HIV/AIDS FIELD GUIDE

A PLANNING AND PRACTICE GUIDE TO INTEGRATING HIV/AIDS INTO THE ICRC'S HEALTH WORK

ICRC

REFERENCE

ICRC

International Committee of the Red Cross
19, avenue de la Paix
1202 Geneva, Switzerland
T + 41 22 734 60 01 **F** + 41 22 733 20 57
E-mail: shop.gva@icrc.org **www**.icrc.org

HIV/AIDS FIELD GUIDE

A PLANNING AND PRACTICE GUIDE TO INTEGRATING HIV/AIDS INTO THE ICRC'S HEALTH WORK

CONTENTS

ABBREVIATIONS 4
FOREWORD 6
ACKNOWLEDGEMENTS 8

SECTION 1: CONTEXT 9
1.1 About the field guide 10
1.2 ICRC policy 12
1.3 HIV/AIDS and conflict 14

SECTION 2: ASSESSMENT AND PLANNING 17
2.1 Introduction 18
2.2 Assessing the conflict environment 19
2.3 Assessing the humanitarian environment 19
2.4 Assessing the HIV/AIDS environment 20
2.5 Introduction to the Planning Guides 27
2.6 Sample Planning Guide: Sick and wounded 29
2.7 Sample Planning Guide: IDPs 32
2.8 Sample Planning Guide: People deprived of freedom 35

SECTION 3: MONITORING AND EVALUATION 39
3.1 National targets 40
3.2 Developing indicators for HIV/AIDS integration 41

ANNEX 1: ACTION GUIDES 43
Using the Action Guides 44
Action Guide 1: Universal precautions and safe blood supply 45
Action Guide 2: Integrating HIV/AIDS into maternal and child health services 50
Action Guide 3: Strengthening HIV/AIDS prevention and care in detention settings 59
Action Guide 4: Strengthening HIV prevention through the integration of STI treatment into primary health care 67
Action Guide 5: Supporting victims of sexual violence 72
Action Guide 6: HIV/AIDS treatment, care and support 79
Action Guide 7: HIV counselling and testing 90
Action Guide 8: Targeted approaches for sub-populations most at risk 99

ANNEX 2: PLANNING TEMPLATES 103
Planning template: Sick and wounded 104
Planning template: IDPs 105
Planning template: People deprived of freedom 106

ABBREVIATIONS

3TC	lamivudine
ABO	blood grouping
AIDS	acquired immune deficiency syndrome
ARV	antiretroviral drugs
ART	antiretroviral therapy
AZT	azidothymidine
BSS	behavioural surveillance survey
CCM	Country Coordinating Mechanism
HIV	human immunodeficiency virus
HPV	human papilloma virus
IASC	Inter-Agency Standing Committee
ICRC	International Committee of the Red Cross
IDP	internally displaced person
IPT	isoniazid preventive therapy
KAP	knowledge, attitudes and practices survey
MCH	maternal and child health
M&E	monitoring and evaluation
MSM	men who have sex with men
NGO	non-governmental organization
NNRTI	non-nucleoside reverse transcriptase inhibitor
NVP	nevirapine
OI	opportunistic infection
PCP	*Pneumocystis jiroveci* pneumonia, formerly *Pneumocystis carinii* pneumonia
PEP	post-exposure prophylaxis

PEPFAR	US President's Emergency Plan for AIDS Relief
PfR	Planning for Results
PHC	primary health care
PID	pelvic inflammatory disease
PMTCT	prevention of mother to child transmission of HIV
RTI	reproductive tract infection
STI	sexually transmitted infection
TB	tuberculosis
TBA	traditional birth attendant
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNGASS	United Nations General Assembly Special Session on HIV/AIDS
UNODC	United Nations Office on Drugs and Crime
VCT	voluntary counselling and testing
WHO	World Health Organization

FOREWORD

The ICRC exists to protect the lives and dignity of victims of armed conflict and other situations of violence and to provide them with assistance. The rationale for its commitment to respond to HIV/AIDS thus springs from the increasing prevalence of HIV in those situations in which the organization is active.

The 28th International Conference of the Red Cross and Red Crescent, held in Geneva in 2003, adopted the Agenda for Humanitarian Action in which the components of the International Red Cross and Red Crescent Movement resolved, among other things, to enhance the protection of victims of armed conflict and other situations of violence and to reduce the risk and impact of diseases.[1] General objective 4 of the Agenda aims to reduce the devastating consequences of HIV/AIDS and other diseases faced, in particular, by groups that are stigmatized, discriminated against or socially marginalized because of their situation or circumstances and often lack access to comprehensive prevention, treatment, care and support.

HIV risk and vulnerability can be exacerbated by armed conflict. This may be because levels of sexual violence increase, because the displacement of communities leads to the breakdown of families and community norms or because communities are cut off from public health messages and services. During armed conflict, people living with HIV/AIDS, like other people with chronic and life-threatening illnesses, may be deprived of health services and require assistance to restore or maintain their health. In keeping with its mission to work

1 28th International Conference of the Red Cross and Red Crescent, *Protecting Human Dignity: Declaration, Agenda for Humanitarian Action, Resolutions*, December 2003.

as closely as possible with the people affected by conflict or violence, the ICRC needs to ensure that attention to issues of HIV/AIDS vulnerability, risk and care is included in its assessments, planning and ongoing work.

This field guide provides the ICRC with a flexible tool for making decisions about how and when the organization needs to incorporate attention to HIV/AIDS into its work, with emphasis on a multidisciplinary approach enabling coordination between health programmes, wider assistance programmes and protection programmes. The type of response will depend on the nature of the conflict, on the extent of HIV/AIDS infection in the population and on the availability of support from other stakeholders.

This field guide should be kept on hand as a working tool. It is hoped that it will enhance ICRC interventions in the countries where it is working, resulting in more effective protection of the victims of armed conflict.

Pierre Krähenbühl
Director of Operations

ACKNOWLEDGEMENTS

Julia Cabassi, HIV and Development Consultant, and Lou McCallum, Director of the AIDS Projects Management Group (APMG), researched and wrote the HIV/AIDS Field Guide under the supervision of the ICRC's Health Unit.

ICRC staff, including staff from the Health Unit and Operations and health staff in the field, commented on the draft.

The field guide was developed with funding assistance from AusAID, the Australian government's overseas aid programme.

SECTION 1:
CONTEXT

1.1 About the field guide

Purpose of the guide

The field guide is designed to assist the ICRC in responding to HIV/AIDS as an integral part of its core health activities. It provides:

- guidance and decision-making tools to help delegations decide *what* to do in response to HIV/AIDS among specific populations in a given context;
- guidance on *how* to integrate HIV/AIDS into core health activities.

Annex 1 contains a series of Action Guides that summarize information on key topics and options for action. These need to be read in conjunction with more detailed technical resources, references to which are provided in each Action Guide.

The guide is also designed to help delegations find strategic entry points to respond to HIV/AIDS as part of the work they do in a given setting and, over time, to build the whole organization's capacity to respond to HIV/AIDS as an integral part of its work.

The aim of the HIV/AIDS Field Guide is to achieve
a consistent approach when considering
an HIV/AIDS response in each setting,
not uniformity of the response in all settings.

Scope and audience

The field guide sets out ways in which the ICRC can integrate HIV/AIDS into its core health activities by adopting strategies to reduce the spread of HIV or to address the impact of HIV/AIDS on its target populations. Its primary focus is HIV/AIDS. Tuberculosis (TB) is covered to the extent that it relates to HIV, as a common co-infection among people living with HIV/AIDS. Guidance on TB programming, particularly with respect to detention, already exists.[2]

2 See: A. Bone *et al.*, *Tuberculosis control in prisons: A manual for programme managers*, ICRC/WHO, 2004; L. Stove *et al.* (eds), *Health in prisons: A WHO guide to the essentials in prison health*, WHO, 2007, chap. 8.

A multi-sectoral approach is essential to address vulnerability to and the impact of HIV/AIDS effectively. Addressing the complex issues surrounding HIV/AIDS requires the cooperation of people from a range of disciplines and coordination between health programmes, wider assistance programmes and protection programmes. For example, ensuring safe access to potable water, adequate shelter and economic security reduces vulnerability to HIV/AIDS infection. Existing resources already deal with these issues, although they may not mention that such efforts contribute to reducing vulnerability to HIV/AIDS.[3]

The content of this field guide is aimed primarily at ICRC health coordinators, delegates and field officers, but it is also relevant for delegation management staff, technical support staff and others involved in planning and implementing the work of the ICRC.

How to use the guide

The field guide will:

→ assist delegations in:
- understanding HIV/AIDS in their specific contexts;
- making strategic decisions about what they are best placed to do to respond to HIV/AIDS, particularly in the framework of the ICRC's annual Planning for Results (PfR) exercise;
- responding to HIV/AIDS as an integral part of their core activities;

→ assist the Health Unit's heads of sector in:
- ensuring HIV/AIDS is being taken into consideration when assessing delegations' annual PfR plans;
- incorporating attention to HIV/AIDS in the monitoring and planning undertaken through the Equipes Régionales de Coordination and other relevant processes;

→ provide staff of the Health Unit at ICRC headquarters with guidance in and resources for delivering technical assistance to the field.

3 For example: ICRC, *Addressing the needs of women affected by armed conflict: an ICRC guidance document*, March 2004; ICRC, *Water, sanitation, hygiene and habitat in prisons*, 2005; Inter-Agency Standing Committee (IASC), *Guidelines for HIV/AIDS interventions in emergency settings*, 2003.

1.2 ICRC policy

A number of key policy documents provide the foundations for this guide.[4]

In the Declaration and Agenda for Humanitarian Action adopted by the 28th International Conference of the Red Cross and Red Crescent in December 2003, the Movement committed to undertake specific actions to "reduce the impact of HIV/AIDS and other infectious diseases with regard to vulnerable people".[5] The proposed actions relevant to the ICRC's work are to:

- undertake operational measures aimed at ensuring continuous progress in the availability of treatment and care for people living with HIV/AIDS, with an emphasis on reaching marginalized groups that do not have ready access;
- carry out awareness and education activities aimed at creating a positive, socially inclusive workplace environment for staff, volunteers and beneficiaries;
- implement socially inclusive prevention and health care interventions appropriate for displaced and marginalized populations;
- address, in a multi-sectoral and coordinated manner, the problems associated with HIV/AIDS in armed conflict, disasters and emergencies, recognizing the special vulnerability and capacity of displaced populations, host communities, military and peacekeeping personnel;
- address the special needs and vulnerabilities of people affected by HIV and AIDS in emergency situations, with special attention to food security;
- implement polices and operational measures in prisons to create a safer environment and reduce the risk of transmission of HIV, TB and other diseases among detainees, prisoners and staff.[6]

4 The key policy documents discussed in this section relate to ICRC programming. The ICRC has also endorsed an internal human resources HIV/AIDS policy and operational guidelines.

5 28th International Conference of the Red Cross and Red Crescent, *Protecting Human Dignity: Declaration, Agenda for Humanitarian Action, Resolutions*, December 2003.

6 *Ibid.*, see paras 4.1.5–4.1.6 and 4.2.1–4.2.5. These are the specific "Actions proposed", on which the ICRC reported to the 29th International Conference of the Red Cross and Red Crescent in November 2007.

The ICRC Assistance Policy Doctrine 49 provides broad guidance, including a strategic approach, and defines the core areas of assistance work.[7] The following core health activities set out in the doctrine are particularly relevant to HIV/AIDS:

- supporting a minimum package of primary health care (PHC) activities, including maternal and child health (MCH) and outpatient curative care using essential drugs;
- support for victims of sexual violence;
- emergency hospital care;
- health in detention.

The ICRC's *Operational framework in regard to HIV/AIDS for victims of armed conflict*, endorsed in 2004, forms part of the organization's Assistance Policy and provides a basic framework for responding to HIV/AIDS in conflict settings. In this document, there is a clear emphasis on working with national HIV/AIDS programmes and on ensuring that the ICRC's contribution to these programmes is in line with its core assistance and protection functions. The framework is supported by supplementary guidelines on HIV/AIDS in prisons, which call for an in-depth local assessment of the nature and extent of HIV/AIDS in a prison setting before decisions are made about possible interventions and for the adoption of a public health approach that is integrated with national efforts.[8]

7 ICRC Assistance Policy: Doctrine 49, Adopted by the ICRC Assembly on 29 April 2004.

8 ICRC, *Supplementary Guidelines to the ICRC's operational framework in regard to HIV/AIDS for victims of armed conflict*, March 2006.

1.3 HIV/AIDS and conflict

The rationale for the ICRC's commitment to respond to HIV/AIDS as an integral part of its work is the increasing prevalence of HIV in the contexts in which the organization works. Many of the world's conflict zones are also places where the burden of HIV/AIDS is very high. In addition, existing HIV epidemics are fuelled by factors that exist in conflict settings, including:

- the forced displacement of communities;
- increased levels of sexual violence and exploitation of women and girls;
- increased incarceration and overcrowding of prisoners and detainees;
- the breakdown of community and State structures and services.

The ICRC is active in a context at the very time that the potential exacerbation of HIV transmission takes place, and the people most affected by it are those that the ICRC is seeking to assist and protect. The presence of HIV/AIDS also affects the ability of a community or nation to recover from a conflict, as illness and death from HIV/AIDS depletes the workforce, erodes community capacity and places an additional strain on public health and welfare systems.

Conflict does not always exacerbate the spread of HIV. Reduced mobility to high prevalence urban areas and the isolation and inaccessibility of some populations, such as internally displaced persons (IDPs), can in some cases offer temporary protection from surrounding epidemics.[9] In such cases, integrated HIV prevention nonetheless becomes necessary as people's isolation decreases and displaced communities come in contact with surrounding host populations.

The ICRC has a unique role in prisons and other detention settings. Even in countries with a low HIV prevalence, detention settings are often where an HIV epidemic is concentrated. In fragile States, living conditions in places of detention are

9 P.B. Spiegel, "HIV/AIDS among conflict-affected and displaced populations: dispelling myths and taking action", *Disasters,* September 2004, Vol. 28, No. 3, pp. 322–339.

particularly poor. Insufficient resources are made available for the adequate provision of food, shelter, water and sanitation. Health services are weak or non-existent and there is often poor coordination between the health and justice sectors. Weakened or inefficient judicial systems result in increased numbers of people on remand, awaiting trial. Overcrowding, sexual violence, and alcohol and drug use increase HIV and TB risk.

The United Nations (UN) General Assembly's commitment to work towards universal access to HIV prevention, treatment and care by 2010 will see a rapid expansion of HIV/AIDS and TB programmes worldwide. Overcoming obstacles to HIV/AIDS and TB prevention and treatment in conflict and detention settings will be crucial to achieving these global targets. The ICRC is uniquely placed to strengthen the global response in this area.[10]

It is anticipated that the universal access agenda will fundamentally change the way that HIV/AIDS treatment and care are delivered. Systems for drug pricing and procurement are being reviewed and strengthened. Treatment and care access points are expanding in many countries, in an effort to increase the number of people who are aware of their HIV status and able to access treatment and care. As the global effort increases, more people with HIV/AIDS will be on antiretroviral therapy (ART) and their access to treatment and medical care will need to be ensured, to avoid increased morbidity and mortality and the development of drug-resistant strains of the virus.

10 The ICRC's work to assist countries in developing their Global Fund applications and/or to participate in Country Coordinating Mechanisms (CCMs) in Armenia, Azerbaijan, Georgia and Kyrgyzstan are examples of its contribution to this process.

SECTION 2:
DECIDING WHAT TO DO – ASSESSMENT AND PLANNING

2.1 Introduction

Section 2 sets out a process for deciding when and how to respond to HIV/AIDS from within the ICRC's core work in countries affected by armed conflict or violence.

