

UNIT 4: PREVENT THE TRANSMISSION OF AND REDUCE MORBIDITY AND MORTALITY DUE TO HIV AND OTHER STIs



1.6 million people living with human immunodeficiency virus (HIV) were affected by humanitarian emergencies in 2013, of whom 68% had no access to treatment.⁷¹ The relationship between HIV transmission in humanitarian settings is complex and dependent on the dynamic interaction of a variety of factors, which include:

- ▶ HIV prevalence and the vulnerability of some groups within the population in the region of origin and the host population;
- ▶ the level of interaction between displaced and surrounding populations;
- ▶ the duration of displacement; and
- ▶ the location and extent of isolation of the displaced population (e.g., urban versus camp-based refugees).

Sexually transmitted infections (STIs), including HIV, have the potential to thrive under crisis conditions where access to means of prevention, treatment, and care are limited. However, findings from conflict settings also show that in some circumstances, where displaced people have been isolated and are less mobile, HIV prevalence is lower than in neighboring countries.⁷² An important resource that outlines the set of minimum multisectoral interventions to prevent and respond to HIV in humanitarian settings is the *Inter-Agency Standing Committee Guidelines for Addressing HIV in Humanitarian Settings*.⁷³

At the end of the unit, learners will be able to:

- ▶ explain what safe and rational use of blood transfusion is and how to make it available;
- ▶ describe what standard precautions are, why they are important, and how to ensure they are used;
- ▶ explain the importance of ensuring the availability of free, lubricated condoms;
- ▶ explain the importance of continuing antiretrovirals and providing co-trimoxazole prophylaxis for opportunistic infections;
- ▶ identify people who should receive post-exposure prophylaxis (PEP); and
- ▶ describe the syndromic management of STIs.

⁷¹ *HIV in Humanitarian Emergencies* (UNAIDS, 2015), <https://www.unhcr.org/566961609.pdf>.

⁷² Brady W. Bennett, Brandon D. L. Marshall, Annie Gjelsvik, Stephen T. McGarvey, and Mark N. Lurie, "HIV Incidence Prior To, During, and After Violent Conflict in 36 Sub-Saharan African Nations, 1990–2012: An Ecological Study," *PLoS One* 10, no. 11 (November 12, 2015), <https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0142343>.

⁷³ *IASC Guidelines for Addressing HIV in Humanitarian Settings, 2010* (IASC, September 2, 2010), <https://interagencystandingcommittee.org/hiv-humanitarian-situations/documents-public/iasc-guidelines-addressing-hiv-humanitarian-settings>.

MISP for SRH objectives and activities

TO PREVENT THE TRANSMISSION OF AND REDUCE MORBIDITY AND MORTALITY DUE TO HIV AND OTHER STIs.

To prevent the transmission of HIV and other STIs, the SRH Coordinator, program managers, and service providers must work with the health sector/cluster to:

- ▶ establish safe and rational use of blood transfusion;
- ▶ ensure application of standard precautions;
- ▶ guarantee the availability of free, lubricated male condoms and, where applicable (e.g., already used by the population), ensure provision of female condoms;
- ▶ support the provision of antiretrovirals to continue treatment for people who were enrolled in an antiretroviral therapy program prior to the emergency, including women who were enrolled in prevention of mother-to-child transmission (PMTCT) programs;
- ▶ provide PEP to survivors of sexual violence as appropriate and for occupational exposure;
- ▶ support the provision of co-trimoxazole prophylaxis for opportunistic infections for patients found to have HIV or already diagnosed with HIV;
- ▶ ensure the availability in health facilities of syndromic diagnosis and treatment of STIs.

Why is preventing the transmission of and reducing morbidity and mortality due to HIV and other STIs a priority?

STIs cause a large proportion of the global burden of ill health. Addressing HIV remains an ongoing challenge, particularly in humanitarian contexts, despite the significant progress made over the last three decades in response to the HIV epidemic globally. Although a significant proportion of people affected by humanitarian emergencies are people at risk of or living with HIV, access to HIV prevention, treatment, and care may not often be prioritized during emergencies. The characteristics that define a complex emergency, such as conflict, mass displacement, loss of livelihood, food insecurity, social instability, lack of employment, infrastructural stress, and environmental destruction and powerlessness, can increase affected populations' vulnerability and risk to HIV. It is necessary to do everything possible to contribute to the efforts to stop new infections and provide treatment to those in need.

What are some risk factors for the spread of HIV in crisis-affected settings?

STIs, including HIV infections, if not addressed or checked, may increase among crisis-affected populations for many reasons:^{74,75,76}

- ▶ There may be reduced access to HIV prevention, treatment, and care services due to the breakdown in health infrastructure (e.g., lack of personal protective equipment, clean needles/syringes, etc.).
- ▶ Staff may feel they are too busy to adhere to, or are not aware of the importance of, standard precautions.
- ▶ A breakdown of social and community structures can increase the incidence of rape, sexual exploitation, and transactional sex to obtain survival needs, and the disruption of social norms governing sexual behavior.
- ▶ Existing inequalities, stigmatization, and marginalization of key populations at risk of HIV and those living with HIV may be exacerbated.
- ▶ The population may move to an area of higher HIV prevalence.
- ▶ There is a limited or no access to condoms, or there is a lack of prioritization of condoms as part of the emergency response.
- ▶ Crisis-affected persons have an increased vulnerability to STIs for many reasons, including poverty, food insecurity, lack of access to health services, mobility, and lack of protection against violence and/or exploitation by the military, peacekeeping forces, and others.
- ▶ Adolescents may begin sexual relations at an earlier age.
- ▶ People may be more likely to take sexual risks, such as having sexual intercourse without condoms.

