HIV Prevention Now

Programme Briefs

No. 7 - **HIV Prevention in Humanitarian Settings**

Social and political conflicts and natural disasters uproot millions of people each year and constitute important aggravating factors fuelling the HIV/AIDS epidemic. Sexually transmitted infections (STIs) and HIV spread faster in communities where there is social disruption and instability, combined with poverty - conditions that are often at their most extreme during armed conflicts and in the aftermath of natural disasters. Addressing the needs of communities and individuals who have lost their security, their homes, and their access to support requires a broad set of humanitarian interventions –food, shelter, sanitation, health, social support and protection measures. These interventions are organized and take different priorities depending upon the local context and the "phase" of the emergency. Such phases are defined by the humanitarian community and range from the acute emergency (the destabilizing event that creates the emergency situation and immediate displacement) through subsequent phases of stabilization, reconstruction and return to normalcy. Within the context of broader humanitarian relief interventions, it is increasingly recognized that HIV/AIDS prevention and other essential sexual and reproductive health services must be seen as an integral part of the response and supported with resources and technical assistance. As such, UNFPA's participation in humanitarian response efforts has grown dramatically in the past few years. As this responsibility is expanded, it is essential for UNFPA staff – especially those in the field - to understand the common operational features and the scope of the Fund's interventions both in emergencies and in recovery situations.

Widespread population displacement, whether caused by war or natural disaster, can severely undermine access to reproductive health information and services at the same time as it increases vulnerabilities to HIV. The specific interventions adopted for provision of STI and HIV prevention, treatment and care must vary according to the circumstances of the emergency and depend on access to the populations at risk. UNFPA's focus on HIV prevention – emphasizing condom promotion and special programmes for young people and pregnant women - is particularly relevant in humanitarian situations and should be seen as a life-saving intervention. The development and implementation of care and support programmes in emergency settings generally fall to our partners and are not explicitly covered in this Programme Brief but are reviewed in the Interagency Manual on Reproductive Health for Refugees.

The Humanitarian Response Unit and The HIV/AIDS Branch

Why is HIV Prevention a Priority in Emergency and other Humanitarian Response Settings?

Today's humanitarian crises — caused by conflict or by natural or man-made disasters — have resulted in unprecedented waves of population displacement, both within and across borders. A very large proportion of these are displaced in or to countries with high HIV prevalence. According to the United Nations Office for the Coordination of Humanitarian Affairs (OCHA) those displaced within national borders, known as "internally displaced persons" (IDPs), were estimated to number over 50 million worldwide at the end of 2001[1]. Of these, 25-30 million lost their homes due to conflict, far exceeding the 11-12 million people who have fled their homes and crossed international borders and are thus classified as refugees. In addition to displacement caused by conflict, each year approximately 210 million people are affected by natural disasters (IFRC).

The number of IDPs due to conflict increased almost 25% in 1999 and continues to grow. Roughly 75% of the world's refugees are women and children – groups known to be more vulnerable to HIV infection (UNHCR). 20-25% are women of reproductive age and 1 in 5 are likely to be pregnant.

The disintegration of community and family life in conflict and refugee situations leads to the break-up of stable relationships and the disruption of social norms governing sexual behavior. Displacement mixes populations of varying HIV prevalence levels; forced migration from

[1] UNHCR: The state of the world's refugees 1997-1998. A humanitarian agenda. DC: Oxford University Press, 1998

rural to heavily populated (often higher prevalence) areas can significantly increase risk as rural populations are often less aware of HIV/AIDS and of means of prevention. Ensuing poverty and desperation can increase risk behaviours, while also diminishing access to information and modes of prevention.

The onset of war or a natural disaster can severely disrupt existing programmes, causing breakdown in health information and communication, damage to health infrastructure, lack of access to services, and shortages of supplies such as STI treatment drugs or condoms. Health workers, often the frontline workers in HIV prevention programmes, may be targeted for violence themselves and may flee from conflict areas, leaving few trained staff to continue programmes.

Many groups contribute to or are affected by the spread of HIV in conflict and disaster settings. As such it is important to look at risk factors among specific groups who may be particularly vulnerable.