Assess the environment that the ICRC is working in:
- The conflict environment
- The humanitarian environment, including basic needs and the leading causes of preventable illness and death

Assess the HIV/AIDS environment:
- The extent of HIV/AIDS
- Risk factors
- The nature of the HIV/AIDS response – policy and programmes
- The critical gaps in the response to HIV/AIDS for the ICRC's target populations

Use Planning Guides to define ICRC action:
- Determine priorities for addressing the gaps
- Determine the right combination of modes of action: persuasion, mobilization, support, substitution

The contexts in which the ICRC works are complex and diverse. There are many different factors that influence both the need to respond to HIV/AIDS and the feasibility of doing so. The landscape is often extremely dynamic. Situations can change rapidly and opportunities for intervention come and go. What is clear is that ICRC policy commits the organization to take into account how HIV/AIDS affects the populations it works with and to take action to address the vulnerability of these populations to HIV infection and the impact on them of HIV/AIDS.

The conflict and humanitarian environments constitute the overall context within which a more detailed consideration of the HIV/AIDS environment takes place.

2.2 Assessing the conflict environment

The stage and degree of a conflict determine the kinds of intervention that are desirable and feasible in a given context. The *degree* of insecurity and the *stage* of the conflict, whether in its early stages, protracted or transitional, affect what can and needs to be done and how the ICRC is positioned to contribute and exert influence. The nature and stage of the conflict also influence the level of the ICRC's involvement in a country and this in turn affects the opportunities for and barriers to taking up particular issues.

The degree of stability and the extent to which a State is functioning and its infrastructure is affected by conflict are further critical factors in determining what the ICRC can do and the modes of action it will choose.

2.3 Assessing the humanitarian environment

Generally, in planning ICRC programming, consideration will be given to:

- → the target population size and demographics;
- → the death rate;
- → the leading causes of preventable illness and death;
- → existing resources and services for target populations in respect of:
  - health;
  - nutrition;
  - water, sanitation and habitat;
  - food and economic security;
  - protection.

Assessing basic needs and planning how to address them are the foundations of more complex preventive and curative interventions. The next stage is to identify the leading causes of preventable illness and death and to map the services and programmes available to the ICRC's target populations and which organizations are already active in this area. Doing so will assist the ICRC in determining its most appropriate role in the multi-sectoral response. Participation in HIV/AIDS and health-sector-wide coordination bodies is essential for the ICRC to make the most appropriate contribution over time.

Once the above assessments have been carried out, consideration should be given to the most appropriate modes of action to address the needs identified. This field guide sets out a range of services and programmes that need to be in place in order to respond effectively to HIV/AIDS. Depending on the context, decisions will be made as to whether the ICRC's role will be to support existing health services, to mobilize others to fill gaps in services or to persuade the government to fulfil its responsibility to meet the needs of the target populations. Often a combination of these modes of action is required.

This field guide introduces the concept of strategic substitution. This involves the provision of goods and services on a short-term basis, combined with specific action to address obstacles to the provision of these goods and services by the government or other providers. This approach recognizes the need to strike a balance, particularly in relation to HIV/AIDS, between short-term health gains and long-term sustainability.

2.4 Assessing the HIV/AIDS environment

In addition to assessments of the conflict and humanitarian environments, an assessment of the HIV/AIDS environment is needed to examine:

- → the extent of the HIV/AIDS problem;
- → risk factors of particular relevance in a given setting;
- → the response to HIV/AIDS – both in terms of policy commitments and the services and programmes available in a given context.

What is known about the number of people living with HIV/AIDS

Even though reliable data on HIV prevalence at population level or among specific populations, such as IDPs and detainees, are not always available, some assessment of the burden of disease from less formal data sources will usually be possible and is critical to decision-making.

What is known about who is becoming HIV infected and why?

Good programming requires an understanding of the factors driving HIV transmission in a country and within specific populations and settings. For example:

- The movement of people into camps or dispersed in communities often disrupts livelihoods, increasing poverty and breaking down the cohesion of communities and the social norms that regulate behaviour.
- Inadequate food and shelter can force women and girls into situations where they engage in transactional sex to meet their basic needs.
- Consensual or non-consensual unprotected sex between men, as well as injecting drug use, in prisons increases HIV transmission in an environment where HIV is often already concentrated.
- Where injecting drug use is common prior to the onset of conflict, HIV risk transmission can increase due to sharing of needles
- Unemployment and boredom in IDP camps often increase men's alcohol intake and affect their ability to protect themselves and their families from HIV infection.

The table below sets out the key issues to examine in an assessment of the HIV/AIDS environment, guiding questions and examples of the data sources that may help to answer these questions.

Most countries have a national AIDS policy or strategy that guides the government's response. Many are guided in part by a Country Coordinating Mechanism (CCM) or national AIDS council or authority. These structures may or may not be functioning, depending on the extent and nature of the conflict. If they do not exist or are not functioning, there is usually an informal mechanism in place, often involving donors and international agencies.

HIV/AIDS policy commitments and coordinating mechanisms provide key leverage for the ICRC to ensure that people in conflict-affected areas have access to HIV prevention, treatment and care equivalent to those available in unaffected

areas of a country. The ICRC's agenda for improving such access needs to be consistent with, and support the achievements of, national HIV/AIDS policy and programme priorities.

Key issues	Guiding questions	Examples of data sources
Extent of the HIV problem	• What is the HIV prevalence in the country and in the geographical area where the ICRC is working? • What is the HIV prevalence among different population groups and has this changed over time? • Who is being hospitalized with HIV-related illnesses? (hospital data on HIV/AIDS morbidity and mortality)	• Surveillance data: UNAIDS, Ministry of Health, health agencies, donors • Behavioural surveillance surveys (BSS) and knowledge, attitudes and practices (KAP) surveys • Local hospital morbidity and mortality data • Trends in AIDS case surveillance reporting • New TB cases • Voluntary blood-donor testing • STI incidence and trends disaggregated by syndrome • Percentage and trends of hospital bed occupancy • HIV and AIDS information from areas of origin of displaced populations • Sentinel surveillance of pregnant women • Sentinel surveillance of high-risk sub-groups (e.g. STI clinics, injecting drug users) • Voluntary counselling and testing services • Prevention of mother to child transmission (PMTCT) services • Post-exposure prophylaxis (PEP) services • Incidence and trends of gender-based violence
Risk factors	• Who is becoming infected with HIV and why? • Are there sub-groups at particular risk? e.g. women and girls involved in transactional sex for food, protection (see Action Guide 8: Targeted approaches for sub-populations most at risk)	• BSS • Social research data from the country or from neighbouring countries with similar populations • Participatory site assessments from NGOs, donors, etc. • Key informant interviews with target populations and service providers

Key issues	Guiding questions	Data sources
Nature of the HIV response: policy	• Does the national HIV/AIDS plan explicitly address the ICRC's target populations? • What is the national plan trying to achieve? e.g. targets and indicators for service access, pre-conflict targets set by the UN General Assembly Special Session on HIV/AIDS (UNGASS)? • How is the national HIV response coordinated? • What is the mechanism for coordination? e.g. CCM or UN theme group • Does the mechanism include key players – government, donors and civil society? • Does the mechanism guide programming priorities at local level?	• National HIV/AIDS plan and related documents, including guidelines, protocols, training materials • Human resources task division (place of counsellors) • Related national strategies – TB, drugs • Donor assessments and reports, e.g. USAID, UK Department For International Development • Proposals to the Global Fund to Fight AIDS, Tuberculosis and Malaria, the US President's Emergency Plan for AIDS Relief (PEPFAR), etc. • Government documents, e.g. UNGASS reports • UN theme group reports • Civil society reports, including associations of people living with HIV/AIDS
Nature of the HIV response: programmes and services	• What HIV prevention, treatment, care and support services and programmes are available? • How effective are they in reaching the ICRC's target populations? • What systems challenges exist? e.g. lack of patient tracking, effective referral and coordination, absence of protocols, lack of drugs and supplies • What are the key barriers to access? e.g. level of stigma, level of HIV/AIDS awareness in communities, health-seeking behaviour, health system cost recovery and indirect costs • How is the implementation of programmes coordinated? e.g. geographically, by population sub-group, by service	• KAP survey and BSS • Information from service providers and communities • Service use data • Referral protocols • District work plans • Health sector work plans • Donor project documents and plans • Civil society reports, including associations of people living with HIV/AIDS

Elements of a comprehensive HIV/AIDS response

The map of available services, developed as part of the assessment of the HIV/AIDS environment, needs to be compared with the range of interventions required for a comprehensive health sector response to HIV/AIDS in order to identify the critical gaps in services and programmes for the ICRC's target populations.

The table below provides a summary of the key elements of a health sector response to HIV/AIDS. This will ensure a strategic and informed approach that enables the ICRC to take on a role in responding to HIV/AIDS in a given context in a way that addresses the critical gaps in services for its target populations and enables it to choose the responses or approaches that it is best placed to provide. It will also ensure that the ICRC's role is an integral part of national and local responses to HIV/AIDS, promoting consistency and sustainability and minimizing duplication.

Responding effectively to HIV/AIDS is a complex, multi-sectoral task. Working in partnership with others is essential to avoid duplication and achieve the level of coverage and reach that will make prevention and care initiatives successful. Sustainability is more likely if assistance is in line with national plans, policies and procedures.

Goal	Strategies	Health sector interventions
Prevent sexual transmission	• Increase knowledge, skills and power to prevent transmission • Increase access to condoms – male and female • Provide care for victims of sexual violence	• Community mobilization and education • Behaviour change communication, including safer sex campaigns • Targeted interventions, e.g. peer outreach, for populations most at risk • Condom social marketing, condom availability • PEP availability
	• Reduce STIs	• Prevention and treatment of STIs through PHC
	• Improve access to male circumcision	• Access to male circumcision
Prevent mother to child transmission	• Reduce transmission to children born to HIV-positive mothers • Improve the health of mothers living with HIV/AIDS	• Prevention of unintended pregnancies in HIV-positive women • Access to comprehensive antenatal care • Promotion of and access to HIV counselling and testing for pregnant women and their partners • ART for mother and newborn to prevent transmission from mother to child • Counselling on strategies to reduce the risk of HIV transmission via breastfeeding – feeding options • Provided in setting, including MCH, PHC
Prevent transmission through blood	• Prevent transmission among injecting drug users	• Information and education through outreach • Access to sterile injecting equipment • Access to drug treatment and drug substitution programmes • Access to PHC, including HIV counselling and testing, treatment, care and support • A supportive legal and policy environment for harm reduction
	• Prevent transmission in health care settings	• Policy and operational guidance on universal precautions • Access to commodities, e.g. needles, syringes, gloves • Safe disposal of sharps and other (contaminated) waste • Policy and procedures for safe blood transfusion, PEP availability

Goal	Strategies	Health sector interventions
People know their HIV status and are able to take action	• Improve knowledge of status to enable people to protect themselves or others from HIV and gain access to prevention, treatment, care and support services	• Supportive testing policy environment and guidelines for implementation • Promotion of and access to HIV counselling and testing integrated into appropriate services, including MCH, STI services, PHC, programmes reaching marginalized groups • HIV counselling, including individual and couple counselling and supported disclosure and services for children • Effective referral to prevention, treatment, care and support
Improve health and life expectancy for people living with HIV/AIDS	• Ensure people living with HIV/AIDS are able to access treatment, care and support when and where they need it	• Provision of acute care by district hospitals • PHC access to: • opportunistic infection (OI) prevention and treatment • clinical care, including ART, psycho-social support, prevention support • Community care and support: • adherence support • home-based and community care • peer support
Programmes supported by an enabling environment	• Ensure evidence-based policies and procedures are effectively implemented at national, district and service level • Address barriers to knowledge of HIV status and reduced access to prevention, treatment, care and support	• Participation in coordination mechanisms • Quality assurance to ensure compliance with national and service policy and procedures • Health stigma and discrimination reduction programmes within communities

2.5 Introduction to the Planning Guides

This sub-section takes the ICRC's three main target populations – sick and wounded, people internally displaced by conflict, and people deprived of freedom – and sets out a mechanism for prioritizing the integration of HIV prevention and care initiatives for each one according to the status of the conflict.

The Planning Guides are intended as tools for discussion, debate and planning. The sample Planning Guides given here are examples of how they might look when completed. Blank planning templates are also provided for delegations or sub-delegations to use when considering what to do to respond to HIV/AIDS for specific populations of concern (see Annex 2). These can be used as part of the ICRC's PfR process, tailored to a particular context.

When using these templates, the following issues need to be kept in mind:

- Overlap in target populations:
  - People deprived of freedom are also members of the community affected by the conflict. They are released into the community and they have families who live in the community.
  - IDPs are sometimes living in camps and are sometimes dispersed in the general community affected by the conflict. They are sometimes sick or wounded.
- Conflicts do not usually follow a linear pattern from crisis to chronic crisis to post-crisis. They are generally dynamic, with periods of relative calm and recovery interspersed with periods of acute conflict or warfare.
- The crisis, chronic crisis and post-crisis phases will vary in duration, from months in some cases to many years in others.
- A different blend of strategic substitution, support and persuasion is required to solve different problems and this blend changes over time according to the circumstances.

The Action Guides in Annex 1 complement the Planning Guides. They provide more detailed guidance in each of the main intervention areas and should be used in conjunction with the planning templates when deciding what to do in a given context.

The starting points given in each Planning Guide for the integration of particular prevention and care initiatives are indications only. They are meant to prompt a consideration and an examination of the need for and feasibility of providing that particular intervention, at that level of the system, at that time in the conflict or transition. The approach that is eventually taken will depend on circumstances, and the narratives accompanying each Planning Guide cover the range of possible approaches and circumstances.

2.6 Sample Planning Guide: Sick and wounded

Domain	Intervention	Mode
District hospital	**Infection control policies, procedures, training and supplies** **Access to safe blood (with HIV screening of donated blood)** **Restoration of district hospital inpatient and outpatient services** Systems: Drugs and supplies management, human resources management, systems guidance Services including: • STI services, support to victims of sexual violence (emergency contraception and STI prevention or treatment) • TB and OI treatment, PEP for victims of sexual violence • HIV counselling and testing • PMTCT, OI prophylaxis, ART • Laboratory and diagnostic services	Substitution, support and mobilization
District health administration	**Assist with priority setting in line with national policy** **Participate in coordination**	Support and persuasion
National	**Participate in coordination** **Drugs and supply systems** **Service protocols, e.g. PEP, PMTCT**	Persuasion
	Crisis → Chronic crisis → Post-crisis	

The Planning Guide for sick and wounded suggests what to consider and when in responding to HIV/AIDS in providing for the sick and the wounded, whether it is in field hospitals or through support to existing hospitals.

Surgical and medical care for the war-wounded

The entry points for setting up care of the sick and the wounded vary enormously. At the height of the conflict, emergency surgical and medical care for combatants and civilians is the highest priority. As conflict subsides, the priority shifts to assisting in the restoration of inpatient and outpatient services (see below).

Universal precautions

When establishing a stand-alone field hospital, guidelines for universal precautions (also known as infection control), supplies and expertise would need to be included in the set-up in order to minimize the risk of HIV transmission during surgery and care. When supporting a district hospital, it may be necessary to substitute supplies until government supply systems can be restored. Building hospital services up from the ground will also usually involve the development of guidelines, staff training and supervision, and the provision of PEP to reduce the risk of HIV transmission during care.

Safe blood supply

Safe blood is required for acute care, and in the crisis phase of a conflict, supplies will usually come from family members and other patients. ICRC protocols provide guidance for the testing and use of donated blood.[11] The timing of the reintroduction of a more formal blood transfusion service will depend on need, available resources and the status of the conflict. All donated blood will need to be screened for HIV and other infectious diseases.

Further information and guidelines are provided in Action Guide 1: Universal precautions and safe blood supply.

11 ICRC, Blood transfusion guidelines, September 2004.

Restoration of inpatient and outpatient services

As the intensity of the conflict decreases, the priority shifts to restoring general inpatient and outpatient services for the civilian population. This involves rebuilding infrastructure, drug and consumables supply and management systems, pharmacy services, and diagnostic and laboratory services. The staged incorporation of MCH services (including PMTCT and STI services), services for victims of sexual violence (including PEP and HIV counselling and testing), and HIV/AIDS treatment and care (including ART) will strengthen HIV/AIDS prevention and care significantly at this point. It will require assistance in identifying or developing guidelines and protocols, strategic substitution of drugs and supplies, persuasion to re-establish the flow of drugs and supplies from the government, and staff training and support (see the references and resources in the related Action Guides).