It is important to note, however, that HIV transmission among crisis-affected populations is complex. The common assumption that these populations' increased vulnerability necessarily translates into more HIV infections is not supported by data. Various competing and interacting factors affect HIV transmission during conflict and displacement.⁷⁷

HIV Transmission

HIV is transmitted through four body fluids: blood, semen, vaginal secretions, and breastmilk. The main transmission routes of HIV are through the entrance of infected fluids into the bloodstream of an uninfected individual, most commonly through unprotected sex, infected blood, and mother-to-child transmission. While the majority of infections are generally a result of unprotected sex, the proportion of transmission routes varies by setting.

⁷⁴ IASC *Guidelines for Addressing HIV in Humanitarian Settings*, 2010.

⁷⁵ *Strategies to Support the HIV-Related Needs of Refugees and Host Populations* (UNAIDS and UNHCR, October 2005) http://data.unaids.org/publications/irc-pub06/jc1157-refugees_en.pdf.

⁷⁶ *Guidelines for HIV/AIDS Interventions in Emergency Settings* (IASC, 2004), <https://www.unfpa.org/sites/default/files/resource-pdf/guidelines-hiv-emergencies.pdf>.

⁷⁷ Bennett, et al., "HIV Incidence ... in 36 Sub-Saharan African Nations, 1990–2012."

The MISP for SRH activity:

Safe and rational use of blood transfusion

The rational and safe use of blood is essential to preventing the transmission of HIV and other transfusion-transmissible infections, such as hepatitis B and C, malaria, and syphilis. Improperly screened or unscreened blood and the incorrect use of blood and blood products increase the risk of transmission of HIV and other infections to recipients. If HIV-contaminated blood is transfused, transmission of HIV to the recipient is almost 100%. Blood transfusions must not be undertaken if the facilities, supplies, and appropriately qualified staff do not exist. If conducted properly, blood transfusion can save lives. However, decreasing the number of unnecessary blood transfusions is also critical to avoid the risk of infection and prevent blood shortages. Unnecessary transfusion can be reduced by ensuring the appropriate clinical use of blood, avoiding the need for transfusion, and the use of alternatives to blood transfusion.

Use the standard criteria for blood transfusions as outlined by the World Health Organization (WHO):⁷⁸

Rational blood transfusion includes the following:

- ▶ Transfusing blood only in life-threatening circumstances and when there is no other alternative.
- ▶ Using medicines to prevent or reduce active bleeding (e.g., oxytocin and misoprostol).
- ▶ Using blood substitutes to replace lost volume, such as crystalloid-based substitutes (Ringer's lactate, normal saline) wherever possible.

Safe blood transfusion includes the following:

- ▶ Screening all blood for transfusion for at least HIV 1 and 2, hepatitis B and C, and syphilis, using the most appropriate assays. One HIV screening test is not sufficient to determine HIV status. Although blood donation services should not be seen as a way for people to access HIV testing, if someone donating blood has a reactive test result, this should be communicated to them. They should then be encouraged to link with clinical services for further testing to confirm their HIV status and, if confirmed, be linked to appropriate services.
- ▶ Collecting blood only from voluntary, unpaid blood donors at low risk of acquiring transfusion-transmissible infections and developing stringent blood donor selection criteria.
- ▶ Linking blood transfusion services with HIV counseling and testing services as soon as these are established as part of the comprehensive response, and referring donors for HIV counseling and testing prior to screening their blood.
- ▶ Conducting ABO grouping and Rhesus D typing and, if time permits, cross-matching.

⁷⁸ The WHO blood transfusion safety webpage is found at <http://www.who.int/bloodsafety/en>.

- ▶ Only transfusing blood to women of reproductive age with appropriate Rhesus type blood.
- ▶ Ensuring safe transfusion practice at the bedside and safe disposal of blood bags, needles, and syringes.⁷⁹

What must the SRH Coordinator and program manager do to make rational and safe blood transfusion available?

