all IRC-supported health facilities in an integrated manner. This includes both client- and provider-initiated HCT and routine HCT for pregnant women. Patients who have tested positive are provided with antiretroviral medications either at the same location or through referral to a nearby accredited facility. HIV positive patients are also linked to available support services, including peer-support mechanisms such as family support groups for mother-baby pairs.

Through its SRH initiatives across Uganda, the IRC conducts routine HIV tests for all pregnant women, providing counseling and antiretroviral drugs to lower the risk of transmission from mother-to-child. The IRC also started family planning counseling for women who are HIV positive and for those who are not planning on having a child at the moment. This is in line with the integrated approach to HCT, linking this with other SRH services such as family planning, chronic illness care, post-abortion care, adolescent SRH, and gender-based violence.

LESSONS LEARNED: The IRC follows standard protocols set forth by the WHO and the Ministry of Health to ensure quality of SRH and HIV services. To support awareness-raising and promote care-seeking behavior, the IRC works with partners on the ground, such as Village Health Team members, to effectively inform communities about HIV prevention and treatment. Community engagement approaches include working through community and religious leaders, use of peer-support groups, and other community fora. The combination of quality health service provision with community level activities to increase awareness and demand for services serves to improve health outcomes for the affected population.

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

BOX 11.19: KEY RECOMMENDATIONS

For antiretroviral therapy for people living with HIV, the following are recommended:

- Perform an HIV test – or obtain a document - to confirm HIV status and a patient card showing the ART regimen that is/was followed
- If the individual is currently on ART, continue the treatment without interruption. If there has been treatment interruption, assess the reasons for the interruption and restart the regimen as soon as possible
- If the same ARV drugs as in the previously followed first-line regimen are not available, and if there is no history of treatment failure or serious adverse reaction to proposed alternative ARVs, substitute another first line regimen immediately, based on national protocols
- Patients who were previously taking protease inhibitors that are not available in the new setting can be prescribed a first-line regimen until second-line regimens become available. However, people who were on protease inhibitors due to an adverse reaction to a first-line regimen must be closely monitored if they are restarted on a first-line regimen. If toxicity recurs and second-line regimens are not available, ART should be discontinued. Continue prevention of opportunistic infections
- Provide adherence counseling and support in light of the emergency context and new adherence barriers

BOX 11.18: WHEN TO START ART

Adults (>19 years old) and adolescents (10–19 years of age)	• ART should be initiated in all adults living with HIV, regardless of WHO clinical stage and at any CD4 cell count • As a priority, ART should be initiated in all adults with severe or advanced HIV clinical disease (WHO clinical stage 3 or 4) and adults with a CD4 count ≤350 cells/mm3
Pregnant and breastfeeding women	• ART should be initiated in all pregnant and breastfeeding women living with HIV, regardless of WHO clinical stage and at any CD4 cell count and continued lifelong.
Children younger than 10 years of age	• As a priority, ART should be initiated in all children <2 years of age or children younger than 5 years of age with WHO clinical stage 3 or 4 or CD4 count ≤750 cells/mm³ or CD4 percentage <25% and children 5 years of age and older with WHO clinical stage 3 or 4 or CD4 count ≤350 cells/mm³ • ART should be started in all TB patients living with HIV regardless of CD4 count • TB treatment should be initiated first, followed by ART as soon as possible within the first 8 weeks of treatment
Timing of ART for adults and children with TB	• HIV-positive TB patients with profound immunosuppression (e.g., CD4 counts less than 50 cells/mm3) should receive ART within the first two weeks of initiating TB treatment • ART should be started in any child with active TB disease as soon as possible and within 8 weeks following the initiation of antituberculosis treatment regardless of the CD4 cell count and clinical stage

BOX 11.20: INITIATING A MINIMUM PACKAGE OF ART SERVICES

- National policies are available and known, standard operating procedures and standard treatment protocols are in place. When available, national protocols should be followed. In the absence of a national protocol, WHO guidelines should be followed
- Trained clinic and community workers with competence in treatment protocols, patient counseling, and community mobilization are available
- A 6 month start-up supply of medicines, including ARV, co-trimoxazole, TB treatment and treatment for other opportunistic and co-infections, and a procurement system to assure an uninterrupted supply of required medicines is in place
- Diagnostic supplies and laboratory capacity, including at least HIV diagnostics, hemoglobin or hematocrit determination, CD4 cell counts, TB diagnostics, malaria and syphilis testing are available
- A patient monitoring system (including patient treatment cards to provide to patients on ART to allow for follow up and continued care in another health facility) and referral and communication networks is established
- Information packages for patient counseling, education and community mobilization exist

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

- Support to people living with HIV, including social protection and psychosocial support
- Treatment adherence support
- Patient information and education
- TB treatment and prophylaxis for opportunistic infections
- Family planning
- Food and nutrition support
- Community/home based care
- Palliative care

SUPPORT TO PEOPLE LIVING WITH HIV

Develop confidential programs to provide psychosocial support for people living with HIV. This may include individual counseling and support, support groups, or friends of people living with HIV and families to whom the patient has disclosed her/his/their HIV status.