For a discussion on district planning and coordination and national persuasion, see the narrative accompanying the IDP Planning Guide.

2.7 Sample Planning Guide: IDPs

Domain	Intervention	Mode
Primary health care	**Basic health care, including MCH, support to victims of sexual violence (emergency contraception and STI prevention or treatment etc.)** **Infection control** **Emergency ART for people already on treatment, PEP for victims of sexual violence** **Restoration of PHC:** • STI services, support to victims of sexual violence (emergency contraception and STI prevention or treatment etc.) **Expansion of services to include:** • TB and OI treatment, PEP for victims of sexual violence • HIV counselling and testing • PMTCT, OI prophylaxis, ART	Substitution, support and mobilization
District health administration	**Assist with priority setting in line with national policy** **Ensure district plan takes into account the specific needs of IDPs (e.g. culture, language, etc.)** **Participate in coordination**	Support and persuasion
National	**Drugs and supply systems** **Service protocols, e.g. PEP, PMTCT** **Explicit inclusion of IDPs in national plan and funding, e.g. the Global Fund**	Persuasion
	Crisis → Chronic crisis → Post-crisis	

The Planning Guide for IDPs suggests what to consider and when in responding to HIV/AIDS as an integral part of addressing the health needs of IDPs, whether in IDP camps or community PHC clinics.

PHC services in the crisis phase

When conflict is acute, the focus of PHC will be on providing or supporting the provision of basic health care, including MCH, with attention to safe birthing and universal precautions (see Action Guide 1: Universal precautions and safe blood supply). As it is common for rape to be used as a method of warfare, support to victims of sexual violence, including emergency contraception and presumptive treatment of STIs, will often need to be considered at an early stage. PEP to prevent HIV transmission can be undertaken without knowledge of the victim's HIV status, so it is not dependent on the availability of HIV counselling and testing but on the availability of antiretrovirals for PEP (see Action Guide 5: Supporting victims of sexual violence).

Where people are already on antiretrovirals and the supply is interrupted by the conflict, immediate action will be needed. Initially, this may involve strategic substitution, through the inclusion of antiretrovirals and PEP in drug kits. This would need to be combined with persuasion to re-establish drug supplies (see Action Guide 6: HIV/AIDS treatment, care and support).

STI prevention and treatment services can be commenced once basic health services have been re-established, because there is no need to know a person's HIV status in order to provide such services.

Strengthening inclusion of HIV/AIDS in PHC as conflict subsides

As the intensity of the conflict decreases, attention will need to be paid to the progressive incorporation of HIV counselling and testing, of PMTCT into MCH services and of access to HIV/AIDS treatment and care for people living with HIV/AIDS, including ART in clinical services. The capacities and availability of health staff (clinical officers and nurses) will be crucial in determining what can be done in this respect.

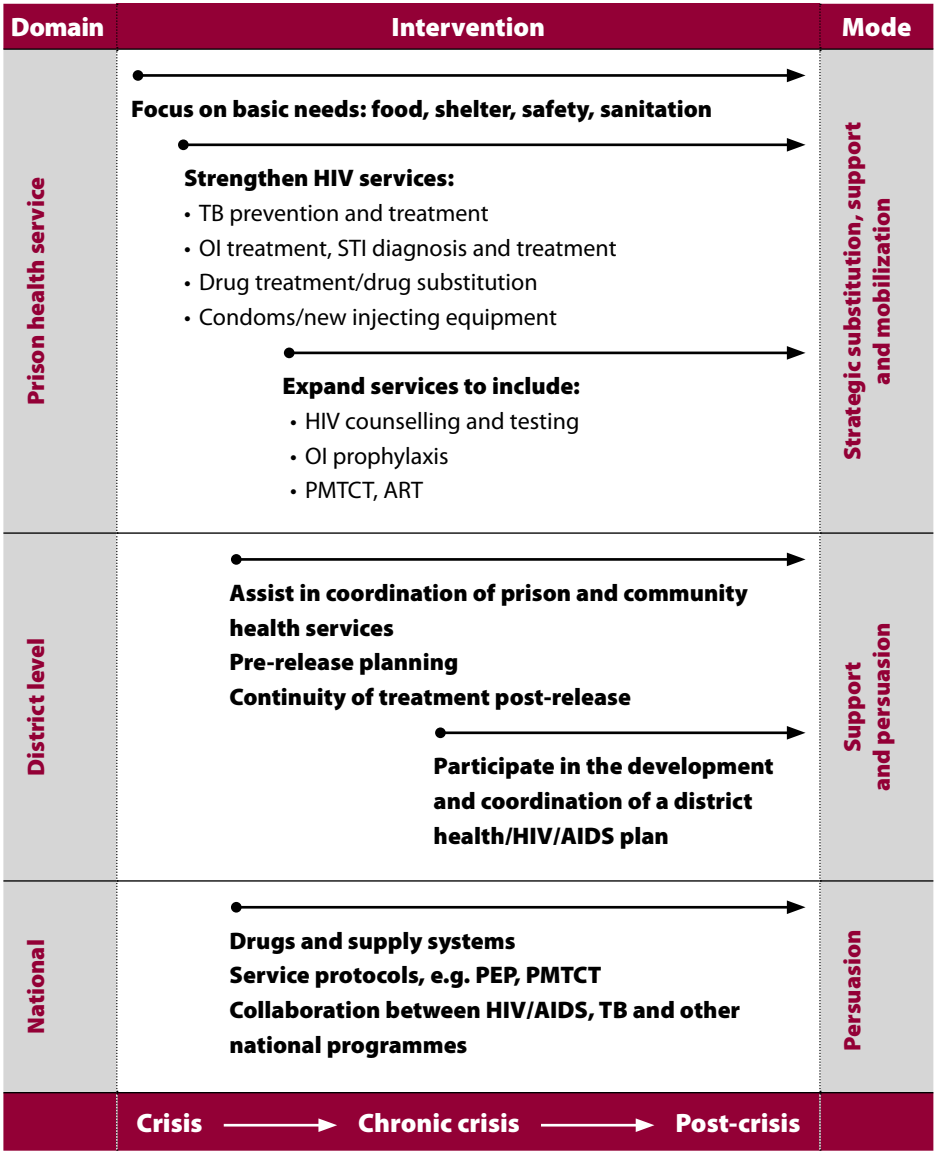
Supporting district planning and coordination

The ICRC is often one of the few organizations able to work in an environment of acute conflict. If it has a good understanding of the HIV prevention and care needs of IDPs, the ICRC can assist the district health administration in identifying needs and setting priorities for HIV/AIDS services for this population and in ensuring their inclusion in the planning of such services. As the conflict eases and the landscape becomes more crowded with service providers and donors, the district health administration will be in a better position to ensure strategic use of resources and coordinate service delivery efforts. The ICRC will also be well placed to coordinate the different actors, as more become involved in providing services for IDPs, and to ensure effective referral to services provided by others.

National effort

Despite the existence of national HIV/AIDS plans committing to the provision of HIV/AIDS-related services, IDPs are often a neglected population. Persuasion will be needed to ensure that governments take steps to meet the needs of IDPs as an integral part of the national response. Obstacles to meeting the HIV/AIDS-related needs of IDPs will likely give rise to specific issues that need to be addressed at national level, such as identifying, developing or improving protocols for HIV counselling and testing, PMTCT, ART, establishing or re-establishing access to drugs and resolving drug supply issues, and ensuring health workers have access to national staff training programmes.

2.8 Sample Planning Guide: People deprived of freedom



The Planning Guide for people deprived of freedom plots what to consider and when in responding to the HIV/AIDS-related needs of people deprived of freedom.

Initial focus on basic needs

The ICRC's work with people deprived of freedom combines the efforts of the organization's assistance and protection divisions.

In the initial engagement in prisons, issues of basic health take first priority; water, sanitation, living conditions, nutrition and safety are paramount. As the ICRC's relationship with the government and prison authorities develops, opportunities arise to work on strengthening health services in particular prisons and to work with the national prison health service as a whole.

Strengthening services that assist in HIV prevention and care

It may be more practical and feasible to focus in the first instance on support to a set of services that do not require HIV counselling and testing, as a way to ensure that HIV prevention outcomes and general health care are strengthened from the outset. Such services include:

- access to basic health care;
- general administration of co-trimoxazole to reduce morbidity and mortality from PCP (*pneumocystis jiroveci* pneumonia, formerly *pneumocystis carinii* pneumonia) and other OIs in settings of high HIV prevalence;
- TB prevention and treatment;
- STI prevention and treatment, including condom distribution;
- MCH services for female detainees and their children;
- support to victims of sexual violence;
- access to drug substitution, drug treatment or sterile injecting equipment for drug users.

(See Action Guide 3: Strengthening HIV/AIDS prevention and care in detention settings.)

Once these services have been established, they can be followed by support for HIV counselling and testing, OI treatment and prophylaxis, ART, and expanded MCH, including PMTCT for female detainees.

Where delegations are seeking to integrate attention to HIV/AIDS into existing prison health support, early efforts will be needed to secure ART access for those already on ART when entering the prison system. It is also very important to develop strategies to secure confidentiality for HIV-positive people.

Collaboration across programmes is particularly important in the detention environment. It requires support and persuasion for the coordination of national TB, HIV/AIDS and malaria programmes and support for local coordination between prison health and community health services.

It is also important that delegations and sub-delegations work together to combine local support with a national support and persuasion agenda to strengthen the whole prison health service. This will ensure that the services supported in individual prisons have the back-up they need in terms of policies and guidelines, financial resources, consistent supply of drugs and other supplies, and the human resources needed to carry out their work.

For a discussion on district planning and coordination and national persuasion, see the narrative accompanying the Planning Guide for IDPs.

SECTION 3:
MONITORING AND EVALUATION

3.1 National targets

Most countries will have in place a set of commitments and indicators that guide their HIV/AIDS response. These will be contained in the national strategy, in Global Fund documents, as a sub-set of the Millennium Development Goals, or in their UNGASS reports.

Under the universal access agenda, governments have committed to work towards universal access to HIV/AIDS prevention and care for all their citizens who need them. The ICRC's target populations are often the most difficult to reach with these programmes, so measurement of the ICRC's contribution to achieving this increased access is extremely important.

The ICRC can assist governments in measuring their progress against these goals by ensuring that ICRC programmes measure outputs and outcomes in a way that is consistent with the indicators and goals and that they support services to monitor and evaluate their work accordingly.

National HIV/AIDS programme indicator guidelines

There are several key documents that guide the development of indicators for HIV/AIDS programmes:

- The Global Fund, *Monitoring and Evaluation Toolkit: HIV/AIDS, Tuberculosis and Malaria*, January 2006, www.theglobalfund.org/pdf/guidelines/pp_me_toolkit_en.pdf
- UNAIDS, *Monitoring and Evaluation of HIV Prevention Programmes for Most-At-Risk Populations*, 2006, http://data.unaids.org/pub/Manual/2007/20070420_me_of_prevention_in_most_at_risk_populations_en.pdf

3.2 Developing indicators for HIV/AIDS integration

The PfR Guidelines recommend that general objectives and specific objectives be SMART – specific, measurable, achievable, relevant and time-bound. The table below sets out some sample indicators to guide the development of indicators when integrating HIV/AIDS into the ICRC's work. This is by no means an exhaustive list and will depend on the general and specific objectives in the PfR.

Subject	Sample output indicators	Sample outcome indicators
PMTCT in MCH services	• Number (or percentage) of clinic staff trained in national PMTCT protocols • Number (or percentage) of community health staff trained in the criteria for referrals • Number of drug stock-outs per health structure	• PMTCT protocols are respected in 80% of prescriptions • 50% of women are referred to the MCH service based on defined criteria • No health structure faced with a drugs stock-out
HIV prevention in detention settings	• Number of voluntary counselling and testing (VCT) services available in TB programmes in prisons • Number of detainees provided with pre-counselling for testing	• VCT is available in 100% of the prisons • 80% of detainees accepted testing after pre-counselling
Access to STI services in IDP populations	• Number (or percentage) of PHC staff trained in syndromic management of STIs	• Syndromic management of STIs is applied in 80% of prescriptions

In practice, the indicators used need to be SMART. Therefore, it will be necessary to determine a specific target for each indicator, for example the percentage increase in the level of PMTCT access over a specific period of time.

ANNEX 1:
HOW TO DO IT – ACTION GUIDES

Using the Action Guides

These Action Guides provide information on how HIV prevention and care interventions can be integrated into health services. They are not intended to be guides to stand-alone short-term projects but to assist in ensuring that attention to HIV prevention and care becomes a routine part of the planning and implementation of ICRC programmes. The Action Guides are to be used in conjunction with the Planning Guides for each of the ICRC's different target populations set out in Section 2.

Each Action Guide contains some basic technical information and options for action. There are also links to resources and guidelines where more detailed technical information can be found. The web version provides hyperlinks to these resources. For the printed version, the HIV/AIDS Field Guide is reproduced in full on the accompanying CD, with hyperlinks to enable easy access to these further resources.

In order to reduce the likelihood of this field guide becoming out of date, specific information such as treatment protocols is provided in the expanded versions of the Action Guides. For the printed version, these expanded Action Guides can be found on the accompanying CD. For the web version, they are provided in separate PDFs available with this guide on the ICRC's website. Thus, the expanded Action Guides can be easily updated as the protocols change over time. Where additional information is available in an expanded Action Guide, the field guide refers to the accompanying CD or PDF versions.

More technical information on HIV/AIDS in the ICRC context is also contained in the ICRC publication *HIV/AIDS: Everything you need to know*.[12]

12 E. Louvel, F. Stauffer, *HIV/AIDS: Everything you need to know*, ICRC, 2007.

ACTION GUIDE 1: UNIVERSAL PRECAUTIONS AND SAFE BLOOD SUPPLY

Universal precautions

Universal precautions are a set of standard procedures to be applied with all patients at all times to minimize the risk of transmission of blood-borne pathogens. They eliminate the need to know whether a particular patient is carrying a blood-borne pathogen and provide protection for staff and patients.

In a conflict setting, an interruption in the availability of supplies, the absence of trained staff and the disruption of normal procedures brought about by the emergency can result in a lack of attention to universal precautions and an increased risk of HIV transmission to both staff and patients.

Key actions

- → Ensure that clear universal precaution guidelines are available and that staff are trained in their use.
- → Promote hand washing and have hand-washing facilities consistently and widely available in all care areas.
- → Ensure an adequate and consistent supply of sterile injecting equipment, sterile intravenous equipment, gloves, masks, gowns, disinfectant, cleaning materials and other supplies to promote adherence to universal precautions.
- → Promote the availability and use of safe systems for the disposal of sharps.
- → Ensure that sterilizers are functioning and that they are used properly.
- → Ensure the safe disposal of all human waste, including through the availability of incinerators.

Adherence to universal precautions needs to be closely monitored in all care settings, and staff training and supervision are essential to ensure consistent good practice. Staff and patients also need access to PEP in case of accidental exposure to HIV in a health care setting.

Generic guidelines on universal precautions

- ICRC, *First aid in armed conflicts and other situations of violence*, 2006
- JHPIEGO, *Infection Prevention Guidelines for Healthcare Facilities with Limited Resources*, 2003, www.jhpiego.net/scripts/pubs/product_detail.asp?product_id=499
- WHO, *Practical Guidelines for Infection Control in Health Care Facilities*, WHO South-East Asia Regional Office (SEARO), 2004, www.searo.who.int/LinkFiles/Publications_PracticalguidelinSEAROpub-41.pdf

Safe blood supply

The ICRC Blood Transfusion Guidelines need to be adhered to when collecting and administering blood in emergency settings. A transfusion of HIV-infected blood is extremely likely to result in HIV infection for the recipient. The timing of the reintroduction of more formal blood transfusion services will depend on need, available resources and the status of the conflict.