The SRH Coordinator and program manager must work with the health sector/cluster partners to ensure that:

- ▶ Referral-level hospitals have sufficient supplies for safe and rational blood transfusion.
- ▶ Staff have appropriate knowledge of safe blood transfusion practices and have access to supplies to reduce the need for blood transfusion.
- ▶ Safe donors are recruited. Safe donors can be selected through a donor questionnaire and by giving clear information to potential donors on requirements for blood safety. Recruit voluntary donors and do not request staff to donate blood.
- ▶ Standard operating procedures for blood transfusion are in place. These are essential components of a quality system in any organization and are used to ensure consistency in performing an activity. The use of standard operating procedures is mandatory for all staff members performing blood transfusions. Keep copies in all local languages in a central location and post them at a place where each procedure is performed so they are available for easy reference.
- ▶ Responsibility for the decision to transfuse is assigned and medical staff are held accountable.
- ▶ Staff are informed of protocols and follow procedures at all times to ensure safe blood transfusion practice at the bedside.
- ▶ Waste products, such as blood bags, needles, and syringes, are safely disposed of.
- ▶ Sites where blood is screened and where transfusion is performed have reliable light sources. To minimize the risk of errors, avoid blood transfusion at night as much as possible, unless sufficient lighting is available.⁸⁰

The MISP for SRH activity:

Ensure application of standard precautions

It is important for the SRH Coordinator to emphasize the importance of standard precautions during the first health and SRH coordination meetings. Keep in mind especially that cleaners and other support staff, who are often newly recruited, may not have worked in health setting environments before and therefore may not have received adequate training.

⁷⁹ For further information on selecting safe donors, visit http://www.who.int/bloodsafety/voluntary_donation/en.

⁸⁰ For further information on blood safety, visit http://www.who.int/bloodsafety/clinical_use/en.

What are standard precautions?

Standard precautions are infection control measures that reduce the risk of transmission of blood-borne and other pathogens (e.g., HIV and hepatitis B and C) through exposure to blood or bodily fluids among patients and health care workers. Under the “standard precautions” principle, blood and body fluids, including semen, vaginal secretions, and breastmilk, from all persons should be considered as infected with HIV, regardless of the known or suspected status of the person.

Why are standard precautions particularly important in humanitarian settings?

In humanitarian settings, there may be a lack of health supplies or infrastructure and an increased workload. Staff working in the health sector may resort to taking shortcuts in procedures, which endanger the safety of both patients and staff. Therefore, it is essential that standard precautions are respected. Regular supervision can help to reduce the risk of occupational exposure in the workplace.

What are the minimum requirements for infection control?

Standard precautions are the minimum requirements for infection control. It is critical to ensure that all staff (both medical and support) in health care settings understand standard precautions.⁸¹

The following are the standard precautions:

- ▶ Frequent hand washing:
 - Wash hands with soap and water before and after all patient contact.
 - Make facilities and supplies for hand washing easily available for all service providers.
- ▶ Wearing gloves:
 - Wear nonsterile single-use gloves for all procedures where contact with blood or other potentially infectious body fluids is anticipated.
 - Wash hands before putting on and after removing gloves. Discard gloves immediately after use. Require staff handling materials and sharp objects to wear heavy-duty gloves and to cover any cuts and abrasions with a waterproof dressing. Ensure sufficient supplies are available.

⁸¹ For further information on infection prevention, see the WHO's "Evidence, Guidelines and Publications" at <http://www.who.int/infection-prevention/publications> and EngenderHealth's Infection Prevention: A Reference Booklet for Health Care Providers at <https://www.engenderhealth.org/pubs/quality/infection-prevention.php>.

- **Note:** Ensure the availability of an adequate and sustainable supply of gloves to carry out all activities. Never reuse or re-sterilize single-use gloves; they become porous.
- ▶ Wearing protective clothing:
 - Waterproof gowns or aprons must be worn where blood or other body fluids might splash.
 - Require staff to wear masks and eye shields where there is possible exposure to large amounts of blood.
- ▶ Safe handling of sharp objects:
 - Minimize the need to handle needles and syringes.
 - Use a sterile, disposable syringe and needle for each injection.
 - Set up injection work area to reduce the risk of injury.
 - Use single-dose vials rather than multidose vials. If multidose vials are used, avoid leaving a needle in the stopper. Once opened, store multidose vials in a refrigerator.
 - Do not recap needles.
 - Position and inform patients correctly for injections.
 - Dispose needles and sharps in puncture- and liquid-proof safety boxes. Ensure puncture-resistant containers for sharps disposal are readily available, close at hand, and out of reach of children. Sharp objects should never be thrown into ordinary waste bins or bags.
- ▶ Disposal of waste materials:
 - Burn all medical waste in a separate area, preferably within the health facility grounds.
 - Bury items that still pose a threat, such as sharp objects, in a covered pit at least 10 meters from a water source.
- ▶ Used-instrument processing (in the following order):
 1. Decontaminate instruments to kill viruses (HIV and hepatitis B) and make items safer to handle.
 2. Clean instruments to remove debris before sterilization or high-level disinfection.
 3. Sterilize (eliminate all pathogens) instruments to minimize the risk of infections during procedures. Steam autoclaving is recommended. High-level disinfection (through boiling or soaking in a chlorine solution) may not eliminate spores.
 4. Use or properly store items immediately after sterilization.
- ▶ Housekeeping:
 - Promptly and carefully clean up spills of blood or other bodily fluids using a 0.5% chlorine solution.

What should SRH Coordinators do to support health sector/cluster workplace policies for occupational exposure?