Ensure that people living with HIV have non-discriminatory access to necessary food supplements and nutrition counseling through food assistance programs. Listing all eligible people without divulging reasons for their inclusion on the supplementary feeding lists helps avoid discrimination.

In humanitarian settings, people living with HIV need to be assured of an adequate supply of safe drinking water as they are more susceptible to infection and less able to recover from bouts of water-borne diseases. For similar reasons, provide people living with HIV with a long-lasting insecticidal net to reduce the risk of contracting malaria in endemic areas.

TREATMENT ADHERENCE SUPPORT

There are many reasons for which ART treatment adherence may be compromised in humanitarian emergencies, including low accessibility of services, lack of availability and accessibility of drugs, and poor quality of services provided. In addition, lack of acceptance or ability of the individual to adhere to the regimen may be influenced by factors including nutrition, stigma, and understanding about HIV and the benefits of ART by the patient. People living with HIV sometimes access ART from more than one health facility which makes follow-up difficult.

In order to support people to adhere to their drug regimen, a number of measures can be taken including:

- Advocating for food support
- Implementing strategies to fight stigma
- Fostering social support through treatment adherence support groups
- Promoting expert patients who can provide support on a one-to-one basis
- Undertaking efforts to increase the level of understanding about HIV and the positive effects of ART
- Providing travel health cards to ensure access to medications

PATIENT INFORMATION AND EDUCATION

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

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

TB TREATMENT AND PROPHYLAXIS FOR OPPORTUNISTIC INFECTIONS

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

To prevent other opportunistic infections in people living with HIV, cotrimoxazole is an effective, well tolerated and inexpensive antibiotic used to prevent pneumocystis pneumonia (PCP) and toxoplasmosis in adults and children with HIV. It is also effective against other infectious and parasitic diseases and demonstrates significant benefits in regions affected by malaria. Furthermore, all HIV-exposed children born to mothers living with HIV must receive cotrimoxazole prophylaxis, commencing at 4-6 weeks of age and continued until HIV infection can be excluded. In all cases follow national guidelines.

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

FAMILY PLANNING

People living with HIV must have access to family planning resources. Offer quality counseling on issues such as contraceptive methods when living with HIV, dual protection with both condoms and a pregnancy prevention method, emergency contraception, abortion, and availability of pregnancy support.

FOOD AND NUTRITION SUPPORT

People living with HIV are particularly vulnerable to food insecurity. There is a correlation between food insecurity and treatment adherence, retention, and success. Food insecurity and limited food consumption can reduce adherence to ART, which exacerbates illness and may lead to drug resistance, and increase transmission. Uninterrupted access to treatment, care, and food and nutrition support is crucial to ensuring adherence and preventing drug resistance and the need for expensive second and third line ART regimens.

Food and nutrition for people living with HIV plays a key role in improving retention and treatment outcomes. Most importantly, it reduces mortality risk among people living with HIV who are malnourished (body mass index (BMI) <18.5). Currently, malnourished people living with HIV are 2 to 6 times more likely to die when starting ART compared to people with optimal nutritional status. Given that the HIV epidemic is often most severe in food-insecure settings, food and nutritional assistance provides critical support to people and helps promote access and adherence to treatment and care in these resource-constrained settings. As part of the continuum of care, nutrition assessment and counseling should be included in the comprehensive package of treatment and care to support nutritional status and health. In specific situations, support, in the form of nutritious food, and household and/or livelihood support, may also be required.

Symptomatic people living with HIV require more calories than people who are HIV-negative. At the same time, HIV and associated opportunistic infections undermine the immune system, limiting nutrient intake, absorption, and use. In the absence of treatment, undernutrition weakens the immune system even further, which increases susceptibility to infections, lowers quality of life and increases mortality risk. Because of the significant association between low BMI and mortality among both people living with HIV and TB patients, patients should be treated for all three conditions (HIV, TB, and malnutrition) concurrently.