Key actions

- Avoid unnecessary use of blood transfusion.
- Screen donated blood for HIV and syphilis (and if possible for hepatitis C and hepatitis B), and screen donors for recent HIV-risk behaviour.
- De-link HIV results from donors, unless referral to VCT services is available.
- Introduce a system to track the use of blood products.

Next steps

Reintroduce standard blood transfusion guidelines and practices including:

- ABO grouping;
- RhD typing;
- cross-matching to rule out ABO incompatibility;
- use O RhD negative blood if grouping and cross-matching are not available.

Resources

- ICRC, *Blood Transfusion Guidelines, Part 1: Theoretical Background* and *Part 2: Practical Guidelines,* September 2004
- WHO, *Blood Safety: Aide-memoire for National Blood Programmes*, 2002, www.who.int/bloodsafety/transfusion_services/en/Blood_Safety_Eng.pdf
- WHO, *Guidelines and Principles for Safe Blood Transfusion Practice, Safe Blood Donation, Screening for HIV, Blood Group Serol*, 2003, www.who.int/bookorders/anglais/detart1.jsp?sesslan=1&codlan=1&codcol=15&codcch=490#

Summary of options for action

Level	Actions
National	• Persuasion to ensure national policy and procedures are in place for universal precautions and safe blood supply **Universal precautions:** • Persuasion to ensure a consistent supply of sterile equipment and other supplies • Support in organizing the national stock supply system (needles, syringes, other supplies, PEP) **Blood safety:** • Support to the restoration of blood transfusion services
Hospital	**Universal precautions:** • Substitution of sterile equipment with other precaution methods until supplies are available • Persuasion of district health administration to ensure a consistent supply of sterile equipment and other supplies • Restoration of sterilization services • Training of staff, PEP access • Re-establishment of systems for the management and disposal of waste (incinerator) • Development and implementation of quality assurance **Blood safety:** • Assistance with strengthening laboratory services • Setting up of systems for testing all blood for transfusion • Gradual restoration of blood transfusion services • Development and implementation of quality assurance

Summary of options for action (cont'd)

Level	Actions
Primary health care	**Universal precautions:** • Introduction of guidelines and training of staff • Strategic substitution of sterile equipment and other supplies until national supplies are available • Persuasion of district health administration to ensure consistent supply of sterile equipment and other supplies • Development and implementation of quality assurance • Access to PEP for occupational exposure
Community	• Provision of supplies, training and support in universal precautions for families caring for people living with HIV/AIDS at home and for traditional birth attendants (TBAs).

ACTION GUIDE 2: INTEGRATING HIV/AIDS INTO MATERNAL AND CHILD HEALTH SERVICES

Context

Every year, an estimated 2.5 million HIV-positive pregnant women give birth and 420,000 children (2007 figure) become infected with HIV. More than 85% of children with HIV/AIDS live in sub-Saharan Africa, although mother to child transmission is also rapidly rising in Eastern Europe and Central Asia.[13]

Where the ICRC's work in PHC involves strengthening MCH services, there are important opportunities to contribute to preventing HIV transmission from mother to child and facilitating women's access to primary HIV prevention services and HIV/AIDS treatment, care and support when required.[14]

HIV transmission from mother to child may occur during pregnancy, labour or delivery or as a result of breastfeeding. Children exposed to HIV either before or during delivery or through breastfeeding have a roughly 3 in 10 chance of becoming infected. About 15–25% of infants born to HIV-positive women will be infected during pregnancy or delivery and an additional 5–20% as a result of breastfeeding.[15]

13 UNAIDS, *Report on the global AIDS epidemic*, 2006.

14 IASC, *Guidelines for HIV/AIDS interventions in emergency settings*, 2003. The guidelines recommend safe deliveries as a minimum response during an emergency and that PMTCT forms part of a comprehensive response in the stabilized phase of a conflict.

15 WHO/UNICEF/UNAIDS/UNFPA, *HIV and infant feeding: A guide for health-care managers and supervisors*, 2003.

A comprehensive approach to the prevention of HIV infection in infants requires:

- primary HIV prevention for women;[16]
- prevention of unintended pregnancies among women living with HIV/AIDS;
- prevention of HIV transmission from HIV-positive mothers to their infants;
- treatment, care and support for mothers living with HIV/AIDS, their children and families.[17]

Existing resources provide detailed guidance on most of the above aspects of a comprehensive approach (see Resources). This Action Guide focuses on information and the ICRC's options for action that ensure PMTCT is addressed as an integral part of MCH.

The information in this field guide supersedes that on PMTCT in the ICRC's *Antenatal Guidelines for Primary Health Care in Crisis Conditions*.[18] The current WHO guidelines are summarized in the present guide.[19]

Access to MCH

Experience has shown that in many resource-poor settings the biggest obstacle to access to PMTCT is the low proportion of pregnant women who have access to basic antenatal care, which is the most likely entry point for PMTCT. In the contexts where the ICRC implements many of its PHC programmes, access to basic antenatal care is often very limited. This adds weight to the argument for prioritizing the restoration of antenatal care in the immediate post-conflict environment.

16 Women who have an STI during pregnancy may be more likely to transmit HIV to the child at the time of delivery. Pregnant and postpartum women may be at increased risk of HIV and STIs. Early diagnosis and treatment of STIs can help prevent mother to child transmission and improve the health of the mother. See Action Guide 4: Strengthening HIV prevention through the integration of STI treatment into primary health care. See also Resources, *HIV prevention in maternal health services: Programming guide*.

17 WHO, *Antiretroviral drugs for treating pregnant women and preventing HIV infection in infants: towards universal access*, 2006.

18 ICRC, *Antenatal guidelines for primary health care in crisis conditions*, 2005, p. 170.

19 WHO, *Antiretroviral drugs for treating pregnant women and preventing HIV infection in infants: towards universal access*, 2006.

Access to HIV counselling and testing

HIV counselling and testing for pregnant women, as early as possible in their pregnancy, provides a critical entry point for PMTCT and treatment, care and support for those who need it. Supporting MCH to provide HIV testing requires attention to: key issues of confidentiality; counselling that enables people to understand their own risk of HIV infection/risk to others; disclosure of results; access to appropriate HIV prevention information, services and commodities; and ART, care and support for women diagnosed as HIV positive.[20] (See Action Guide 7: HIV counselling and testing.)

ART for pregnant women living with HIV/AIDS

Where treatment is indicated, access to ART for pregnant women living with HIV/AIDS both promotes the health of the woman and is a highly effective form of PMTCT. Illness or death of the mother is likely to undermine any improvements in survival of the child achieved as a result of antiretroviral prophylaxis to prevent mother to child transmission of HIV. The survival of the mother is a strong predictor of the child's survival. (See Action Guide 6: HIV/AIDS treatment, care and support.)

Prevention of mother to child transmission

PMTCT requires attention to delivery, safe birthing, including safe blood transfusion, antiretroviral prophylaxis, and counselling on infant breastfeeding. Elective caesarean section can reduce mother to child transmission where the woman is not on ART. However, this is likely to be of limited relevance in the contexts in which the ICRC works, unless there are also complications in childbirth that indicate an emergency caesarean section is necessary.[21]

20 WHO, *Pregnancy, childbirth, postpartum and newborn care: A guide for essential practice*, updated second edition, 2007, section G.

21 See ICRC, Doctrine 49, core activities for emergency hospital care, 2004, pp. 27 and 31.

Antiretroviral prophylactic regimens

Where pregnant women do not have access to ART or treatment is not indicated, the antiretroviral prophylactic regimen for PMTCT recommended by WHO is set out below.[22]

The recommended regimen at the time of writing is discussed in order to provide a clear overview of this complex area of policy and practice. It is important to check whether this regimen remains current at the time of use.

Recommended regimen	
Mother	
Pregnancy:	Azidothymidine (AZT) from 28 weeks of pregnancy or as soon as possible thereafter*
Labour:	AZT and lamivudine (3TC) plus a single dose of nevirapine (NVP)
Postpartum:	AZT and 3TC x 7 days
Infant	Single dose NVP and AZT x 7 days

* If a course of less then four weeks of AZT has been given to the mother during pregnancy, it is necessary to give the infant AZT for four weeks.

The WHO guidelines recognize that operational contexts vary considerably and, where capacity is limited, it may be necessary to use alternative regimens. These options, and the advantages and disadvantages of each option, are provided in the expanded Action Guide 2. (For the printed version, see the CD accompanying this field guide. For the web version, see the separate PDF accompanying the web version.)

22 WHO, *Antiretroviral drugs for treating pregnant women and preventing HIV infection in infants: towards universal access*, 2006.

The WHO guidelines make it clear that a single dose of NVP for both mother and child is the absolute minimum and should be considered as a temporary measure while steps are taken to identify and address the specific obstacles to the provision of more effective regimens. Therefore, it is important to understand the disadvantages of this regimen, particularly that it is less effective than the recommended regimen and that there is a high risk of the patient developing resistance to NVP, thereby limiting future treatment options. The ICRC has a clear role to play in persuading governments to improve PMTCT protocols as ART becomes more widely available in countries affected by conflict.

Where women living with HIV/AIDS have not received ART or antiretroviral prophylaxis during pregnancy, several prophylactic regimens have been shown to have an impact on reducing mother to child transmission during labour and postpartum. The recommended regimen is the same as the recommended regimen in the table above, except the AZT for the infant is given for four weeks instead of one. There are also alternative regimens for women seen only in labour and only postpartum.[23]

Considerations for informed treatment decisions

Pregnant women living with HIV/AIDS will need to have sufficient information, based on local realities, to give informed consent to treatment. The choice between giving ART and antiretroviral prophylaxis will depend on the availability of ART, the woman's current level of HIV illness and the quality of the prophylaxis available. It may be better for her to take ART earlier than indicated by her HIV disease than to take a sub-optimal antiretroviral prophylaxis.

23 *Ibid.*, see alternatives, including the advantages and disadvantages in Tables 7 and 8, pp. 38–40.

Infant breastfeeding

Breastfeeding is vital to the health of children, reducing the impact of many infectious diseases and preventing chronic diseases. The UN recommends that infants be exclusively breastfed, that is, fed with nothing but breast milk, for the first six months of life.[24] However, 5–20% of infants born to HIV-positive women acquire HIV infection through breastfeeding.[25] Exclusive breastfeeding for up to six months has been shown to decrease the risk of transmission of HIV three- to fourfold compared with non-exclusive breastfeeding. Exclusive formula feeding has also proved an effective way to prevent postnatal mother to child transmission, but this may not be a viable option in settings where there is not a continuous supply of formula, fuel and clean water.

Pregnant women need to know their HIV status in order to make informed decisions about infant feeding, as well as all the options for addressing their own health needs. Where women do not know their HIV status or know they are HIV negative, it is recommended that they breastfeed exclusively for six months and continue breastfeeding combined with complementary feeding[26] after six months.

UN guidelines recommend that when formula feeding is acceptable, feasible, affordable, sustainable and safe, women with HIV/AIDS do not breastfeed. Where these preconditions are not met, women should either:

- exclusively breastfeed, stopping as soon as formula feeding is possible; or
- exclusively breastfeed for six months and continue breastfeeding combined with complementary feeding after six months, weaning for as short a time as possible.

24 This means no food or liquids, including water. The only exceptions are drops and syrups consisting of vitamins, mineral supplements and medicines.

25 WHO, *HIV and Infant Feeding: Framework for Priority Action*, 2003.

26 Any food manufactured or locally prepared, suitable as a complement to breast milk or to infant formula, when either become insufficient to satisfy the nutritional requirements of the infant. WHO, *Breastfeeding and replacement feeding practices in the context of mother to child transmission of HIV*, 2001.

Women living with HIV/AIDS need to be supported in making informed decisions on infant feeding options. This means providing counselling based on a local assessment of the benefits and risks of the available options, taking into consideration factors such as cultural, economic or social barriers or fear of stigma that might make formula feeding unacceptable. Access to a continuous supply of formula and all the ingredients necessary to prepare formula, including fuel and clean water, are also key considerations.[27]

Options for action

In deciding what to do to prevent mother to child transmission, consider:

- How are MCH services functioning?
- What is the background prevalence of HIV ? (see Section 2)
- Does a national protocol for PMTCT exist and are antiretrovirals for prophylaxis and ART available in the country?
- Where is PMTCT supposed to be delivered in the health system?
- What are the obstacles to access to PMTCT for the ICRC's target populations?
- How can these obstacles be addressed?

It is likely that national protocols for PMTCT exist and there will be some availability of ART and antiretrovirals for prophylaxis in the country, although consistency of supply and availability of drugs in the settings in which the ICRC works are likely to be obstacles that need to be addressed. The steps the ICRC can take to promote access to PMTCT for its target populations will depend on the level in the health system at which the ICRC is supporting MCH services.

27 WHO, *Pregnancy, childbirth, postpartum and newborn care: A guide for essential practice*, updated second edition, 2007, sections K2–3, G7–8; WHO, *HIV and infant feeding counselling tools*, 2005, 2008.

Level	Actions
National	**Persuasion to:** • Develop and implement PMTCT protocols • Improve existing protocols: paving the way for access to PMTCT at clinic level; addressing sub-optimal regimens (e.g. single dose NVP) • Include HIV tests and antiretrovirals for treatment and prophylaxis on the national drug supply list and ensure availability in the country • Ensure a continuous supply of antiretrovirals in ICRC settings • Ensure equitable access to HIV/AIDS services for ICRC target populations
Hospital	• Development of staff capacity to deliver HIV counselling and testing, antiretroviral prophylaxis for PMTCT, infant feeding counselling, and HIV/AIDS treatment, care and support • Strategic substitution to fill short-term interruptions in drug supply or to initiate access • Persuasion of district health administration to ensure access to and continuous supply of antiretrovirals for treatment and prophylaxis; improvement of access to PMTCT at health clinic level • Ensure culturally and linguistically appropriate service delivery for ICRC target populations
Primary health care clinic	If PMTCT is available at clinic level: • Development of staff capacity to deliver HIV counselling and testing, antiretroviral prophylaxis for PMTCT, infant feeding counselling, and HIV/AIDS treatment, care and support • Strategic substitution to fill short-term interruptions in drug supply or to initiate access • Persuasion of district health administration to ensure access to and continuous supply of antiretrovirals for treatment and prophylaxis • Ensure culturally and linguistically appropriate service delivery for ICRC target populations
Community	• Support to community health workers and TBAs to: – Effectively refer pregnant women to HIV counselling and testing, PMTCT and HIV/AIDS treatment and care as necessary – Provide infant feeding counselling and ongoing support – Monitor access to PMTCT and identify obstacles to inform the persuasion agenda at district and national level – Apply universal precautions during birthing • Persuasion of district health administration to ensure access to and continuous supply of antiretrovirals for treatment and prophylaxis; improve access to PMTCT at health clinic level

Resources

- United Nations Population Fund, *HIV prevention in maternal health services: Programming guide*, Engender Health, 2004, www.unfpa.org/upload/lib_pub_file/319_filename_hiv_prevention_MH_program_gde.pdf
- WHO, Resources on HIV and infant breast feeding, www.who.int/child-adolescent-health/NUTRITION/HIV_infant.htm:
- *HIV and infant feeding: A guide for health care managers and supervisors*
- *HIV and infant feeding counselling: A training course*
- *HIV and infant feeding: Counselling tools*
- WHO, *Testing and Counselling for Prevention of Mother-to-Child Transmission of HIV: Support Tools*, 2005, www.women-childrenhiv.org/wchiv?page=vc-10-00
- WHO, *Pregnancy, Childbirth, Postpartum and Newborn Care: A guide for essential practice*, 2006, www.who.int/reproductive-health/publications/pcpnc/pcpnc.pdf
- WHO, *Antiretroviral drugs for treating pregnant women and preventing HIV infection in infants: Towards universal access*, 2006, www.who.int/hiv/pub/guidelines/pmtctguidelines3.pdf

ACTION GUIDE 3:
STRENGTHENING HIV/AIDS PREVENTION AND CARE IN DETENTION SETTINGS

HIV and detention

HIV is an issue of particular concern in prisons. In many countries, rates of HIV infection are much higher among detainees than in the general population.[28] Unsafe injecting practices are a key driver of many HIV epidemics, and injecting drug users are over-represented in prisons. HIV-risk behaviours, including unsafe injecting practices and tattooing, often occur in detention. The prison environment can also increase HIV-transmission risk through unprotected consensual and non-consensual sex and poor access to means of prevention (condoms). This affects both men and women and includes sex between men. Detention settings are often characterized by overcrowding, which increases transmission of TB and OIs, and by lack of access to clean water, good nutrition, and medical care and treatment. This contributes to HIV-related morbidity and mortality.