Despite standard precautions being put in place and adhered to, occupational exposure to HIV may occur. SRH Coordinators must advocate and provide assistance within the health sector/cluster to ensure that workplace policies for occupational exposure are established and implemented, including the following:

- ▶ Maintain confidentiality of the exposed health worker and the person who is the source of exposure at all times.
- ▶ Assess the risk of HIV transmission in case of occupational exposure: the type of exposure (percutaneous injury, mucous membrane splash, etc.), the type of exposed material (blood, other body fluids, etc.), and the likelihood of HIV infection of the source patient.
- ▶ Counsel the source patient regarding HIV testing and conduct an HIV test if consent is obtained.
- ▶ Provide counseling for the exposed worker on the implications of the exposure, the need for PEP, how to take it, and what to do in case of side effects.
- ▶ Only after receiving informed consent, take a medical history and conduct an exam of the exposed worker, recommend HIV voluntary counseling and testing, and provide PEP when appropriate. An HIV test is not required (neither for the source patient or the health worker) before prescribing PEP, and no one should be forcibly tested.
- ▶ Educate on risk reduction through a review of the sequence of events.
- ▶ Advise exposed worker to use condoms to prevent secondary transmission during the next three months.
- ▶ Provide HIV voluntary counseling and testing at three and six months after the exposure, whether or not the exposed worker received PEP.
- ▶ Complete an incident report.

How can SRH Coordinators work with the health sector/cluster partners to ensure the application of standard precautions?

- ▶ Ensure that protocols for standard precautions are posted in each health facility in all local languages and that supervisors enforce adherence to these.
- ▶ Ensure supplies are available to implement protocols for standard precautions at all health service delivery levels.
- ▶ Organize in-service orientation sessions on standard precautions for health care workers and auxiliary staff where needed.
- ▶ Establish supervisory systems such as simple checklists to ensure compliance with protocols.
- ▶ Ensure first-aid measures in case of occupational exposure are posted in all local

languages and staff are informed and know where to confidentially report and obtain PEP if needed.

- ▶ Review occupational exposure incident reports regularly to determine when and how exposure occurs, and to identify safety concerns and possible preventative measures.

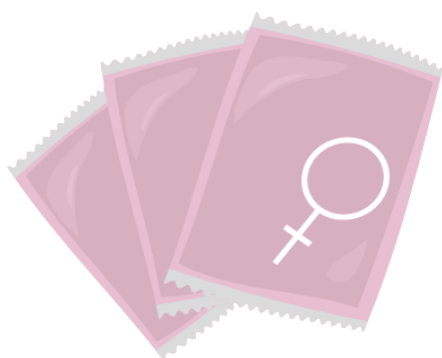
The MISP for SRH activity:

Guarantee the availability of free, lubricated male condoms and, where applicable (e.g., already used by the population), ensure provision of female condoms

Condoms are a key method of protection for the prevention of HIV, other STIs, and unintended pregnancy. Ensure lubricated male condoms and, where applicable (e.g., already used by the population prior to the crisis), female condoms are available in accessible and private areas, and promoted from the earliest days of a humanitarian response. Sufficient supplies of good-quality condoms should be ordered immediately. (See box below on how to calculate the correct number of male condoms to order.)

Female Condoms

Female condoms provide women and girls with a female-initiated method of protecting themselves against HIV and other STIs, as well as unintended pregnancy. This is especially important since many women and girls are unable to negotiate male condom use with their partners due to a lack of power in their relationship. Female condoms are typically more expensive and are usually not as well known as male condoms among the population. In most settings female condoms should not be procured at the onset of an acute-emergency. However, female condoms can be procured at the onset of an emergency if the affected community is known to use female condoms prior to the emergency. In planning for comprehensive SRH services, explore whether it is possible to secure a stable supply of female condoms, if the affected community is not familiar with them. Once a stable phase of the emergency is reached, provide information to the population about this method and provide training for women, girls, men, and boys on correct use.



Calculate a 3-month supply of male condoms for a population of 10,000

sexually active male population = 20%	$10,000 \times 0.2 = 2,000$ males
percentage of sexually active men who use condoms = 20%*	$2,000 \times 0.2 = 400$ users
condoms used per month per male = 12	$400 \times 12 = 4,800$ condoms
wastage or loss = 20%	$4,800 \times 0.2 = 960$ condoms
condoms used per month + wastage or loss	$4,800 + 960 = 5,760$ condoms
calculate for a 3-month supply**	$5,760 \times 3 = 17,280$ condoms

* Twenty percent is a general estimate that can be modified if additional information from previous surveys or studies indicate a higher or lower condom usage rate.

** Condoms usually come in boxes of 144.

This is the content of one IARH Kit 1A.

Where can humanitarian staff order condoms?

The United Nations Population Fund (UNFPA) can rapidly ship bulk quantities of good-quality condoms to the field as part of the Inter-Agency Emergency Reproductive Health (IARH) Kits. Male condoms are available in the IARH Kit 1, and female condoms are in the IARH Complementary Commodity Kit 1B (starting in 2020). These IARH Kits contain sufficient supplies to cover the needs of a population of 10,000 people for three months (see calculations above). Leaflets explaining the appropriate use of male and female condoms are also included. For detailed information on ordering IARH Kits, see Unit 9.