Women and girls are vulnerable at all phases of conflict or natural disasters. Risk of infection from sexual violence and exploitation is all too common in conflict and often increases in post-conflict settings. Sexual coercion and levels of "survival sex", often characterized by intermittent involvement, can skyrocket as women and girls suffer exploitation simply to gain access to basic needs such as food, water, shelter or security for themselves and family. Rape is sometimes used as an integral tool of war – a method of ethnic or political persecution in systematic campaigns of terror and intimidation. The violent physical nature of rape and coercive sex itself results in tears or other genital injuries in women increasing the risk of infection.

Displaced men and boys – especially prisoners and captives - may also be powerless and therefore vulnerable to physical abuse or subjected to similar forms of sexual violation. (For additional information refer to Programme Brief No.4 Addressing Gender Perspectives in HIV Prevention.) Psycho-social consequences of sexual violence including depression, stigma, and discrimination can be profound and long-lasting and lead to further cycles of exploitation and other high risk activities such as drug use or prostitution.

Adolescents, often a high proportion of a fleeing population, are often left without role models or support systems to guide their development and are extremely vulnerable to exploitation of all types. Experience from refugee camps shows that children and young people with too little to occupy themselves, with uncertain futures, and often with no one to account to for their behavior, tend to become sexually active at an earlier age than they would under normal conditions. Many resort to substance abuse and to other unhealthy behaviours.

Most *military forces and other armed combatants* are composed of young men who are away from their homes and their stable relationships; many engage in commercial sex or other sexual interactions which may be unprotected.

Host communities, the population already living in the area into which there is an influx of refugees or where those refugees are established in camps, may also be at risk of increased infection if there is interaction between the two groups. This is especially the case when the new settlers are coming from a higher prevalence situation than the one they are arriving in. On the other hand, the deployment of troops or the influx of humanitarian activities which bring staff with resources, may also contribute to increasing the local sex trade.

What have we learned so far?

Lessons learned about STIs/HIV in emergencies and within humanitarian responses depend on the type of emergency or conflict and the cultural environment(s) in which relief efforts are undertaken. Some of the more generally applicable lessons include:

- **Ensuring the availability of adequate, appropriate food and basic services as well as protection would reduce vulnerability to STI and HIV infection.** Food, shelter, health and sanitation are primary priorities. Sex is often used as a means of barter to obtain these necessities. Inadequate protection, including the design of camp structures and lack of full legal access leaves displaced persons extremely vulnerable to those with access to goods and power. Sexual exploitation of refugees and internally displaced persons by others in the community or even by humanitarian workers or local authorities is all too common.
- **Advocacy is essential to raise HIV/AIDS awareness and build commitment among humanitarian actors, donors, and host governments.** The limited recognition of HIV as an issue and the lack of sexual and reproductive health services in many emergency settings has resulted in an inadequate response to the specific needs of vulnerable groups. This is especially true in the acute initial phases of an emergency unless traditional focus has been on the immediate survival. Change has begun yet more systematic advocacy is still needed at all levels, including among politicians, the donor community, humanitarian organizations, and national governments for the promotion of partnerships and to improve operational coordination.

- **Disruption of health infrastructure in acute emergency settings and inadequate supplies and access to resources impedes HIV prevention efforts.** HIV/AIDS and other health programmes that may have been in place will most likely not be operational in the wake of an emergency, due to damage to facilities and loss of staff and supplies. During the acute phase, this lack of infrastructure can increase the risk of HIV transmission through neglect of universal precautions, transfusion of contaminated blood, and unavailability of condoms[2]. Rehabilitating services and reestablishment of infrastructures should be a priority as situations stabilize.
- **Mixing of civilians with military forces and armed combatant groups increases risks of STI and HIV transmission and should be a primary focus of attention for awareness and prevention activities.** Some studies have shown infection rates 3-5 times higher among military groups, increasing to 50 times higher in wartime settings (UNAIDS). Peacekeeping forces can have a positive or negative impact of HIV transmission given the widely varying levels of knowledge about HIV as well as different patterns of interaction with the local population. Prevention programmes should capitalize on established military hierarchy, discipline, training programmes and medical systems. Prevention interventions among non-state combatant groups is much more difficult, but even here there are often possibilities. Demobilization programmes also offer a clear opportunity for STI/HIV prevention interventions; educating troops to work as change agents in their home communities can show enormous dividends.
- **New interventions should be carefully targeted and integrated into those which already exist.** Nothing can replace trust and good working relationships with those in authority and with operational partners. A solid understanding of both the existing structures and of the new transmission factors is critical. Different groups will have different skills and levels of awareness and interventions must take this into account. It is important to identify "messengers" that the target audience respects and from whom it is willing to receive information on sensitive issues such as HIV prevention. For example, the best health educators may be volunteers mobilized from within the displaced community and locally procured condoms may be accepted than international brands.
- **Data collection** in communities affected by crisis is notoriously poor, yet is critical for the development of appropriate and effective services including HIV prevention, monitoring the impact of emergencies on demographic and health factors, enhancing advocacy and programming effort.