All these factors underscore the need for focused efforts to prevent the spread of HIV in prisons and to address the impact on detainees living with HIV/AIDS.

> The general aim of an ICRC intervention with respect to HIV/AIDS in prisons is to provide detainees with access to HIV prevention, care, treatment and support equivalent to that available to people in the community outside prison.[29]

28 K. Dolan *et al.*, "HIV in prison in low-income and middle-income countries", *Lancet Infectious Diseases*, 2007, Vol. 7, No. 1, pp. 32–41; UNODC/WHO/UNAIDS, *HIV/AIDS Prevention, Care, Treatment and Support in Prison Settings: A Framework for an Effective National Response*, 2006.

29 UNODC/WHO/UNAIDS, *HIV/AIDS Prevention, Care, Treatment and Support in Prison Settings: A Framework for an Effective National Response*, 2006.

Even in non-conflict settings, it has proved difficult to achieve the principle of equivalence. Acknowledging that HIV-risk behaviour occurs in prisons has been difficult for many governments and providing access to means of prevention has presented significant challenges. Yet there is compelling evidence for what works to prevent the spread of HIV and how best to address the HIV/AIDS-related health needs of detainees for sterile equipment and other supplies.[30]

To work towards equivalence with services available in the community:

- Examine the national AIDS policy and local HIV/AIDS treatment and care policy and practice and compare these with what detainees receive.
- Work with the prison health system and other organizations to identify a set of priorities for detainees and take action to address their basic health needs, HIV prevention, HIV counselling and testing, and HIV/AIDS treatment, care and support.

Address basic health needs

The ICRC's *Health in Detention Practical Guide* sets out a framework for assessing health-related issues in prisons.[31] Attention to the basic issues of shelter, sanitation, water and nutrition remains a high priority, as these factors also significantly affect HIV/AIDS morbidity and mortality.

People with HIV/AIDS have compromised immune systems, so overcrowding, poor ventilation and a lack of isolation areas for people with infectious illnesses exposes them to TB and life-threatening OIs. Poor nutrition also contributes significantly to HIV/AIDS morbidity, so improvements in general nutrition will have a positive impact.

Poor access to health services will adversely affect the health of all detainees, and will certainly increase morbidity and mortality for detainees with HIV/AIDS. Improving the regularity and quality of health services for detainees is an important place to start.

30 WHO/UNAIDS/UNODC, *Effectiveness of Interventions to Manage HIV in Prisons – HIV care, treatment and support*, Evidence for Action Technical Papers, 2007.
31 ICRC, *Health in Detention Practical Guide: A guide for assessment and documentation of health-related issues when visiting prisoners*, 2004.

Strengthening TB programmes, malaria prevention and treatment programmes in malaria-prone areas, and access to medical services in prisons will have a positive impact on morbidity and mortality for undiagnosed people with HIV/AIDS.

HIV prevention

The WHO/UNODC/UNAIDS policy brief on reducing HIV transmission in prisons sets out four key areas of intervention that have been extensively studied:

- the provision of bleach to clean syringes and needles between use;
- the provision of sterile needles and syringes;
- substitution treatment programmes;
- condom availability.[32]

These form the cornerstone of effective responses in HIV prevention programming in prisons and can be supported by:

- the incorporation of STI diagnosis and treatment in prison health clinics;
- communication on risk reduction;
- services for victims of sexual violence;
- access to HIV counselling and testing and to partner notification and family support;
- universal infection control policy and procedures.

HIV prevention in prisons is challenging. This often leads to the choice of single specific interventions, such as behaviour change communication in the form of information, education and communication materials or peer education for detainees, which are more acceptable to prison authorities. Supporting detainees in understanding their own HIV risk and in developing the knowledge and skills to protect themselves is of little value if they do not have access to means of prevention – condoms, sterile needles and syringes, sterile razors and sterile tattooing equipment.[33] Knowledge about how HIV is transmitted, without the power and the means to apply that knowledge, will not prevent HIV transmission.

32 WHO/UNODC/UNAIDS, *Policy Brief: Reduction of HIV Transmission in Prisons,* Evidence for action on HIV/AIDS and injecting drug use, 2004.

33 UNODC/WHO, *HIV/AIDS in places of detention: A toolkit for policy makers, managers and staff*, 2007.

A combination of the above strategies that address people's knowledge, power and access to means of prevention is needed to prevent the spread of HIV.

Behaviour change programmes, as part of a comprehensive approach to HIV prevention in prisons, have a role to play in promoting safer sexual and injecting behaviours. Behaviour change interventions need to support detainees in understanding their own risk and in gaining the knowledge, skills and commodities to protect themselves and others from infection. Information is often best delivered by peers, particularly because there is greater trust among peers than towards the prison authorities.

For further information on incorporating the HIV prevention strategies outlined above into practice, see:

- → **Action Guide 1:** Universal precautions and safe blood supply
- → **Action Guide 4:** Strengthening HIV prevention through the integration of STI treatment into PHC
- → **Action Guide 5:** Supporting victims of sexual violence
- → **Action Guide 7:** HIV counselling and testing

HIV counselling and testing as a gateway to care

Knowledge of HIV status can improve health outcomes by assisting health staff in providing the most appropriate treatment regimens for OIs and by acting as a gateway to accessing HIV/AIDS treatments. However, it has particular ramifications for people in detention. For the individual, it can increase the psychological burden of detention and can lead to discrimination, violence and exclusion from health services, as confidentiality in the detention environment is difficult to protect.

The introduction of access to HIV testing has to be carefully planned and provided only where knowledge of HIV status will enable improved care, such as treatment of OIs and the provision of ART. HIV counselling and testing should be provided in accordance with the principles set out in Action Guide 7: HIV counselling and testing.

The three Cs – counselling, confidentiality, consent – are essential in prisons, just as they are in the community. Yet mandatory HIV testing – testing detainees without their consent – remains a common practice. Mandatory testing should be opposed and all efforts made to persuade prison authorities that coercive approaches are unethical and ineffective. In many countries where mandatory testing in prisons has been practised, it has later been abandoned because it is both costly and inefficient.[34]

Incorporating attention to HIV issues in TB programmes

TB is a common co-infection in people with HIV/AIDS. The presence of HIV in a community exacerbates a TB epidemic, just as the presence of HIV/AIDS in individuals can cause a relapse of latent TB or their compromised immune systems can make it easier for them to contract TB. HIV not only increases the number of TB cases, but also alters the clinical course of TB disease.

As HIV-related immunosuppression increases, the clinical pattern of TB disease changes, with increasing numbers of smear-negative pulmonary TB and extra-pulmonary TB cases. TB is more likely to be disseminated and more difficult to diagnose as immunosuppression progresses.[35] Whilst access to high-quality laboratory diagnostic services is important for the management of this group, revised diagnostic algorithms are available to speed diagnosis and commencement of treatment.

Treatment protocols and training programmes for managing TB in detention settings need to incorporate information on HIV/TB co-infection. People with HIV/AIDS need access to TB screening. Specific guidelines exist for HIV/TB co-management. These guidelines recommend delaying the commencement of ART until TB treatment has been completed, if the immunological status of the person with HIV/AIDS is not too compromised to tolerate this delay.[36]

34 WHO, *Health in prisons*, 2007, chap. 7, HIV infection and human rights in prisons, pp. 61–70.
35 WHO, *Guidelines for Implementing Collaborative TB and HIV Programme Activities*, 2003.
36 WHO, *Tuberculosis Care with TB-HIV Co-management*, Integrated Management of Adolescent and Adult Illness (IMAI), 2007.

Improving health monitoring and HIV/AIDS treatment and care

Key strategies include:

- training of prison health staff in the diagnosis and treatment of OIs and the prescribing and monitoring of ART;
- securing access to a consistent supply of OI treatments and antiretrovirals in line with national treatment protocols;
- choice of a specific HIV/AIDS treatment combination and timing of ART and hepatitis treatment where a person is co-infected with hepatitis C or B;[37]
- management of HIV/TB co-infection;[38]
- fostering strong links between detention and community health services;
- paying particular attention to the treatment, care and support needs of incarcerated women and their children – ART access for women with HIV/AIDS, ART or PMTCT for pregnant women with HIV/AIDS;
- supporting infrastructure and the development of policy and procedures so as to ensure that detainees with acute HIV illness can be transported to external health facilities when necessary – transport, availability of custodial staff;
- support treatment adherence by detainees on ART, with special attention to the management of drug supply.

Detailed information on providing HIV/AIDS treatment, care and support in prison settings is set out in WHO/UNAIDS/UNODC's *Effectiveness of Interventions to Manage HIV in Prisons – HIV care, treatment and support*.[39] Generally, see also Action Guide 6: HIV/AIDS treatment, care and support.

37 WHO, *Antiretroviral therapy for HIV infection in adults and adolescents: Recommendations for a public health approach*, 2006.
38 WHO, *Tuberculosis care with TB-HIV co-infection*, IMAI, 2007.
39 WHO/UNAIDS/UNODC, *Effectiveness of Interventions to Manage HIV in Prisons – HIV care, treatment and support*, Evidence for Action Technical Papers, 2007.

Linking people to community services post-detention

Key strategies include:

- working with other agencies to link detainees to outside services immediately before and then following release;
- attention to issues of disclosure to family members and of testing, treatment and care of family members;
- transfer to external drug treatment programmes for drug users on substitution therapy;
- working with the families of detainees.

Options for action

At national level, persuasion will be needed to ensure people deprived of freedom are explicitly included in the national HIV/AIDS plan and that the plan commits to the provision of HIV/AIDS-related services equivalent to those available in the community.

This Action Guide addresses the detention setting, while most other Action Guides address specific types of services or programmes that also need to be provided in prisons. See each of these Action Guides for options for action at national, prison hospital and prison clinic levels:

- **Action Guide 1:** Universal precautions and safe blood supply
- **Action Guide 2:** Integrating HIV/AIDS into MCH services (for detention facilities with female inmates)
- **Action Guide 4:** Strengthening HIV prevention through the integration of STI treatment into PHC
- **Action Guide 5:** Supporting victims of sexual violence
- **Action Guide 6:** HIV/AIDS treatment, care and support
- **Action Guide 7:** HIV counselling and testing
- **Action Guide 8:** Targeted approaches for sub-populations most at risk

See also the case study on institutional support in prisons. (For the printed version, see the CD accompanying this field guide. For the web version, see the separate PDF accompanying the web version.)

Resources

- UNODC/WHO/UNAIDS, *HIV/AIDS Prevention, Care, Treatment and Support in Prison Settings: A framework for an effective national response*, 2006, www.unodc.org/pdf/HIV-AIDS_prisons_Oct06.pdf
- UNODC/WHO, *HIV/AIDS in places of detention: A toolkit for policy makers, managers and staff*, 2007, www.unodc.org/documents/hiv-aids/UNODC%20toolkit%20final%20draft.pdf
- WHO, *Health in prisons: A WHO guide to the essentials in prison health*, WHO Europe, 2007, www.euro.who.int/document/e90174.pdf
- WHO/UNAIDS/UNODC, *Effectiveness of Interventions to Address HIV in Prisons – HIV care, treatment and support,* Evidence for Action Technical Papers, 2007, www.who.int/hiv/idu/Prisons_HIV%20treatment.pdf
- WHO/UNODC/UNAIDS, *Interventions to Address HIV in Prisons: Prevention of sexual transmission*, Evidence for Action Technical Papers, 2007, www.who.int/hiv/idu/oms_ea_sexual_transmission_df.pdf
- WHO/UNODC/UNAIDS, *Interventions to Address HIV in Prisons: Needle and syringe programmes and bleach and decontamination strategies*, Evidence for Action Technical Papers, 2007, www.who.int/hiv/idu/Prisons_needle_syringe%20programmes.pdf
- WHO, *Tuberculosis Care with TB-HIV Co-management: Training materials*, Integrated Management of Adolescent and Adult Illnesses (IMAI), 2007, www.who.int/hiv/TB_HIVModuleCover23.05.07.pdf
- WHO/ICRC, *Guidelines for the Control of Tuberculosis in Prisons*, 1998
- WHO/ICRC, *Tuberculosis Control in Prisons – A Manual for Programme Managers*, 2000, www.who.int/docstore/gtb/publications/prisonsNTP/PDF/tbprisonsntp.pdf
- WHO, *Status Paper on Prisons and Tuberculosis*, WHO Europe, 2007, www.euro.who.int/Document/E89906.pdf
- Bollini, P (ed.), *HIV in Prisons: A reader with particular relevance to the newly independent states*, WHO Office for Europe, 2001, www.euro.who.int/document/E77016.pdf

ACTION GUIDE 4: STRENGTHENING HIV PREVENTION THROUGH THE INTEGRATION OF STI TREATMENT INTO PRIMARY HEALTH CARE

Context

A man or woman with an STI is at far greater risk of contracting HIV during unprotected sex than a person without an STI. Ulcerative STIs (chancroid, syphilis, herpes) break down the protection provided by the mucosal layer of the host and allow easier access of HIV to blood and inflammatory cells. Studies show that for each episode of unprotected vaginal sex, the risk of HIV transmission for women increases 10 to 50 times in the presence of an ulcerative STI and the risk for men increases 50 to 300 times.[40]

Inflammatory STIs such as gonorrhoea or chlamydia also increase the viral load (concentration of HIV) in genital fluids. Increased viral load in semen has been estimated to increase the likelihood of HIV transmission during unprotected vaginal sex by 8 to 10 times.[41]

So, reducing the burden of STIs in a community can contribute significantly to HIV prevention and can provide a relatively quick and simple starting point for a more comprehensive HIV prevention effort.

40 T.D. Mastro *et al.* "Probability of female-to-male transmission of HIV-1 in Thailand", *Lancet*, January 1994, Vol. 343, No. 8891, pp. 204–7; S.M. Mehendale *et al.*, "Incidence and predictors of human immunodeficiency virus type 1 seroconversion in patients attending sexually transmitted disease clinics in India", *Journal of Infectious Diseases*, December 1995, Vol. 172, No. 6, pp. 1486–91.

41 C.D. Pilcher *et al.* "Acute HIV revisited: new opportunities for treatment and prevention", *Journal of Clinical Investigation*, April 2004, Vol. 113, No. 7, pp. 937–45.

STI-related morbidity and mortality

There are other good reasons for early incorporation of STI diagnosis and treatment into the recovery of PHC systems in post-conflict environments and into the PHC services provided to IDPs during conflict.

Persistent undiagnosed STIs seriously compromise women's health

- **Infertility:** Gonorrhoea and chlamydia are the main preventable causes of infertility. Between 10 and 40% of women with untreated chlamydial infection develop symptomatic pelvic inflammatory disease (PID). Post-infection tubal damage is responsible for 30–40% of cases of female infertility.
- **Cervical cancer:** Human papilloma virus (HPV) infection results in approximately 500,000 cases of cervical cancer annually. It is the second most common cancer in women after breast cancer, causing about 300,000 deaths yearly, mostly in resource-poor settings.