If an organization would like to procure condoms in bulk, ensuring the quality of both male and female condoms is essential. There are many brands of condoms on the market. Ensure that the procurement office responsible for bulk purchases for emergencies sources only WHO- and UNFPA-approved condoms and adds a certificate in the relevant language to all shipments declaring that the condoms have been quality tested on a batch-by-batch basis by an independent laboratory. Agencies with limited experience in condom procurement can procure them in bulk through UNFPA.⁸²

⁸² Contact information is available at <https://www.unfpaprocurement.org/home>.

Adolescents

Without access to adequate information and services, adolescents are more likely to be exposed to unsafe sexual practices that could result in unintended pregnancy, unsafe abortion, STIs, and HIV. Provide discreet information and access to free condoms at adolescent-identified distribution points. Further, ensure adolescent-friendly health services are available and that health workers provide condoms to adolescents presenting to facilities.

How should condoms be made available?

In addition to providing condoms upon request in health facilities, humanitarian staff should make sure that condoms are made available in accessible, private areas in the community. Condoms can be set out at health facilities, as well as at various other sites, such as registration desks, food and non-food distribution points, youth and community service offices, and anywhere that people congregate or come to access services or supplies. It may be a good idea to make condoms available in private locations, such as latrines, and to supply hotels, coffee shops, and bars. Condoms should also be made available to the surrounding community, aid agency staff, staff in uniformed services, aid delivery truck drivers, and others, along with culturally appropriate messages and information about correct use and disposal.

It is useful to discuss condom distribution with leaders and members of the crisis-affected community so they understand the need for and importance of condom use and to ensure distribution takes place in a culturally appropriate manner to increase community acceptance of condoms. Another option is consulting with local staff about how condoms can be made available in a culturally sensitive way, particularly for adolescents and key populations, such as sex workers and their clients, men who have sex with men, persons using injectable drugs, and transgender persons. Key populations and adolescents are helpful in identifying locations where their peers congregate, and these volunteers can be enlisted to distribute condoms to their peers.



Noted Practice: Making Condoms Available

When asked by a national staff member why there were condoms in the toilet area, an international organization representative explained: “X agency is an international organization and, wherever we work in the world, we make condoms available to prevent HIV transmission in the region we are working.” The staff person was satisfied with this answer and condoms slowly began to be taken from the condom basket in the staff toilet.

The MISP for SRH activity:

Support the provision of antiretrovirals to continue treatment

Antiretroviral drugs reduce the transmission of HIV and excess mortality and morbidity from opportunistic infections and acquired immunodeficiency syndrome (AIDS)-defining illnesses.

Why is the continuation of antiretrovirals a priority?

Continuation of antiretrovirals for those already on treatment prior to the emergency is a priority because a sudden disruption of treatment can cause deterioration of an individual's health (by allowing opportunistic infection and immune-deficiency progression), potential transmission (due to viral rebound), and development of antiretroviral resistance. Antiretrovirals should be continued for people who were enrolled in a program prior to the emergency, including women who were enrolled in PMTCT of HIV and syphilis programs.

How can it be determined who has been on treatment and what regimen they were taking?

To determine who has been on treatment, examine health records or patient cards, ensuring that confidentiality is safeguarded. Where possible, existing networks of people living with HIV can be useful to disseminate information about the availability of antiretroviral therapy for continuation of treatment.

To determine the regimen, use patients' treatment cards where available. In general terms, first-line treatment will suffice. However, where the exact regimen (e.g., second-line regimen) is not available, the regimen should be matched with equivalent available first-line drugs, bearing in mind the national guidelines and WHO protocols for switching regimens.⁸³ Per WHO recommendations, people who are already taking antiretrovirals should not be retested for HIV. People on antiretroviral therapy should also be offered condoms.

What is the role of the SRH Coordinator in supporting the provision of antiretrovirals?

The SRH Coordinator should work with the HIV Coordinator (if one exists) or national HIV representative to support the health sector/cluster to rapidly:

1. Understand the HIV coordination system in the country. It is usually done through mechanisms led by the national HIV program, UNAIDS, the UN HIV coordination team, and civil society organizations.

⁸³ Consolidated Guidelines on the Use of Antiretroviral Drugs for Treating and Preventing HIV Infection: Recommendations for a Public Health Approach (WHO, June 2016), <http://www.who.int/hiv/pub/arv/arv-2016/en>.

2. Ensure that the affected population is included in the national HIV program, including the national antiretroviral therapy program.
3. Inform the national HIV program about the urgent need to adjust its antiretroviral and co-trimoxazole distribution plans to address the needs of the crisis-affected population.
4. Quantify needs using rough total population estimates and pre-crisis statistics of prevalence and treatment rates (the MISIP for SRH Calculator can support this, see Appendix C).
5. Ensure that focal points are identified (primarily health care providers or networks of people living with HIV) and that the community is informed about how to reach focal points that will help them to get their treatment and care.
6. Facilitate the continuity of treatment of women and infants enrolled in the PMTCT of HIV and syphilis program prior to the crisis.
7. Ensure that HIV is included in needs assessments to inform scaling up HIV services once the situation stabilizes.

The SRH Coordinator should not take the responsibility for:

- ▶ the procurement of antiretrovirals for first- or second-line treatment and co-trimoxazole;
- ▶ active case identification and case management; or
- ▶ setting up the national monitoring system.

These responsibilities are under the remit of the national HIV Program, UNAIDS, and the United Nations HIV Coordination team.