United Nations General Assembly Special Session (UNGASS) on HIV/AIDS targets and recommendations (paragraphs 75-78):

- *By 2003, develop and begin to implement national strategies that incorporate HIV/AIDS awareness, prevention, care and treatment elements into programmes or actions that respond to emergency situations, recognizing that populations destabilized by armed conflict, humanitarian emergencies and natural disasters, including refugees, internally displaced person, in particular women and children, are at increased risk of exposure to HIV infection; and, where appropriate, factor HIV/AIDS components into international assistance programmes;*
- *Call on all United Nations agencies, regional and international organizations, as well as non-governmental organizations involved with the provision and delivery of international assistance to countries and regions affected by conflicts, humanitarian crises or natural disasters, to incorporate as a matter of urgency HIV/AIDS prevention, care and awareness elements into their plans and programmes and provide HIV/AIDS awareness and training to their personnel;*
- *By 2003, have in place national strategies to address the spread of HIV among national uniformed services, where this is required, including armed forces and civil defense forces, and consider ways of using personnel from these services who are educated and trained in HIV/AIDS awareness and prevention to assist with HIV/ AIDS awareness and prevention activities, including participation in emergency, humanitarian, disaster relief and rehabilitation assistance;*
- *By 2003, ensure the inclusion of HIV/AIDS awareness and training, including a gender component, into guidelines designed for use by defense personnel and other personnel involved in international peacekeeping operations, while also continuing with ongoing education and prevention efforts, including pre-deployment orientation, for these personnel;*

[2] The UNAIDS publication on HIV and Emergencies provides basic information on actions to protect affected populations at the onset of an emergency. The United Nations High Commissioner for Refugees (UNHCR) and the World Health Organization (WHO) have also developed guidelines to address medical support and post-exposure prophylaxis for victims of sexual violence. The Interagency Manual on Reproductive Health for Refugees provides a set of tools for assessing risks and for development of interventions within stabilized refugee or IDP settings.

What should be our guiding principles?[3]

- **The Minimum Initial Service Package (see MISP box) for reproductive health must be provided in acute emergency situations,** followed by provision of comprehensive reproductive health services as soon as the situation permits. (for more information see Inter-agency Field Manual, 1999)
- **Building effective HIV prevention for displaced populations requires partnerships among a broad set of stakeholders** - including national governments, regional authorities, UN Agencies, NGOs, bi-laterals, private sector, refugees/IDPs communities and those providing care. – and **utilizes a multi-sectoral approach to prevention** which addresses cross-cutting issues such as poverty, human rights, security, peace building initiatives and violence against women and girls.[4]
- **Advocating for the rights of refugees and displaced populations and to raise the awareness of the relationship between forced migration, conflict, and HIV, can positively contribute to slowing the spread of HIV and AIDS.** This includes advocating specifically for reproductive rights and concerns, for the protection of women and girls against sexual and gender based violence and for improved awareness among the humanitarian community about the importance of addressing such issues during times of instability.
- **Providing the necessary knowledge and skills to prevent HIV infection is essential especially among uniformed service personnel including peacekeeping forces.** Both in emergencies and in contingency planning, new recruits, out posted national and international military personnel, and demobilized personnel should be targets of prevention activities. Special attention should be given to the needs and vulnerability of women and child combatants, both in service and when being demobilized.

What can UNFPA do?

UNFPA is committed to assisting and protecting women, men and youth made vulnerable by natural disaster, armed conflict, persecution and other causes. This includes refugees forced to flee their home countries, IDPs uprooted within national boundaries and all those affected when a community is in crisis.