STIs are major causes of adverse pregnancy outcomes

- **Ectopic pregnancy:** Women who have had PID are 6–10 times more likely to develop an ectopic (tubal) pregnancy than those who have not; 40–50% of ectopic pregnancies can be attributed to previous PID.
- **Stillbirth:** In pregnant women with untreated early syphilis, 25% of pregnancies result in stillbirth and 14% in neonatal death – an overall perinatal mortality rate of about 40%.
- **Premature delivery:** Up to 35% of pregnancies among women with untreated gonococcal infection end in spontaneous abortion or premature delivery and up to 10% in perinatal death.
- **Infant blindness:** In the absence of prophylaxis, 30 – 50% of infants born to mothers with untreated chlamydia or gonorrhoea develop ophthalmic neonatorum, which can lead to blindness.

Adapted from WHO/SEARO, *Regional Strategy for the Prevention and Control of Sexually Transmitted Infections, 2007–2015*.

Reducing sexual transmission of HIV

STI prevention and control is a significant HIV prevention strategy that fits well within the ICRC's core activity of assisting in the rebuilding of PHC services and within the ICRC's core competencies. It can later be complemented with other longer-term prevention initiatives such as behaviour change communication and condom social marketing that are difficult to achieve in the immediate post-conflict environment and that may be better carried out by other agencies as they require longer-term programming and community development strategies to ensure maximum effectiveness.[42]

42 Global HIV Prevention Working Group, *Proven HIV Prevention Strategies Fact Sheet*, 2006.

Incorporating STI prevention and control into primary health care services

Starting point: syndromic management

There is no need to wait for laboratories to be up and running to treat STIs. Many STIs and reproductive tract infections (RTIs) can be successfully identified and treated on the basis of characteristic symptoms and signs. *Symptoms*, the things the patient complains of, and *signs*, the things that the health worker observes, can be grouped together into *syndromes*. Syndromic management of STIs/RTIs is an approach that involves the presumptive treatment of STI/RTI symptoms and signs based on the organism most likely to be causing the problem.

Algorithms combining symptoms, signs and risk assessment are used to guide the health worker in managing the seven most common STI/RTI syndromes – urethral discharge, genital ulcers, vaginal discharge, lower abdominal pain, scrotal swelling, inguinal bubo and neonatal conjunctivitis.

This means that the patient is treated on the spot, avoiding loss to follow-up, and that the treatment can be offered even in settings where basic laboratory services are not available. Having consistent and locally adapted algorithms also allows for task-shifting from doctors to PHC nurses, increasing access to treatment in settings where doctors are not consistently available. Obviously, syndromic management misses asymptomatic STIs, and efforts to strengthen local diagnostic capacity will improve overall STI management.

Many countries have their own adapted algorithms in place. These are preferable to generic algorithms as they contain local drug treatment information and tailored risk assessment questions. Generic algorithms and training materials are available at www.who.int/reproductive-health/stis/training.htm. A sample algorithm is provided in the expanded Action Guide 4. (For the printed version, see the CD accompanying this field guide. For the web version, see the separate PDF accompanying the web version.)

Options for action

Strengthening the capacities of PHC services is a gradual process. In most settings, it will require a blend of mobilization and support.

Issue	Action
Protocols	Identify or develop relevant syndromic management algorithms: • Are there nationally adapted or regionally appropriate algorithms available? • Are these available in health centres? • Which syndromes are going to be covered?
Drug supply	Identify which drugs will be needed and how they will be supplied: • Are these drugs on the national supply list? • Are they getting to health centres? • If there are supply interruptions, how can these be minimized? • Is strategic substitution necessary? (combined with persuasion to ensure ongoing supply)
Health worker capacity and quality of care	Identify which staff members will diagnose, prescribe and counsel the patients: • Are they sufficiently skilled and confident to carry out syndromic management? • How can local training be made available to bring them to the appropriate level of knowledge and skill? • What quality assurance measures can be put in place to ensure quality and continuous improvement?
Access to services	Identify strategies for maximizing access to services: • What can the clinic staff do to minimize stigma and normalize the treatment of STIs? • How will patients' privacy be maintained? • Can other community members (community volunteers) be used to spread the word about the availability and quality of the services? • What partner notification strategies are in place?
Laboratory strengthening	Progressively build the capacities of the services to improve the accuracy of diagnosis and access: • In what areas can local laboratory capacity be strengthened? • How do algorithms need to be adjusted to take account of the gradual availability of laboratory diagnosis?

Resources

- Family Health International/Ministry of Health and Population, Egypt, Wall chart: Management of Sexually Transmitted Infections, 2006, www.fhi.org/NR/rdonlyres/e5a4josjlzpwjidqno25byvhp3lsxdz2kkiohxv3zbyipr4s6b4x2ybapl4bvd5njmlpwhilqmzcbh/STIwallchart.pdf
- Family Health International/Ministry of Health and Population, Egypt, *Training Manual for the Management of Sexually Transmitted Infections*, 2006, www.fhi.org/NR/rdonlyres/escrgy7j7igz56mgsozgeqcpoenrazy4jmzspgar6xf4qdeubvpgdirlf5hybjh3nofr46gfntqygk/STITrainingManualA.pdf
- WHO, *Sexually transmitted and other reproductive tract infections – A guide to essential practice*, 2006, Chapter 8: Management of symptomatic STIs/RTIs, www.who.int/reproductive-health/publications/rtis_gep/syndromic_mngt.htm

ACTION GUIDE 5: SUPPORTING VICTIMS OF SEXUAL VIOLENCE

Context

Conflict environments are characterized by increased sexual violence and exploitation of women and girls, the breakdown of health and social welfare systems, disruption of livelihoods, and the weakening of the social norms and cohesion of communities that regulate behaviour. The nature, extent and impact of sexual violence, including rape, forced prostitution and sexual slavery, perpetrated against women and girls in armed conflict and its aftermath are well documented.[43] Men and boys are also subject to sexual violence, particularly in detention settings, underscoring the need for support to victims of sexual violence in prisons.

The ICRC's primary health care work includes supporting victims of sexual violence and provides important opportunities to contribute to preventing HIV transmission and ensuring women have access to HIV counselling and testing and to HIV/AIDS treatment, care and support where required.

Comprehensive health care for victims of rape requires compassionate and confidential services that include:

- the preparation of victims for medical examination;
- medical examination, including documentation and treatment of injuries, collection of forensic evidence, assessment of HIV and other STI risk and pregnancy risk;
- emergency contraception;
- treatment or preventive treatment of STIs;
- psycho-social counselling and social support;
- PEP to prevent HIV transmission;
- HIV counselling and testing;
- access to HIV/AIDS treatment, care and support where required.

43 ICRC, *Women facing war*, 2001. While it is recognized that men and boys may also be victims of sexual violence, this Action Guide refers to victims of sexual violence as female and uses female pronouns, recognizing that the vast majority of victims of sexual violence are women.

Existing resources provide detailed guidance on most of the above aspects of a comprehensive programme (see Resources). This Action Guide focuses on information and the ICRC's options for action to ensure HIV is addressed as an integral part of support to victims of sexual violence.[44]

Treatment or preventive treatment of STIs

Treatment or preventive treatment for STIs is an integral part of health care for victims of sexual violence. A person with an STI is at far greater risk of contracting HIV during unsafe sex than a person without an STI. So STI treatment and preventive treatment also contribute to HIV prevention. (See Action Guide 4: Strengthening HIV prevention through the integration of STI treatment into primary health care.)

Post-exposure prophylaxis [45]

PEP is a short-term antiretroviral treatment to reduce the likelihood of HIV infection after potential exposure. It should be commenced as soon as possible after the rape occurs, within the first 4 hours where possible, and no later than 72 hours after the assault. There is no conclusive evidence of the effectiveness of PEP in preventing HIV transmission after rape. However, based on experience with occupational exposure and PMTCT, it is considered beneficial. PEP is recommended as part of a minimum response after rape.[46]

Assess risk

Health care providers must assess the risk of exposure and discuss this with victims of sexual violence to enable them to make an informed decision about whether to undertake PEP. In assessing risk, consider the circumstances of the assault, including the number of assailants, whether there was penetration, injuries sustained and HIV prevalence in the region.

44 The key resources are the primary references for the material in this Action Guide.
45 WHO/UNHCR, *Clinical Management of Rape Survivors*, Protocols for post-exposure prophylaxis of HIV infection, 2004, Annex 10.
46 WHO/UNHCR, *Clinical Management of Rape Survivors*, 2004.

There is increased risk of transmission if:

- there is more than one assailant;
- the victim has torn or damaged skin or mucosa;
- the assault was an anal penetration;
- the assailant is known to be HIV positive;
- the HIV prevalence in the region is high.

Counselling

At the outset, establish whether the woman already knows her HIV status. If she is aware she is HIV positive, PEP is not necessary. While it will not do any harm, there is no benefit. These women should be referred to HIV/AIDS treatment, care and support services.

Where a woman's HIV status is negative or not known, the following issues should be raised with her to enable her to decide whether she wishes to undertake PEP:

- that the level of risk of HIV transmission as a result of rape is not exactly known, but risk exists, particularly in settings where HIV prevalence is high;
- the health provider's assessment of the woman's risk (see Assessing the risk above);
- that the effectiveness of PEP in preventing HIV transmission after rape is not known, but experience based on prophylaxis after occupational exposure and PMTCT indicate it is likely to be effective in reducing the risk of HIV transmission after rape;
- that there are common side effects of PEP drugs, such as tiredness, nausea and flu-like symptoms (these side effects are temporary and do not cause long-term harm, and most can be relieved with ordinary analgesics, such as paracetamol);
- adherence to treatment is very important for the effectiveness of the treatment.

The timing of counselling regarding HIV testing needs be carefully considered. Wherever possible, HIV counselling and testing should be considered in a subsequent consultation (see PEP follow-up below). Some women may already be HIV positive prior to the assault, but are unaware of it. An HIV-positive diagnosis at this time is likely to compound the immediate trauma of rape. However, if a woman wishes to undertake an HIV test immediately, she should be free to do so and be referred appropriately.

Preventive treatment

Commence PEP, following national PEP protocols where they exist, as soon as possible, within the first 4 hours, where possible, and no later than 72 hours after the assault occurs.

PEP usually consists of two or three antiretroviral drugs given for 28 days. In settings where triple-combination ART is widely available, it is likely that the HIV virus may be resistant to one of the drugs. In this case, three drugs need to be used. Find out which drugs are used to treat HIV locally in order to determine the choice of drugs for PEP, but never use NVP for PEP. PEP combining two antiretrovirals can be used in settings where triple-combination ART is not available.

The antiretroviral combination recommended at the time of writing this guide is set out in the expanded Action Guide 5. (For the printed version, see the CD accompanying this field guide. For the web version, see the separate PDF accompanying the web version.)

A one-week supply of PEP should be provided on the first visit, with the remainder of the medications (three weeks' supply) given at the one-week follow-up visit. For women who cannot return for follow-up for logistical or economic reasons, a full supply with clear dosing instructions should be given at the first visit.

PEP follow-up

As part of the standard one-week follow-up visit:

- assess PEP side effects and adherence;
- if not supplied at the first visit, provide an additional three weeks' supply of PEP medication;
- check that the woman has had an effective course of medication for STIs (usually single dose, but may be a longer course);
- assess the likelihood of STIs and treat as appropriate;
- counsel on baseline testing for HIV and retesting after the window period has passed;
- if the woman is diagnosed as HIV positive, refer her for HIV/AIDS treatment, care and support.

See Action Guide 7: HIV counselling and testing and Action Guide 6: HIV/AIDS treatment, care and support.

Options for action

In deciding what to do, consider:

- Does a national protocol for PEP exist and are antiretrovirals for prophylaxis and treatment available in the country?
- Where is PEP supposed to be delivered in the health system?
- What are the obstacles to access for ICRC target populations?
- How can these obstacles be addressed?

Even where a national protocol for PEP exists and there is or will be some availability of antiretrovirals for prophylaxis and treatment in the country, consistency of supply and availability of the drugs in the settings in which the ICRC works are likely to be obstacles that need to be addressed.

The steps the ICRC can take to promote access to PEP for its target populations will depend on which level/s in the health system the ICRC is supporting services for victims of sexual violence.

Level	Action
National	Persuasion to: • Develop and implement PEP protocol if required • Ensure antiretrovirals for treatment and prophylaxis are on the national drug supply list and available in the country • Ensure antiretrovirals are getting to settings where the ICRC works and address obstacles to continuous supply • Ensure equitable access to HIV/AIDS services for the ICRC's target populations
Hospital	• Develop staff capacity to assess risk, counsel and deliver PEP as an integral part of support services • Strategic substitution to fill short-term interruptions in supply • Persuasion of district health administration to ensure access to and continuous supply of antiretrovirals for treatment and prophylaxis; improve access to PEP at health clinic level • Ensure culturally and linguistically appropriate service delivery for the ICRC's target populations
Health centres	If PEP is available at health centre level: • Develop staff capacity to assess risk, counsel and deliver PEP as an integral part of support services • Strategic substitution to fill short-term interruptions in supply • Persuasion of district health administration to ensure access to and continuous supply of antiretrovirals for treatment and prophylaxis • Ensure culturally and linguistically appropriate service delivery for the ICRC's target populations
Community	• Support and train community health workers and TBAs to: – effectively refer women to support services for victims of sexual violence – reduce stigma in the community towards victims of sexual violence, to reduce the vulnerability of victims

Resources

- ICRC, *ICRC frame of reference on sexual violence in armed conflict and other situations of violence*, June 2007 (French version, English translation in progress at time of writing)
- ICRC, *Addressing the needs of women affected by armed conflict: An ICRC guidance document*, 2004, www.icrc.org/Web/Eng/siteeng0.nsf/htmlall/p0840/$File/ICRC_002_0840_WOMEN_GUIDANCE.PDF!Open
- WHO/UNHCR, *Clinical Management of Rape Survivors: Developing protocols for use with refugees and internally displaced people*, 2004, www.who.int/reproductive-health/publications/clinical_mngt_rapesurvivors/clinical_mngt_rapesurvivors.pdf

ACTION GUIDE 6:
HIV/AIDS TREATMENT, CARE AND SUPPORT

Context

Untreated HIV infection is life threatening. It destroys the immune system and allows OIs such as TB to develop. The life expectancy of untreated people with HIV/AIDS with a normal health and nutritional status is around ten years; it is significantly less for people with a poorer health and nutritional status.

Effective OI treatment and prophylaxis and the administration of ART have significantly altered the prognosis for people with HIV/AIDS, and whilst they do not represent a cure, they have turned HIV into a chronic, manageable illness. The development of simplified treatment and monitoring protocols means that ART can be delivered safely and effectively in resource-limited settings.

Whilst securing ongoing access to ART is the most effective determinant of long-term survival for people living with HIV/AIDS, there are still treatment, care and support initiatives that can be put in place that prolong life, reduce morbidity and increase quality of life in the absence of the availability of ART. These are the **absolute minimum standard** and should be available in all settings:

- improvements in access to nutritious food, good shelter and clean water;
- primary health care that is able to prevent or detect and treat TB co-infection and common opportunistic and concurrent infections;
- home-based care to relieve symptoms and provide support;
- counselling and psychological support.

Treatment of OIs

HIV weakens the immune system and prevents the body from fighting off a range of infections that a healthy immune system can usually manage. These are called opportunistic infections. Even in an environment where HIV counselling and testing is not available, people with undiagnosed HIV will present to health services with OIs that can be effectively treated.[47] In developing countries, many people with HIV/AIDS still die from preventable or treatable OIs.

Common OIs:

- oral and oesophageal candidiasis (thrush)
- *Pneumocystis jiroveci (ex-carinii)* pneumonia (PCP)
- TB
- toxoplasmosis
- cryptosporidiosis
- Kaposi sarcoma – a form of cancer of the skin and internal organs

Comprehensive guidelines for syndromic diagnosis, prophylaxis and treatment of OIs exist and have been tailored to local contexts. These should be used to guide PHC practice.[48]

TB/HIV co-infection

In many settings, TB co-infection is the most significant cause of morbidity and mortality for people with HIV/AIDS. Coordination between HIV and TB programmes is essential for effective management. This includes the offer of HIV counselling and testing through TB services and attention to TB prevention and treatment in HIV/AIDS services. It also includes:

47 The Body, *Opportunistic Infection Fact Sheet,* 2006.

48 C.A. Benson *et al.*, Treating Opportunistic Infections among HIV-infected Adults and Adolescents: Recommendations from CDC, the National Institutes of Health, and the HIV Medicine Association/Infectious Diseases Society of America, MMWR Recommendation Report, December 2004, Vol. 17, No. 53, pp. 1–112; The Body, *Opportunistic Infection Fact Sheet*, 2006; Treatments AIDS Campaign, *Guidelines to opportunistic infections associated with HIV/AIDS*, South Africa, 2001.