The MISIP for SRH activity:

Provide PEP to survivors of sexual violence and for occupational exposure

Providing PEP to survivors of sexual violence is part of providing compassionate and confidential treatment and counseling, as outlined in Unit 3.⁸⁴ PEP treatment protocols for occupational exposure are the same as those for survivors of sexual violence.

⁸⁴ More information on PEP can be found in the *Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings 2018*, p. 32–33.

The MISP for SRH activity:

Support the provision of co-trimoxazole prophylaxis for opportunistic infections

Why is it important to give co-trimoxazole prophylaxis to people living with HIV?

Co-trimoxazole prophylaxis is an antibiotic used to prevent pneumocystis pneumonia and toxoplasmosis, as well as other infectious and parasitic diseases in people living with HIV. It is a lifesaving, simple, well-tolerated, and cost-effective intervention and should be implemented as an integral component of the HIV chronic care package and as a key element of pre-antiretroviral therapy. Co-trimoxazole prophylaxis needs to continue after antiretroviral therapy is initiated until there is evidence of immune recovery.

Who is co-trimoxazole prophylaxis recommended for?

Co-trimoxazole prophylaxis is recommended for adults (including pregnant women) with severe or advanced HIV clinical disease and/or with a CD4 count of ≤ 350 cells/mm³. In settings where malaria and/or severe bacterial infections are highly prevalent, co-trimoxazole prophylaxis should be initiated regardless of CD4 cell count or clinical disease severity. Co-trimoxazole prophylaxis is recommended for infants, children, and adolescents with HIV, irrespective of clinical and immune conditions.⁸⁵ It is a priority to engage staff who are adolescents or members of key populations. These populations are also helpful to identify locations where their peers congregate including for the distribution of condoms.

The MISP for SRH activity:

Ensure the availability of syndromic diagnosis and treatment of STIs

What is the syndromic management of STIs?

The syndromic management of STIs is a method built from algorithms (decision trees) based on syndromes (patient symptoms and clinical signs) to arrive at treatment decisions on a single visit using standardized treatment protocols. The guidelines and algorithms were developed by WHO and can be found in the WHO's *Guidelines for the Management of Sexually Transmitted Infections*.⁸⁶ Antibiotics recommended by WHO for syndromic treatment of STIs are available in the IARH Kits.

⁸⁵ *Guidelines on Post-Exposure Prophylaxis for HIV and the Use of Co-Trimoxazole Prophylaxis for HIV-Related Infections Among Adults, Adolescents and Children: Recommendations for a Public Health Approach* (WHO, December 2014) https://apps.who.int/iris/bitstream/handle/10665/145719/9789241508193_eng.pdf?sequence=1.

⁸⁶ *Guidelines for the Management of Sexually Transmitted Infections* (WHO, February 2004), <http://apps.who.int/medicinedocs/en/d/Jh2942e>.

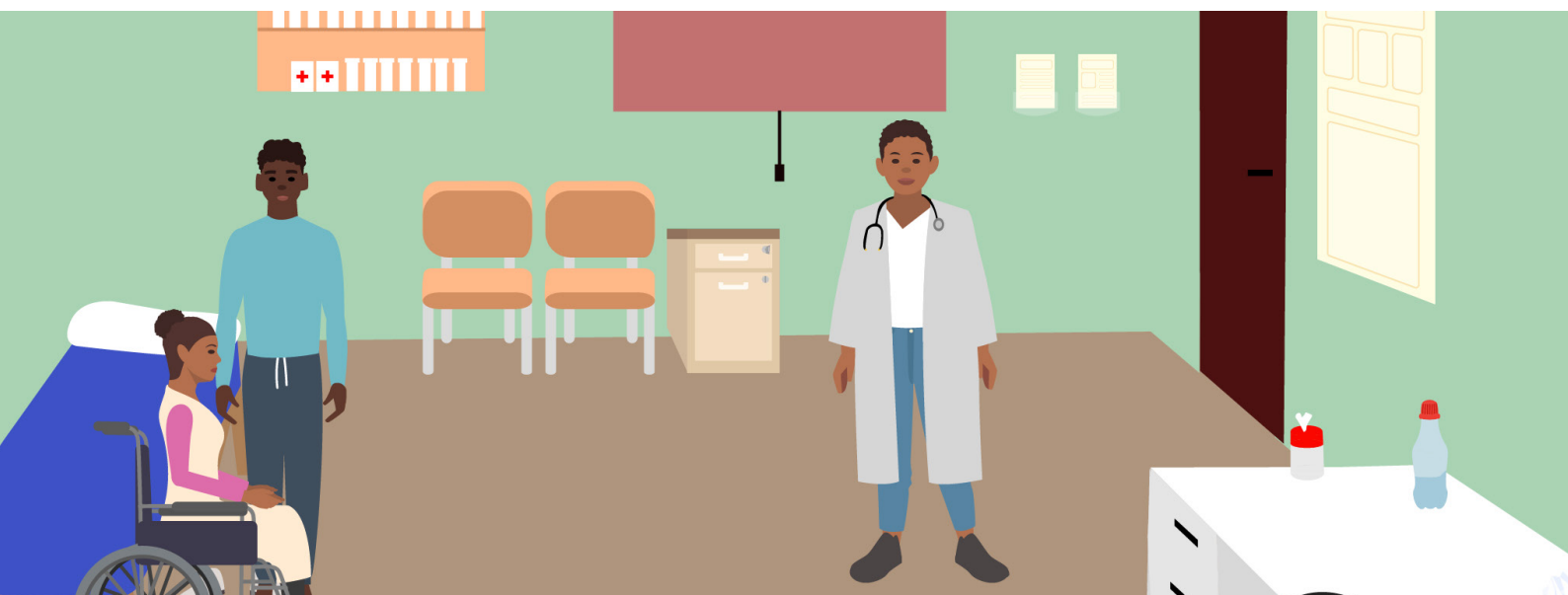
Why is syndromic management and treatment of STIs a priority?