The following basic checklist of activities for HIV prevention programmes in emergencies is intended to help guide field offices in their preparations for emergencies and implementation of reproductive health and HIV interventions in the different phases of an emergency. (See Interagency Field Manual for details)

1. Emergency preparedness and contingency planning can help reduce the impact of crises on the affected population. By definition, emergencies are not planned. Being as prepared as possible is the key to efficient and effective responses in an emergency situation. The importance of strong coordination cannot be overemphasized. UNFPA should:

Objectives of the **Minimum Initial Service Package (MISP)*** are to meet the minimum reproductive health requirements in acute emergencies, with the expectation that comprehensive reproductive health services will be provided as soon as the situation allows. Components of the MISP include:

1. Identification of an organization(s) or individual(s) to facilitate the coordination and implementation of the MISP.
2. Prevention and management of the consequences of sexual violence.
3. Reduction of HIV transmission by: a) enforcing respect for universal precautions against HIV/AIDS and b) guaranteeing the availability of free male and female condoms.
4. Preventing excess neonatal and maternal morbidity and mortality by: a) providing clean delivery kits for use by mothers or birth attendants to promote clean home deliveries; b) providing midwife delivery kits to facilitate clean and safe deliveries at the health facility; and c) initiating the establishment of a referral system to manage obstetric emergencies.
5. Planning for the provision of comprehensive reproductive health services, integrated into Primary Health Care (PHC), as the situation permits.

* as defined by the IAWG-Reproductive Health for refugees

[3] General recommendations and principles adopted in various international fora are reflected in the detailed guidelines developed for the Interagency Manual of Reproductive Health for Refugees as well as in the checklist provided in the SPHERE project. The InterAgency Standing Committee for Humanitarian Affairs Reference Group on HIV and Emergencies, of which UNFPA is a member, is working on a set of guidelines for UN coordination of HIV prevention, care, and support interventions in emergency and post-conflict settings.

[4] UNFPA has established formal memoranda of understanding with a number of humanitarian actors, including UNHCR, IOM, and IFRC, as well as with a number of NGOs working on reproductive health, including HIV, in emergency and post-conflict situations.

- √ Participate in all contingency planning and coordination activities with UN, national authorities, and other partners to ensure that population and sexual and reproductive health concerns, including HIV prevention, are reflected in preparatory and contingency plans;
- √ Facilitate and support stocking and prepositioning of essential HIV/STI preventive commodities (condoms, diagnostic kits, safe delivery kits, drugs for treating STIs). This can be done by ordering emergency reproductive health kits which can be immediately deployed at the outbreak of emergency;
- √ Support capacity building in HIV/STI prevention and sexual and reproductive health emergency response through training of service providers and introduction of reproductive health kits;
- √ Support the collection of demographic data and data on HIV prevalence;
- √ In partnership with other organizations, initiate awareness-raising activities with uniformed services and relief workers;
- √ As it is often impossible to estimate the length of time that persons will be displaced or in refugee status (in some cases refugee camps have operated for decades), programming for the above activities should be included as part of regular country programme activities.

2. Both the destabilizing event and the acute phase of an emergency are chaotic times when lives are threatened and support for blood safety and universal precautions and essential supplies to prevent HIV transmission will be the priority. Effective coordination and collaboration is essential. At this point UNFPA should:

- √ Work with the identified emergency response coordinator, who will assume responsibility for operations. Country offices should maintain close contacts with other partners in the country and begin to develop plans for the stabilization phase including assessment of the scope of potential interventions, coordination with stakeholders, and fund raising;
- √ Support a rapid needs assessment/situation analysis vis-à-vis a contingency plan and rapid operationalization of an action plan;
- √ Support provision of basic information and increase advocacy campaigns on the prevention of HIV/AIDS;
- √ Support immediate implementation of the MISP;
- √ Help ensure the availability and accessibility of free condoms (male and female);
- √ Maintain close contact with UNFPA Humanitarian Response Unit for the latest developments in the crisis, technical support for operations and funding availability.