→ **Preventing the progression of latent TB infection to active TB among people with HIV/AIDS, using:**
- isoniazid preventive therapy (IPT) to decrease the progression from latent TB;
- TB preventive therapy to decrease the risk of recurrent episodes after completion of treatment (this is not yet validated by WHO).

→ **Decreasing morbidity and mortality for people with HIV/AIDS-related TB by:**
- improving diagnosis of TB among people living with HIV/AIDS;
- implementing a comprehensive directly observed treatment, short course (DOTS) strategy/self-administration treatment;
- expanding ART access for people with HIV/TB;
- providing comprehensive care and support for people with HIV and AIDS;
- increasing access to co-trimoxazole prophylaxis.

→ **Strengthening the health system's response to HIV/AIDS and TB by:**
- ensuring that all TB patients receive access to HIV counselling and testing;
- enhancing collaboration between HIV/AIDS and TB programmes;
- advocating for political commitment to tackle HIV/AIDS and TB;
- mobilizing resources;
- improving surveillance;
- building partnerships with communities, people living with HIV/AIDS, and NGOs;
- strengthening the health system's capacity to provide prevention, care and treatment services;
- establishing referral systems;
- ensuring accountability, monitoring and evaluation;
- conducting operational research.[49]

49 WHO, *Regional Strategic Plan on HIV/TB*, WHO South East Asia Regional Office (SEARO), 2006.

Knowledge of HIV status

Knowledge of HIV status is a key link between HIV prevention and care. Access to HIV counselling and testing allows people to know their HIV status and, if HIV positive, to take steps to access treatment and prevent transmission to others, including to their unborn children. Access to HIV counselling and testing is an essential part of HIV prevention, treatment and care. See Action Guide 7: HIV counselling and testing.

Simplified ART and monitoring protocols

ART, or "combination therapy" as it was once called, is a combination of drugs from several drug classes that work together to reduce viral replication and therefore the amount of HIV in the body (viral load). The guidelines for prescribing ART are quite complex, but most people with HIV/AIDS start on what is called "first-line" therapy, a relatively simple combination of drugs with few side effects.[50] If this combination stops working, they are switched to a more complex regimen (second-line therapy). Second-line regimens are more complex and more expensive, and not yet widely available in resource-limited settings. This makes it extremely important that people in resource-limited settings get maximum benefit from their first-line treatment.

ART formulations continue to improve, reducing the burden of adherence to treatment on people with HIV/AIDS. Simplified formulations and regimens make it increasingly possible to deliver ART in settings that were previously thought to be too difficult.[51] Simplified monitoring, in the absence of a CD4 count that indicates immune function, is also possible and effective. WHO advocates a public health approach that involves simplification and standardization of regimens and clinical monitoring, "task shifting" to reduce dependence on scarce doctors, and increasing the use of nurses and lay personnel in clinical follow-up and adherence support.[52]

50 WHO, *Antiretroviral therapy guidelines for HIV infection in adults and adolescents: Recommendations for a public health approach*, 2006,

51 International HIV/AIDS Alliance, *ARV treatment fact sheet 07: Commonly used ARVs – basic information*, 2007.

52 C.F. Gilks *et al.*, "The WHO public-health approach to antiretroviral treatment against HIV in resource-limited settings", *Lancet*, 2006, Vol. 368, No. 9534, pp. 505–510.

The *Clinical Guidelines on Antiretroviral Therapy Management for Displaced Populations* set out a clear rationale and practical pathways for ART provision in fragile environments.[53]

ART is a life-saving intervention

In principle, ART should be lifelong and sustainability should therefore be key. However, even if sustainability is not guaranteed or is uncertain, immune reconstitution on ART, even for short periods, can yield significant clinical benefits.

UNHCR/South African HIV Clinicians Society, Clinical ART Guidelines, p. 6

The decision to provide or support ART in a fragile environment is a complex one. For instance, there may be little value in providing ART for a short period without any firm plan for the person to access ongoing treatment. However, a mix of strategic substitution and persuasion to secure access to ART for conflict-affected populations can be life saving.

Adherence to treatment

HIV/AIDS treatment is for life and needs to be taken at the correct dose *every day* in order to avoid treatment failure and the development of resistance. This can be challenging in any environment. Resistance can be caused by skipping doses, by interruptions in supply, by OIs that reduce absorption of the drug in the gut, and by reduced dosing brought about by sharing medications with family members and others. People with AIDS on ART require information and counselling to help them manage their medications and avoid interruptions in treatment. Training community health workers and family members to support and assist people living with HIV/AIDS to maintain their therapeutic regimen has also proven effective in maintaining adherence.

53 Southern African HIV Clinicians Society/UNHCR, *2007 Clinical guidelines on antiretroviral therapy management for displaced populations*, 2007.

Adherence is not just an issue for the person on ART. Interruptions in supply of ART, due to stock-outs at local, district or national level, or because people are cut off from treatment centres by conflict or emergencies, present significant adherence problems and can compromise health outcomes for people living with HIV/AIDS. The ICRC has a role to play in maintaining a supply when it is cut off by conflict. This requires contingency planning.

Home-based and community care for people with HIV/AIDS

Access to ART is only part of the picture of treatment, care and support for people with HIV/AIDS. Most of their time is spent living in families and communities, and family and community support is essential to their survival. There is evidence to show that resources within communities, and support from communities, make a difference to households and individuals affected by HIV/AIDS and to HIV prevention.[54]

Creating a more supportive environment for families caring for a person with HIV or AIDS at home involves working to increase acceptance and reduce fear of HIV and AIDS in communities and mobilizing the formal and informal care structures that exist – TBAs, community health workers, and the paid and unpaid people at the lowest levels of the health system. Informal health structures exist in many of the ICRC's settings – IDP camps and prisons, for example – and these resources can be mobilized to contribute to HIV and AIDS care and support.[55]

In many settings, the ultimate aim of ICRC persuasion, mobilization, substitution and support is to secure for its target populations the same standard of HIV/AIDS treatment, care and support that other people living with HIV/AIDS in the country are receiving.

54 R. Loewenson, "Exploring Equity and Inclusion in the Responses to AIDS", *AIDS Care*, Vol. 19, No. S1, 2007, pp. 2–11.

55 J.S. Mukherjee, Fr E. Eustache, "Community health workers as a cornerstone for integrating HIV and primary healthcare", *AIDS Care*, Vol. 19, Issue S1, 2007, pp. 73–82; The Synergy Project, *Community, Care, Change, and Hope: Local Responses to HIV in Zambia*, 2004.

Options for action

Level	Actions
National	**Guidelines/policy:** • Assist in the development/implementation of national treatment and care policies • Advocate for access for ICRC target populations to national treatment and care programmes **Commodities:** • Support the strengthening of national procurement and supply systems for OI and ART medications
District/ hospital	**Guidelines/practice:** • Assist in the development of OI/ART protocols in line with national guidelines • Support patient tracking, quality assurance and referral systems • Provide staff training • Monitor the patients under treatment (cohort follow-up) by the Ministry of Health system, if any **Commodities:** • Assist in ensuring consistent supply of OI and ART medications • Assist in pharmacy organization, stock management **Laboratory:** • Assist in laboratory strengthening for diagnosis and monitoring
Primary health care	**Guidelines/practice:** • Train staff in use of OI/ART protocols • Promote the use of low-tech monitoring (WHO staging for ART) • Link to community care, HIV prevention • Monitor the patients under treatment (cohort follow-up) by the Ministry of Health system, if any **Commodities:** • Ensure consistent supply of medications and supplies – strategic substitution leading to strengthened national/local systems **Link to prevention:** • Promote the link to prevention (PMTCT, prevention counselling, testing and counselling of partners, condom availability)

Options for action

Level	Actions
Community	**Referral and follow-up:** • Assist community workers in linking people living with HIV/AIDS to services **Support/home-based care for people living with HIV/AIDS:** • Support the establishment of support groups for people living with HIV/AIDS • Train people living with HIV/AIDS to assist in prevention and care • Foster adherence-support strategies – community outreach, expert patients with HIV/AIDS • Support home-based and community care for people living with HIV/AIDS and for their families

Scenarios

Scenario 1:
Interruption in supply for a pre-treated population of people with HIV/AIDS

Recent efforts by WHO, the Global Fund and the USAID-supported PEPFAR initiative have resulted in a significant expansion in access to ART for people with HIV/AIDS in resource-limited settings. Any interruption in supply can compromise health outcomes for people living with HIV/AIDS. The needs of this population should be incorporated into planning if it is cut off from health services by conflict or an emergency. Recent examples, such as the war in Lebanon, the earthquake in Indonesia and the internal conflict in Kenya, have demonstrated the need to include attention to ART substitution and the guarantee of drug supply for this group in emergency planning.

In the first instance, an intervention would involve strategic substitution, for example making ART available to people who are already on ART and have been cut off from access to it or preserving access to PMTCT. This would be combined with persuasion to reconnect these people to government programmes.

If the conflict continues and the services in, say, an IDP camp become more established over time, an intervention could

move on to supporting HIV counselling and testing and commencing newly diagnosed people with AIDS on ART.

Scenario 2: Incorporation of access to ART in the re-establishment of PHC for IDPs and conflict-affected communities

A key element of the ICRC's post-conflict work involves persuasion, mobilization of others and direct support to the re-establishment of health services for displaced populations or for populations returning to their home communities as stability increases. In this effort, the ICRC works at several levels of the health system: at the community level with TBAs and other community carers; at PHC level in health centre; at district hospital level, rebuilding infrastructure and supporting the strengthening of health services; and at national level, in persuasion for access to national programmes for people in the ICRC's care.

At PHC level, this support would involve:

- securing and maintaining a consistent supply of OI and ART medicines – either by strategic substitution followed by access to national distribution programmes, or by a direct link to national supplies;
- training staff in the use of national or regional OI and ART treatment protocols;
- supporting the establishment of patient monitoring systems;
- assisting in the establishment of HIV counselling and testing services (see Action Guide 7: HIV counselling and testing);
- supporting awareness among health staff of the need to link STI, TB, MCH and HIV/AIDS services, that is, fostering an understanding of the need to think about the comprehensive needs of the patients they are treating;
- supporting community health workers, such as volunteers and TBAs, to link families affected by HIV/AIDS to the clinic and in adherence to treatment;
- supporting the strengthening of home and community care, using available community resources to reduce stigma and discrimination and improve capacity to provide care.

This work would be complemented at district and national level by:

- supporting the strengthening of district pharmacy services, laboratory services and district hospital services;
- assisting with the development of district HIV/AIDS plans;
- working with other agencies to minimize duplication and ensure access to a comprehensive set of services (across geographical areas and sectors);
- persuasion at national level to improve consistent access to appropriate medications and supplies.

Scenario 3:
Introduction of ART in prison health programmes

People with HIV/AIDS in detention are often the last group in the community to gain access to ART. Whilst this underscores the difficulty of securing access for this group, there are many emerging examples of integration of ART into prison health services. (See also Action Guide 3: Strengthening HIV/AIDS prevention and care in detention settings.)

General guidance:

- Do not attempt to introduce ART in prison health programmes in isolation. Integrate it with:
  - strengthening the overall prison health system, including universal precautions;
  - the improvement of general living conditions – water, sanitation, nutrition;
  - STI services;
  - TB prevention and treatment;
  - access to means of prevention – condoms, injecting equipment, drug treatment;
  - OI treatment and prophylaxis.
- Link services in detention to post-release services to ensure continuity of treatment and care.

Resources

ART Guidelines:

- International HIV/AIDS Alliance, *ARV treatment fact sheet 07: Commonly used ARVs – basic information*, 2007, www.aidsalliance.org/sw37208.asp
- Partners in Health, *PIH Guide to the Community-Based Treatment of HIV in Resource-Poor Settings*, Second Edition, 2006, www.pih.org/inforesources/pihguide-hiv.html
- Southern African HIV Clinicians Society/UNHCR, *Clinical Guidelines for antiretroviral therapy management for displaced populations: Southern Africa*, 2007, www.unhcr.org/protect/PROTECTION/4683b0522.pdf
- WHO, *Antiretroviral therapy guidelines for HIV infection in adults and adolescents: Recommendations for a public health approach*, 2006, www.who.int/hiv/pub/guidelines/artadultguidelines.pdf
- WHO, *Antiretroviral therapy guidelines for HIV infection in infants and children: towards universal access*, 2006, www.who.int/hiv/pub/guidelines/paediatric020907.pdf

Home and community care

- The Synergy Project, *Community, Care, Change, and Hope: Local Responses to HIV in Zambia,* 2004, www.synergyaids.com/documents/ComCareChangeHope_Zambia.pdf

ACTION GUIDE 7: HIV COUNSELLING AND TESTING

What is HIV counselling and testing?

HIV counselling and testing is an intervention[56] that involves:

- confidential counselling that enables people to assess their risk of acquiring HIV, helps them to decide whether to do the test, and provides information and support when a person receives the results; and
- taking and analysing blood or body fluids for the presence of antibodies produced in response to HIV. There are many technologies available today, including high-quality rapid tests, many of which do not require laboratory services.[57]

Why is it important?

HIV counselling and testing enables people to make an informed decision to test, know their HIV status and take action to protect and promote their health. For people who test positive, it provides the gateway to HIV treatment and care and assists them in preventing transmission of HIV to others. For those who test negative, it provides the opportunity to understand their likely risk of HIV infection and to take steps to avoid HIV infection in the future.

As access to HIV/AIDS treatment and care and PMTCT improve, there are more benefits to people knowing their HIV status. Increasingly, health care providers offer HIV counselling and testing as a part of patient care in places where HIV prevalence is high or as part of diagnosis and clinical management where a person presents with an STI, TB or symptoms suggestive of HIV illness.

56 As distinct from HIV testing for surveillance purposes.

57 Adapted from Family Heath International, *Voluntary counselling and testing for HIV Fact Sheet*, 2006, www.fhi.org.

When is it necessary?

The introduction of access to HIV testing has to be carefully planned and provided only where knowledge of HIV status will enable improved care, such as the treatment of OIs and the provision of ART.

Knowledge of HIV status is needed to:	Knowledge of HIV status is NOT needed to:
• Start a person on ART • Assist in differential diagnosis and treatment of OIs • Start a pregnant woman on prophylaxis to prevent mother to child transmission	• Adopt safe behaviours for the prevention of HIV transmission, e.g. condoms, sterile needles • Treat STIs • Start PEP following rape or occupational exposure • Treat TB • Conduct surgical procedures

What to consider when providing HIV counselling and testing

While access to HIV counselling and testing can bring significant benefits for the individual and community, knowledge of HIV status can also have serious negative consequences for people. HIV-related stigma and discrimination are pervasive and take many forms: violence and harassment by family members, communities, uniformed services, or service providers; loss of home and/or livelihood; or imprisonment. While the widespread availability of treatment has the potential to reduce the stigmatization of HIV, many people living with HIV/AIDS still face stigma and discrimination, regardless of whether treatment is available. HIV-related stigma and discrimination continue to prevent people from having an HIV test. This underscores the need for HIV counselling and testing to be provided in a manner that minimizes these negative consequences.