The transmission of HIV and STIs are closely linked. Certain STIs facilitate the transmission of HIV, and the weakened immune systems of people living with HIV can make them more susceptible to STIs. Syndromic management is predictable, cost effective, satisfactory for the patients, and has a strong public health base and impact. This approach is particularly relevant at the onset of a crisis, where people are less likely to come for follow-up visits and where access to laboratories might be difficult, impossible, or expensive.



Noted Practice: Preventing the Transmission of and Reducing Morbidity and Mortality Due to HIV and Other STIs in Jordan

- ▶ There was an existing Jordanian HIV policy before the crisis, as well as accessible and stocked blood banks.⁸⁷
- ▶ Safe blood from a blood bank was available for transfusion in both the Zaatari camp and in Irbid.
- ▶ Most facilities enforced standard precautions, including use of disposable needles and syringes and sharps disposal boxes.
- ▶ In the event of a health worker's occupational exposure to HIV, occupational post-exposure treatment was available in Amman, although it was limited.
- ▶ In Zaatari camp, male condoms were available through clinics and in women's safe.



⁸⁷ Krause, et al., "Reproductive Health Services for Syrian Refugees." *Conflict and Health*, February 2, 2015.

Unit 4: Key Points

- ▶ STIs, including HIV infections, if not addressed or checked, may increase among crisis-affected populations where access to means of prevention, treatment, and care are limited.
- ▶ The SRH Coordinator and program managers must ensure that rational and safe use of blood is available to prevent the transmission of HIV and other transfusion-transmissible infections, such as hepatitis B and C and syphilis.
- ▶ The importance of standard precautions (frequent hand washing, wearing gloves and protective clothing, safe handling of sharp objects, disposal of waste materials, instrument processing, and cleaning up spills) should be emphasized and respected.
- ▶ Workplace policies for addressing occupational exposure should be established and implemented.
- ▶ Lubricated male condoms and, where applicable (e.g., already used in the population prior to the crisis), female condoms should be available in accessible and private areas in health facilities and the community and promoted from the earliest days of a humanitarian response.
- ▶ Antiretrovirals should be continued for people who were enrolled in a program prior to the emergency, including women who were enrolled in PMTCT of HIV and syphilis programs.
- ▶ It is important to give co-trimoxazole prophylaxis to prevent pneumocystis pneumonia and toxoplasmosis, as well as other infectious and parasitic diseases in people living with HIV.
- ▶ PEP should be provided to survivors of sexual violence and occupational exposure. An HIV test is not required (neither for the source patient or the health worker) before prescribing PEP, and no one should be forcibly tested.
- ▶ Syndromic management of STIs is a standardized treatment protocol based on syndromes (patient symptoms and clinical signs) that allows for treatment decisions in a single visit.



Challenges and Solutions

Challenges	Solutions
What if the health facilities do not have the capacity to screen donors for HIV?	Do not administer blood that has not been screened. Strongly advocate to the Ministry of Health, United Nations agencies such as WHO and UNFPA, and/or a humanitarian organization such as the International Committee of the Red Cross to establish blood-screening services.
What if the culture of the crisis-affected population objects to condoms?	<p>It is important to guarantee the availability of condoms. Humanitarian workers sometimes assume that making condoms widely available may be frowned upon by some cultures. Because such an assumption may not be true or may not be true for everyone in the population, condoms are sometimes not made visible and available.</p> <p>There are creative ways to provide condoms for those who want to protect themselves or others from HIV transmission, such as placing condoms in less public yet still accessible areas. As an example, realizing people were reluctant to ask for condoms, doctors at a hospital in South Sudan placed a basket of condoms in an easily accessible location in the hospital (under a tree) where they could be taken without asking a health provider. The doctors informed the community where the basket was located. After some time, people started coming for the condoms, and now the basket needs to be refilled on a weekly basis.</p>
What if health records or patient treatment cards for individuals living with HIV are unavailable or have been destroyed?	Generally, first-line treatment will suffice for people living with HIV and whose treatment is unknown. Where the exact regimen (e.g., second-line regimen) is not available, the regimen prescribed should be matched with the equivalent available first-line drugs, bearing in mind the national guidelines and WHO protocols for switching regimens. ⁸⁸

⁸⁸ *Guidelines for the Management of Sexually Transmitted Infections*. (WHO, February 2004), <http://apps.who.int/medicinedocs/en/d/Jh2942e/>.