3. In post-acute and stabilization phases, <u>in addition to all activities initiated in earlier phases</u>, UNFPA should support broader and expanded services and programmes including:

- √ Comprehensive sexual and reproductive health services;
- √ Full-fledged programme(s) to address such issues as sex and gender-based violence;
- √ Advocacy for support to people living with HIV/AIDS;
- √ Formal and informal education programmes for youth;
- √ Behavior change communication (BCC) programmes and life skills education for various vulnerable groups (including commercial sex workers);
- √ Voluntary counseling and testing services (may train –as necessary-and employ displaced persons as educators/counselors);
- √ Prevention in pregnant women, mothers and transmission to their children programmes (Reference Programme Brief No.2 HIV Prevention in Pregnant Women);
- √ Further strengthening of local capacities and infrastructures to provide HIV prevention services.

It is important to note that pregnancies (both planned and unwanted) and childbirths continue to happen even in emergencies. Given that most emergency and refugee settings can not yet support nevirapine prophylaxis for pregnant women, <u>prevention of infection among pregnant women and of unwanted pregnancy should be priorities.</u> Family planning services should be provided as quickly as possible.

UNFPA can also contribute to other priority actions common to emergencies:

- Other groups will be mobilized quickly in emergencies to provide logistics and basic services including for **food security, shelter and sanitation needs**. From the early planning stages, partnerships are critical. UNFPA should use these established channels to

[5] Universal precautions are a set of safety measures designed to prevent the transmission of HIV and other infections from patient to patient, healthcare worker to patient and patient to healthcare worker. Blood safety programmes ensure that all individuals have access to blood and blood products that are as safe as possible, available at reasonable cost and adequate to meet their needs. Armed conflicts and natural disasters are often situations in which injuries may require blood transfusions and use of invasive procedures including emergency obstetric care.

programme for sexual and reproductive health services, including HIV prevention.

- Although other agencies, such as WHO or ICRC or IFRC, support **ensuring universal precautions and blood safety[5] as a part of the MISP,** UNFPA can contribute through immediate provision of emergency reproductive health supplies in the form of prepackaged kits designed for various interventions. (e.g. including materials for clean home delivery; safe blood transfusion; assisted deliveries at health centers or tertiary care facilities), and by supporting advocacy and training on universal precautions and helping mobilize resources for reestablishment of blood safety systems in post-conflict settings
- UNFPA should support the development and implementation of targeted reproductive health interventions, including for **STI/HIV prevention** and assessment of reproductive health commodity needs.
- **Monitoring and surveillance** is often weak in conflict and disaster settings, especially during the early stages of an emergency. Efforts must be made to strengthen data collection especially as the situation begins to stabilize. UNFPA should work closely with the UN Country Team to carry out rapid needs assessments and situation analyses, which provide important information for HIV prevention and care programmes.
- In refugee and IDP situations, available resources for HIV testing should be devoted, first and foremost, to ensuring a safe blood supply for transfusions. **Voluntary HIV testing and counselling (VCT)** programmes are a lower priority in these situations but should not be ruled out if resources are available and if these services are available in the host country or were available in the country of origin. Given these parameters, UNFPA should support VCT as part of the comprehensive reproductive health services set up as the situation permits. (Reference Programme Brief No. 5 Voluntary Counseling and Testing (VCT) for HIV Prevention)
- As previously noted, **advocacy remains a key component of HIV/AIDS prevention programming in emergency settings.** UNFPA should engage in systematic advocacy to raise awareness, build political commitment and ensure that planned interventions are in line with the national programme. As well, UNFPA can help reassure governments, especially those hosting refugees, that the international community is aware of the extra burdens being imposed on them and will do what is possible to help them.

Most of the described activities will need to be initiated by the field offices and may require additional funding and technical support. Coordinated through the specialized Humanitarian Response Unit, various Divisions in UNFPA HQ will support field offices in implementing these operations through provision of technical support and resources, limited emergency financing, access to global stocks of emergency supplies and support for resource mobilization. Field offices should budget for contingency planning and emergency preparedness building through regular programme resources. Such efforts would include mobilizing additional resources needed for emergency response jointly with field offices and full participation in UN Interagency Consolidated Appeal Process (CAP).

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Published Programme Briefs available on the UNFPA Website (http://www.unfpa.org/aids/index.htm):

No. 1 - Overview
No. 2 - Prevention of HIV Infection in Pregnant Women
No. 3 - Preventing HIV Infections in Young People
No. 4 - Addressing Gender Perspectives in HIV Prevention
No. 5 - Voluntary Counselling and Testing (VCT) for HIV Prevention
No. 6 - Condom Programming for HIV Prevention