Guiding principles

When integrating HIV counselling and testing into a service, careful planning is required, guided by the following principles:

- HIV testing should be voluntary, not mandatory.
- HIV testing should only occur when confidentiality of test results can be assured.
- People should have sufficient information, understanding and freedom of choice to give their informed consent to be tested.
- HIV testing should be accompanied by pre-test counselling that enables people to give their informed consent to testing (in overloaded services, this part can be done in groups).
- HIV testing should be accompanied by post-test counselling that enables people who test positive to understand the meaning of their diagnosis and how to prevent HIV transmission to others and that provides referral to HIV/AIDS treatment, care and support services.
- HIV testing should be accompanied by post-test counselling that enables people who test negative to understand the result and their own risk of HIV infection and how to avoid HIV infection in the future.
- HIV test results and counselling records should be confidential and only those health care workers with a direct role in the management of the person's care should have access to the information.
- The quality of HIV counselling and testing should be maintained by a system of quality assurance.

THE THREE Cs

Counselling: Should be provided before and after HIV testing.

Consent: People should be tested only with their informed consent, meaning that it is both informed and voluntary.

Confidentiality: HIV testing should only occur when confidentiality of test results and the fact of seeking testing is assured. [58]

While remaining committed to the "three Cs", WHO guidance on provider-initiated HIV testing recommends an "opt out" approach, whereby people must specifically decline the test if they do not wish to be tested.[59] There is debate about whether the "opt out" approach actually supports informed consent. If a person does not feel empowered to refuse, then the pre-conditions for informed consent may not be met.[60] Therefore, the ICRC approach, detailed below, is that the person must specifically consent to be tested.

58 UNAIDS and WHO, Policy Statement on HIV Testing, 2004.

59 WHO/UNAIDS, *Guidance on provider-initiated HIV testing and counselling in health facilities*, 2007.

60 Open Society Institute, *Increasing Access to HIV Testing and Counseling While Respecting Human Rights*, 2007.

HIV counselling and testing flow chart

Person requests or health care provider offers HIV counselling and testing where test is indicated

Pre-testing counselling:
- How HIV is transmitted and how transmission is prevented
- Purpose of test, clinical and prevention benefits of testing, and potential risks such as discrimination
- HIV/AIDS prevention, treatment, care and support services are available
- Test results are confidential
- Person has the right to decide whether to test, and a decision to decline will not affect access to services that do not depend on knowledge of HIV status
- In the event of an HIV-positive result, disclosure to sexual partner(s) is encouraged
- Opportunity to ask questions

Person chooses not to test

Information on:
- HIV transmission
- Safer sex and injecting practices
- Condom use and availability

Person chooses to test

HIV test conducted

HIV positive

Post-test counselling (will require more than one session):
- Explain test result simply and clearly, allow person time to consider, ensure s/he understands the result
- Allow person to ask questions
- Help cope with emotions arising from the test result
- Discuss immediate concerns and assist in determining who in their network may be available for support
- Describe follow-up HIV treatment, care and support available within the service and/or elsewhere
- Provide information on how to prevent HIV, including provision of and guidance on use of female and male condoms
- Provide information on preventive health measures, e.g. OI prevention regimens such a co-trimoxazole
- Discuss possible disclosure of result, when, how and with whom
- Encourage and offer counselling and testing for partner and children
- Assess the risk of violence or suicide and discuss possible steps to ensure physical safety, particularly of women
- Arrange a specific time for a follow-up visit or referral for HIV/AIDS treatment, care and support (e.g. TB screening and treatment, prophylaxis for OIs, STI treatment)
- Referral to harm-reduction services for injecting drug users

HIV negative

Post-test counselling:
- Explain test result, including information about the window period for the appearance of HIV antibodies
- Recommend to retest in case of recent exposure (window period)
- Provide information on how to prevent HIV, including provision of and guidance on use of female and male condoms
- Referral to harm-reduction services for injecting drug users

Pre- and post-test counselling for pregnant women

Pre-test counselling for pregnant women should also include:

- the risk of transmitting HIV to the infant;
- measures that can be taken to reduce mother-to-child-transmission; including antiretroviral prophylaxis and infant feeding counselling (this can be done later);
- the benefits to infants of early diagnosis of HIV.

Post-test counselling for pregnant women whose test results are HIV positive should be done in serial sessions. Also address the following:

- use of ART for the woman's own health and to reduce mother to child transmission or antiretroviral prophylaxis for PMTCT;
- infant feeding options and support to carry out the mother's feeding option;
- childbirth plans to ensure women have access to antiretroviral prophylaxis and infant feeding support;
- HIV testing for the infant and the follow-up that will be necessary;
- partner testing.

(See also Action Guide 2: Integrating HIV/AIDS into maternal and child health services.)

Partner disclosure

Encouraging and offering HIV counselling and testing for a person's partner in the course of post-test counselling can raise complex issues. The decision to disclose rests with the HIV-positive person, unless the law states otherwise.

In conflict settings, often HIV counselling and testing is provided only as an entry point to PMTCT. This results in a disproportionate number of women being identified as HIV positive, creating a culture that blames women for bringing HIV into families. This can exacerbate violence and discrimination against women.

Discussions regarding disclosure need to address the risk of violence, abandonment or discrimination. Men who have been at risk of HIV outside their primary relationship are often reluctant to disclose to their partner. Delaying or avoiding disclosure places the partner at continued risk. HIV counselling and testing protocols and training need to equip health care workers to address these realities, as well as comply with any relevant laws relating to disclosure.

Operational issues

For the populations the ICRC serves, HIV counselling and testing is best provided as part of an integrated PHC service, for example, as part of MCH, TB, STI and prison health services.

When supporting the provision of HIV counselling and testing, there are a range of operational issues that will need to be considered and addressed.[61] The requirements will vary depending on the setting, be it a clinic, an IDP camp or a detention centre. Among the factors to be considered are:

- the expected volume of clients;
- the availability and capacity of staff;
- the infrastructure and supplies needed;
- protocols;
- staff training needs;
- quality assurance;
- patient flow after tests;
- how to assure confidentiality;
- legal issues (children, adolescents).

The basic infrastructure requires private counselling space and testing areas. The supplies needed include HIV test kits, together with gloves and other medical supplies for universal precautions (see Section 2). If national HIV counselling and testing protocols exist, they should be implemented. If protocols do not exist, these will need to be developed to guide pre- and post-test counselling and the conduct of testing. A system of maintaining confidentiality of records will need to be put in place and staff trained to implement it. Staff will need to be trained in confidentiality, to conduct pre- and post-

61 For resources, see WHO's Online Toolkit for HIV Testing and Counselling, 2005.

test counselling and to conduct rapid HIV tests and analyse the results. A system of quality assurance will also need to be developed and implemented.

Summary of options for action

The actions required to support quality HIV counselling and testing are outlined in the Action Guides, where knowledge of a person's HIV status is needed, such as starting a person on ART or starting a pregnant woman on prophylaxis to prevent mother to child transmission.

Unless services are available, there is no justification for provision of HIV counselling and testing alone. The table below summarizes the actions related to HIV counselling and testing outlined in this and related Action Guides. (See: Action Guide 2: Integrating HIV/AIDS into maternal and child health services; Action Guide 3: Strengthening HIV/AIDS prevention and care in detention settings; and Action Guide 6: HIV/AIDS treatment, care and support.)

Level	Action
National	Persuasion to: • Develop or improve HIV counselling and testing protocols and ensure its implementation • Ensure access to and continuous supply of HIV test kits, together with gloves and other medical supplies for universal precautions • Avoid mandatory testing policy and practices
Hospital	• Development of staff capacity to conduct pre- and post-test counselling and rapid HIV tests and analyse the results • Ensure policy and procedures are in place to maintain confidentiality of records and staff trained to implement them • Persuasion of district health administration to ensure access to and continuous supply of HIV test kits, together with gloves and other medical supplies for universal precautions • Strategic substitution to fill short-term interruptions in supply • Ensure culturally and linguistically appropriate service delivery for the ICRC's target populations • Development and implementation of a system for monitoring and quality assurance

Summary of options for action (cont'd)

Level	Action
Primary health care clinic	• Development of staff capacity to conduct pre- and post-test counselling and rapid HIV tests and to analyse the results • Ensure that policy and procedures are in place to maintain confidentiality of records and staff trained to implement them • Persuasion of district health administration to ensure access to and continuous supply of HIV test kits, together with gloves and other medical supplies for universal precautions • Strategic substitution to fill short-term interruptions in supply • Ensure culturally and linguistically appropriate service delivery for the ICRC's target populations • Develop and implement a system of monitoring and quality assurance

Resources

- → Centers for Disease Control and Prevention/WHO, HIV Rapid Test Training Package, wwwn.cdc.gov/dls/ila/hivtraining/
- → UNAIDS/WHO, Policy Statement on HIV Testing, 2004, www.who.int/hiv/pub/vct/en/hivtestingpolicy04.pdf
- → WHO, Online Toolkit for HIV Testing and Counselling, 2005, www.who.int/hiv/topics/vct/toolkit/en/
- → WHO/UNAIDS, *Guidance on provider-initiated HIV counselling and testing in health facilities*, 2007, http://whqlibdoc.who.int/publications/2007/9789241595568_eng.pdf

ACTION GUIDE 8: TARGETED APPROACHES FOR SUB-POPULATIONS MOST AT RISK

Context

This Action Guide focuses on approaches to addressing the needs of sub-populations at particular risk of HIV, where vulnerability to HIV is often compounded by marginalization.

To assist in setting priority approaches to responding to HIV/AIDS, epidemics are often characterized as either concentrated or generalized. Concentrated and generalized epidemics are fundamentally different and require different approaches.[62] In concentrated epidemics, where HIV prevalence is consistently over 5% in at least one defined sub-population and remains below 1% in pregnant women in urban areas, concerted focus on populations most at risk, with high coverage of proven evidence-based approaches, is required. For example, in epidemics where injecting drug use is the major driver of HIV infection, comprehensive harm-reduction strategies are critical.[63]

In generalized epidemics, where HIV is firmly established in the general population, with HIV prevalence consistently over 1% in pregnant women, the target population is much broader. HIV prevention and care programmes target the entire population and aim to reduce sexual risks and change community attitudes and practices. These are complemented by the integration of HIV prevention and care into PHC. However, in generalized epidemics, while this broad response is clearly needed, targeted efforts to reduce HIV transmission among specific populations at risk will also be required.[64]

62 Definitions in this section have been adapted from UNAIDS, *A guide to monitoring and evaluating national HIV prevention programmes for most-at-risk populations in low-level and concentrated epidemic settings, with applications for generalized epidemics*, 2006.

63 WHO, *Policy and Programming Guide for HIV/AIDS Prevention and Care among Injecting Drug Users*, 2005.

64 UNAIDS, *A guide to monitoring and evaluating national HIV prevention programmes for most-at-risk populations in low-level and concentrated epidemic settings, with applications for generalized epidemics*, 2006.

These epidemiological definitions have their limitations. For instance, as data improve, it is increasingly clear that HIV epidemics in Africa are less generalized and more diverse than previously recognized. Southern Africa's epidemics are highly generalized, with HIV prevalence ranging from 15–35%. In East Africa, for many years grouped with Southern Africa, HIV prevalence is far lower, ranging from 2–7%. Prevalence in West Africa ranges from 1–5%.[65] These figures underscore the need for attention to specific populations at risk, even when responding in epidemics that have been categorized as generalized.

Sub-populations at increased risk

Conflict and displacement can contribute to increased vulnerability to HIV infection. However, not all of the ICRC's target populations are equally vulnerable.

Out of sight, out of mind ... a familiar vicious circle: no data equals no problem, no problem equals no intervention, no intervention equals no need to collect data. Within that circle, HIV can spread undetected.[66]

It is important to understand both the factors that make people vulnerable to HIV infection and how marginalization of specific populations at risk often compounds this vulnerability. For example, societies disapprove of and sometimes harshly punish sex between men, marginalizing men who have sex with men (MSM). Denial of sex between men often results in a lack of data to demonstrate the need for interventions targeting MSM. Stigma and discrimination often prevent MSM from accessing mainstream health services. Where they do access services, they are unlikely to disclose that they have sex with men, and services will often fail to address their specific needs. For example, STI protocols rarely include attention to anal STIs.[67]

65 D. Wilson, *HIV Epidemiology: A review of recent trends and lessons*, First draft, The World Bank, 13 September 2006.
66 Monitoring the AIDS Pandemic (MAP) network, *Male-Male sex and HIV/AIDS in Asia*, MAP Network Report, 2005.
67 UNAIDS, *HIV and sex between men: Policy brief*, 2006.

When assessing the HIV/AIDS environment, consideration must be given to the following:

- → Who is contracting HIV and why?
- → Are there sub-populations at particular risk? e.g. MSM, injecting drug users, women and girls involved in sex work or transactional sex for food or protection (see possible data sources in the section on Assessing the HIV/AIDS environment).
- → Are specific targeted interventions, e.g. specific services for injecting drug users, required?
- → Is it possible to reach these sub-populations through targeted interventions?
- → Do these sub-populations experience barriers to accessing available health services, e.g. for fear of discrimination or the services are not appropriate to their needs?
- → What action is required to ensure mainstream services are accessible and appropriate for specific sub-populations at risk?

Options for action

Issue	Action
Sub-populations at particular risk	• During assessment, ensure attention to identifying sub-groups at particular risk • Identify needs and gaps in services
Barriers to accessing mainstream health services	• Assess barriers to accessing services, e.g. attitudes of staff, opening hours, appropriateness of services • Involve members of the sub-population in addressing barriers • Amend policies and procedures • Sensitize and train staff
Reaching sub-populations at particular risk	• Involve members of sub-population/s in the design and delivery of targeted interventions, e.g. peer support, outreach • Establish referral pathways to mainstream health services

Resources

- International HIV/AIDS Alliance, *Between men: HIV/STI prevention for men who have sex with men*, 2003, www.aidsalliance.org/graphics/secretariat/publications/msm0803_between_men_Eng.pdf
- ICRC, *Addressing the needs of women affected by armed conflict: An ICRC guidance document*, 2004, www.icrc.org/Web/Eng/siteeng0.nsf/htmlall/p0840/$File/ICRC_002_0840_WOMEN_GUIDANCE.PDF!Open
- Women's Commission for Refugee Women and Children, *Displaced Women and Girls At Risk: Risk Factors, Protection Solutions and Resource Tools*, 2006, www.womenscommission.org/pdf/WomRisk.pdf
- WHO, *Policy and Programming Guide for HIV/AIDS Prevention and Care among Injecting Drug Users*, 2005, http://www.who.int/hiv/pub/prev_care/policyprogrammingguide.pdf
- WHO, *Rapid Assessment and Response Adaptation Guide on HIV and Men Who Have Sex with Men*, 2004, www.who.int/hiv/pub/prev_care/en/msmrar.pdf
- F. Tercier Holst-Roness, *Violence against girls in Africa during armed conflicts and crises*, ICRC, 2006

ANNEX 2:
PLANNING TEMPLATES

Planning template: Sick and wounded

Domain	Intervention	Mode
District hospital		Substitution, support and mobilization
District health administration		Support and persuasion
National		Persuasion
	Crisis → Chronic crisis → Post-crisis	

Planning template: IDPs

Domain	Intervention	Mode
Primary health care		Substitution, support and mobilization
District health administration		Support and persuasion
National		Persuasion
	Crisis → Chronic crisis → Post-crisis	

Planning template: People deprived of freedom

Domain	Intervention	Mode
Prison health services		Substitution, support and mobilization
District health administration		Support and persuasion
National		Persuasion
	Crisis → Chronic crisis → Post-crisis	

Notes

Notes

Notes

Notes

Notes

MISSION

The International Committee of the Red Cross (ICRC) is an impartial, neutral and independent organization whose exclusively humanitarian mission is to protect the lives and dignity of victims of armed conflict and other situations of violence and to provide them with assistance.

The ICRC also endeavours to prevent suffering by promoting and strengthening humanitarian law and universal humanitarian principles.

Established in 1863, the ICRC is at the origin of the Geneva Conventions and the International Red Cross and Red Crescent Movement. It directs and coordinates the international activities conducted by the Movement in armed conflicts and other situations of violence.

ICRC

0953/002 11.2008 2,000