What if no one seems to be addressing HIV?

Speak to the SRH Coordinator to inquire directly or ask in the next health sector/cluster meeting about who the national representative is and what is being done to support the availability of antiretrovirals and co-trimoxazole for people living with HIV in the crisis-affected population. If services are not currently available, advocate within the health sector/cluster to support the Ministry of Health and others to establish services.

Request information about how the SRH working group can support any existing or new efforts to inform the community about the availability and location of services for people living with HIV.

Contacting UNAIDS or the national vertical HIV programme to ensure the inclusion of the target population in HIV services.



MISP FOR SRH MONITORING CHECKLIST: PREVENT THE TRANSMISSION OF AND REDUCE MORBIDITY AND MORTALITY DUE TO HIV AND OTHER STIs

The MISP for SRH Monitoring Checklist, below, can be used to monitor SRH service provision in humanitarian settings.

4. Prevent and Respond to HIV			
4.1	Safe and rational blood transfusion protocols in place	Yes	No
4.2	Units of blood screened/all units of blood donated x 100	%	
4.3	Health facilities have sufficient materials to ensure standard precautions in place	Yes	No
4.4	Lubricated condoms available free of charge	Yes	No
	Health facilities		
	Community level		
	Adolescents		
	LGBTQIA		
	Persons with disabilities		
	Sex workers		
4.5	Approximate number of condoms taken this period		
4.6	Number of condoms replenished in distribution sites this period Specify locations:		
4.7	Antiretrovirals available to continue treatment for people who were enrolled in antiretroviral therapy prior to the emergency, including PMTCT		
4.8	PEP available for survivors of sexual violence; PEP available for occupational exposure		
4.9	Co-trimoxazole prophylaxis for opportunistic infections		
4.10	Syndromic diagnosis and treatment for STIs available at health facilities		

MATERIALS AND SUPPLIES

Which supplies are needed or which IARH Kits could be ordered to prevent the transmission of and provide treatment for HIV and other STIs?

IARH Kits (2019)

The IARH Kits are categorized into three levels, targeting the three health service delivery levels. The kits are designed for use for a three-month period for a specific target population size.^{89,90}

Note: The IARH Kits are not context specific or comprehensive. Organizations should not depend solely on the IARH Kits and should plan to integrate procurement of SRH supplies in their routine health procurement systems as soon as possible. This will not only ensure the sustainability of supplies but also enable the expansion of SRH services from the MISP to comprehensive care.

Antiretrovirals to continue treatment for people who were enrolled in an antiretroviral therapy program prior to the emergency, including women who were enrolled in PMTCT programs, **are not included in the IARH Kits**. Please go through the vertical HIV/AIDS program and/or contact UNAIDS for a sustainable source of supplies.

Health Care Level	Kit Number	Kit Name*
Community/health post	Kit 1	Male Condoms
Community/health post	Kit 3	Post-Rape Treatment
Community/health post	Kit 5	Treatment of STIs
Referral hospital (CEmONC)	Kit 12	Blood Transfusion

*Additional standard precautions supplies are in kits 2, 4, 6, 8, 9, and 11

Complementary commodities

Complementary commodities can be ordered according to the enabling environment and capacities of health care providers. Complementary Commodities will be available from UNFPA in 2020.

Service Delivery Level	Item	To Complement
Community/health post	Kit 1B, female condoms	Kit1

89 Most kits include supplies to ensure universal standard precautions. In addition, the Reference and Training Package, a library of resource materials, is included with each kit order. The Inter-Agency IARH Kit booklet is available at <https://www.unfpa.org/resources/emergency-reproductive-health-kits>.

90 The 2019 IARH Kits will be available for procurement in early 2020. Check with UNFPA (<https://www.unfpa.org>) or IAWG (<http://iawg.net/resource/inter-agency-reproductive-health-kits-2011>) to verify whether the revised kits are available. For information regarding kits available before 2020, see the *Inter-Agency Reproductive Health Kits for Crisis Situations* (5th ed., 2011) at <http://iawg.net/resource/inter-agency-reproductive-health-kits-2011>.

Unit 4 Quiz: Prevent the Transmission of and Reduce Morbidity and Mortality Due to HIV and Other STIs

1. The syndromic management of STIs is a method used to treat STIs based on multiple visits to the clinic using standardized treatment protocols.

True or False

2. What is the role of the health provider in an emergency setting when a person presents for continued antiretroviral treatment? Select all that apply:

- a. Ensure confidentiality
- b. Provide condoms
- c. Provide co-trimoxazole, as recommended
- d. Provide antiretrovirals
- e. Advise the person to return for treatment in a couple of months when the emergency phase is over

3. Which of the following are minimum requirements for infection control (also known as standard precautions)?

- a. Safe handling of sharp objects
- b. Wearing of protective clothing
- c. Proper disposal of waste material
- d. Frequent hand washing
- e. All of the above

4. Condoms can be made available at:

- a. Health facilities
- b. Food and non-food distribution points
- c. Latrines
- d. Popular bars or coffee shops in urban areas
- e. All of the above

5. The SRH Coordinator should not take responsibility for the procurement of antiretrovirals.

True or False