COMMUNITY/HOME-BASED CARE

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

PALLIATIVE CARE

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

BOX 11.21: IMPLEMENTING COMPREHENSIVE CARE FOR CHILDREN LIVING WITH HIV

Children present different challenges in the management of HIV especially in the diagnosis and treatment. The following actions are recommended for the care of children with HIV:

- **Early diagnostic approaches vs. Nucleic Acid Testing (NAT), including point of care diagnosis**
- **Base initiation of treatment for children on national guidelines**
- **Use WHO guidelines for clinical HIV diagnosis where diagnostic and monitoring facilities are not available**
- **When ordering syrup formulations, be prepared to have sufficient refrigerated storage space and a functioning cold chain as they come in large volumes**
- **In settings where the diagnosis of HIV in children born to HIV-positive mothers may be delayed due to lack of laboratory testing capacity, start these children on cotrimoxazole at 4-6 weeks of age, or on first contact with health services**
- **Where polymerase chain reaction (PCR) monitoring is not available, and in children < 18 months who are diagnosed clinically, counsel parents to seek confirmatory testing after 18 months of age with conventional antibody tests**
- **Unaccompanied minors and orphaned children need specific attention and may need to enter a special legal process or agreed upon guardian/caregiver arrangements**
- **The best interests of the child should drive all decisions**

11.3.8 Coordinating and making linkages

HIV prevention and treatment and people living with HIV service provision should be integrated with other elements of SRH including contraception, comprehensive abortion care, and GBV and STI prevention and response. Further, HIV programming is critical for adolescent sexual and reproductive health, maternal and newborn health, LGBTQIA health, and mental health programming.

Coordinating with agencies and stakeholders working with key at-risk populations and incorporating people living with HIV into the design and implementation of initiatives is crucial. Engagement with other sectors is also critical and should include:

- Working with the local/host community health system
- Coordinating with the local/host country justice/ security system
- Coordinating with respect to the supply chain for medical supplies, including ARVs, HIV testing kits, etc.
- Coordinating among sectors and stakeholders (government, international NGOs and UN agencies working on the displaced/refugee program), to integrate HIV and HIV prevention messages in:
    - Protection: Protect against HIV-related human rights violations, orphans and unaccompanied.
    - Education: Promote access to relevant and proactive sexual education for all children and young people (see Chapter 6)
    - Shelter: Integrate HIV in shelter activities
    - Food security, nutrition and livelihood support: Ensure food security, nutrition and livelihood support and provide nutritional support to people living with HIV
    - Camp coordination: Integrate HIV in camp coordination and camp management.
    - Water, sanitation and hygiene: Integrate HIV in water, sanitation and hygiene programs
- Coordinating with human rights organizations and other local organizations

11.3.9 Advocacy

In humanitarian settings, advocacy for HIV is fundamental to securing equitable access to HIV and health services. Hostile policies, marginalization of vulnerable groups, criminalization of key populations, and inadequate funding are barriers requiring strong advocacy efforts. Significant advocacy is often required to secure buy-in and support from national governments, local authorities, and international partners and donors. SRH Coordinators and health program managers should advocate to relevant stakeholders to ensure that populations affected by emergencies have access to quality HIV prevention, care, and treatment services including treatment for opportunistic infections. It is particularly necessary to advocate for MISP interventions in the acute phase of the emergency and then to progressively and consistently advocate for comprehensive services as the emergency stabilizes.

All SRH actors should:

- Advocate for and create awareness of the importance of integrating HIV within emergency preparedness during the pre-crisis period through inclusion in the humanitarian response plan to ensure that HIV interventions are promptly implemented once a crisis occurs
- Advocate for national HIV policies to be aligned with the latest WHO guidelines and that displaced people are integrated into the national HIV policy, programming, and resource allocation. These populations are often overlooked
- Advocate for the provision of basic assistance to people living with HIV who are chronically ill, including adequate shelter, nutritional support, and palliative care. Because people living with HIV often have higher nutritional needs, include advocacy for additional nutritional provisions
- Advocate for cross-cutting health system strengthening to ensure durability of services and infrastructure. This is often challenging, but it is important to have a long-term view of disaster response and mitigation.
- Advocate for the inclusion of people representing affected communities in local, regional, and national coordination forums. It is especially important to

ensure the involvement of communities in creating local solutions in order to strengthen ownership and effectiveness of services

- Advocate for adoption and introduction of effective interventions at all levels. For instance, advocacy for inclusion of PrEP in national guidelines could be essential in countries that have yet to adopt it
- Advocate for children's and women's rights and gender-sensitive policies and interventions. Women, young girls, and children are at risk of sexual violence, abuse, and exploitation especially in emergency settings. Protecting children and women is a priority. To mitigate gender inequalities, gender-based violence and exploitation, advocacy for girls' education, economic empowerment and rights is often necessary. In addition, advocacy for gender-sensitive interventions and response programs to gender-based violence that are linked to HIV prevention is often essential
- Advocate for SRH information and services for adolescents, especially girls and key young populations. This includes advocacy on meeting contraceptive needs for women
- Advocate against social and structural drivers of stigma and discrimination of people living with HIV and key populations. This may include attitudes, employment practices, or legislation and laws that stigmatize or discriminate against these populations. Where there are legal obstacles to accessing evidence-based HIV prevention (for example needles and syringe or OST for people who inject drugs), care, and treatment, advocate for these to be repealed
- Advocate and support governments to meet their accountability obligations under international human rights commitments and national policies. This may include advocacy related to government and donors fulfilling their commitments to providing the best possible care to people regardless of their displacement status, migration, race, and other characteristics and that these services meet accepted minimum standards

11.4 HUMAN RIGHTS AND LEGAL CONSIDERATIONS

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

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

their HIV status will be disclosed or revealed

- The right to access asylum procedures and protection from expulsion and refoulement. For those who are asylum seekers, their HIV status does not constitute a bar to accessing asylum procedures. The right to be protected against refoulement is the cornerstone of international refugee law and HIV status is not a ground for any exception to this principle. HIV status would also not fall within the permitted grounds for expulsion to a third country
- The right to HIV-related protection measures for women, girls and boys. Women and girls are disproportionately affected by HIV and AIDS and gender inequality can play a significant role in the protection problems they face, including increased exposure to violence. Appropriate measures need to be taken to ensure their protection against sexual or physical violence and exploitation. Special attention must also be paid to children affected by HIV, including those orphaned or otherwise made vulnerable by HIV
- The right for people in prisons to access health services equivalent to the community. Health care in prisons should have the same standards, same ethics, adapted to the needs and linked to health services in the community

States have recognized the importance of gender equality, empowerment, and participation of women and girls in all aspects of HIV prevention and response. In particular, gender-specific protection must be adequately addressed and special attention must be paid to the health needs of women and girls, including ensuring access to reproductive health care and services, and appropriate counseling and treatment in all cases of sexual and gender-based violence.

Children are entitled to special protection under international law, as highlighted in the UN Committee on the Rights of the Child. In particular, the Convention on the Rights of the Child specifies that non-discrimination, best interests of the child, the right to life, survival and development, and participation of the child should guide the responses in all cases involving children.

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

11.5 MONITORING AND EVALUATION

If collected systematically across sectors and agencies, the set of indicators listed on Table 11.3 can help gauge the degree to which the set objectives of the multi-sectoral response are achieved. The information collected will help HIV program planners and managers, as well as humanitarian actors, to monitor whether:

- HIV preparedness is in place for an emergency situation
- The required HIV interventions, for both the MISP and comprehensive services, are in place during a humanitarian crisis
- The needs of key populations at higher risk of exposure to HIV and other groups at-risk are adequately addressed
- The desired coverage and impact of the intervention is achieved

TABLE 11.3 PRIORITY INDICATORS

NAME	DESCRIPTION	FORMULA	STANDARD	REMARKS
Quality of blood donation screening	Percentage of donated blood units screened for HIV in a quality assured manner	Number of donated blood units screened for HIV in a quality assured manner/Total number of donated blood units screened x 100	100%	Measure blood safety for transfusion. Assumes blood transfusion kits are available and used correctly
PMTCT coverage	Proportion of first time ANC visits who were pre-test counseled	Number of first ANC visits pre-test counseled/Number of first ANC visits	100%	
PMTCT post-test counseling and result	Proportion of first ANC visit clients tested for HIV, who receive post-test result and counseling	Number of first ANC visit clients who receive post-test result and counseling/Number of first ANC visit clients tested for HIV x 100	100%	Indirect measure of the quality of counseling and testing within a PMTCT program
Coverage of ARV in PMTCT programs	Percentage of HIV-positive pregnant women receiving ART to reduce the risk of mother-to-child transmission	Number of pregnant women who swallowed ARV according to protocol/Total number HIV positive deliveries x 100	100%	
Coverage of ART among infants	Percentage of infants born to HIV-infected women receiving antiretroviral (ARV) prophylaxis for PMTCT			
ART Coverage	Percentage of people living with HIV receiving ARVs (according to national protocol)			

11.6 FURTHER READING AND ADDITIONAL RESOURCES

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