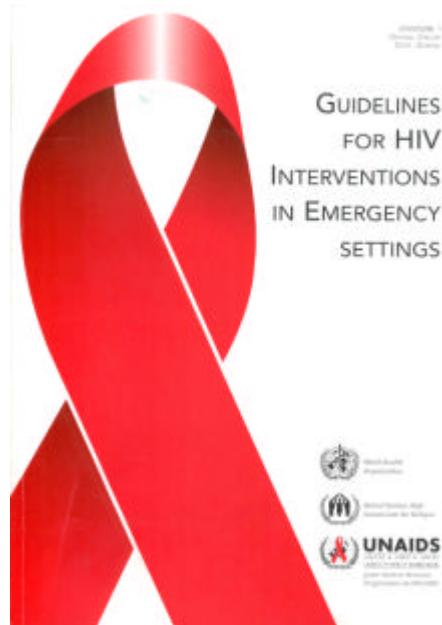


GUIDELINES FOR HIV INTERVENTIONS IN EMERGENCY SETTINGS

UNHCR/WHO/UNAIDS, 1996



ACKNOWLEDGEMENTS

WHO and UNHCR wish to thank the many people who gave so generously of their time, experience and insights during the research for developing these guidelines. Special recognition is extended to members of the Interagency Advisory Group on AIDS who contributed to the successful outcome of the guidelines:

- ILO, Geneva, Switzerland
- FAO, Rome, Italy
- UNESCO, Paris, France
- ICAO Aviation Medical Section, Montreal, Canada
- The World Bank, Washington, D.C., USA
- IMO, London, UK
- United Nations, New York, USA
- UNOV, Vienna, Austria
- UNOG, Geneva, Switzerland
- UNICEF, New York, USA
- UNDP, New York, USA
- UNFPA, New York, USA
- World Food Programme, Rome, Italy
- UNHCR, Geneva, Switzerland
- UNDCP, Vienna, Austria

We also acknowledge the assistance received from colleagues within WHO and UNHCR who are too numerous to mention individually. In addition, our special thanks go to William Brady and Sue Armstrong for their valuable contributions to technical input and writing of the document, respectively.

**GUIDELINES FOR HIV INTERVENTIONS
IN EMERGENCY SETTINGS**

Geneva, 4 September 1995

CONTENTS

	<u>Page</u>
1. Introduction	1
2. Why is HIV/AIDS a priority in emergencies?	2
3. The importance of advocacy	4
4. Stages of an emergency	5
Stage 1: The destabilizing event	5
Stage 2: Loss of essential services	6
Stage 3: Restoration of essential services	6
Stage 4: Relative stability	8
Stage 5: Return to normality	9
5. The essential minimum package	9
Prevention of HIV transmission through blood transfusion	10
Prevention of HIV transmission through universal precautions	12
Prevention of HIV transmission through provision of condoms	17
Prevention of HIV transmission through provision of information ...	22
Prevention of HIV transmission through STD care	24

6. Mobilization of the minimum package	27
7. HIV/AIDS-related human rights and ethics during emergencies	28
8. Comprehensive care for people with HIV/AIDS in the post-acute phase	32
9. Needs assessment for HIV interventions in emergencies	34
Appendix 1 – A. Example of a medical history questionnaire	36
B. Example of a donor information leaflet from a blood transfusion service in Africa	38
Appendix 2 – Essential items for blood transfusion in emergency settings	39
Appendix 3 – A. Contents of WHO/UNICEF presentation package of materials on injection safety	42
B. Information on cleaning and disinfection	44
Appendix 4 – Example: How to use the right condoms the right way	46
Appendix 5 – Example of a brochure on safer sexual behaviour	51
Appendix 6 – Needs assessment: continuous and discontinuous data ...	54

1. INTRODUCTION

Over recent decades the world has experienced a great number of emergencies,¹ both natural and man-made, that have caused massive social and political disruption and trauma to vast numbers of people. According to UNHCR, there are at present some 40 million people worldwide who have been driven from their homes by emergencies caused by natural disasters such as earthquakes, drought or floods, or else by war and civil strife, and who are living as refugees in foreign lands or as displaced persons within their own countries. Some have remained in this precarious situation for 20 years or more as the conflicts that drove them from home have not been resolved and the refugee camps to which they went have become more or less permanent settlements.

For those whose job it is to respond to an emergency, the most immediate concern is the people who are at risk of imminent death from injury, starvation, exposure or disease, and priorities for action are largely dictated by this concern. In the late 1970s/early 1980s, a new element entered the scene: HIV/AIDS. WHO estimates that, by late 1995, at least 20 million people worldwide have been infected with the human immunodeficiency virus (HIV) that causes AIDS – a figure that is expected to rise to 30-40 million by the year 2000.

Until recently, HIV/AIDS prevention has not been seen as a priority in emergencies, especially in the early acute phases, because it is not an immediate threat to life. However, the Rwanda crisis in 1994 signalled the need for a change of attitude. Never before had there been an emergency of such magnitude in a country with such high HIV prevalence, and it soon became clear that the epidemic posed a threat that could not simply be ignored until some sort of stability was re-established.

¹ UNHCR has, in a training course, defined refugee **emergency** as “any situation in which the life or well-being of refugees will be threatened unless immediate and appropriate action is taken, and which demands an extraordinary response and exceptional measures”. WHO has a working definition of **emergency** as being a “sudden occurrence demanding immediate action, that may be due to epidemics, to natural or technological catastrophes, to strife, or to other man-made causes”.

The purpose of these guidelines is to enable governments and cooperating agencies, including the United Nations agencies and NGOs, at the earliest opportunity, to adopt the measures necessary to prevent the rapid epidemic spread of HIV in emergency situations, and to care for those already affected. They can also be used for fund-raising.

The guidelines necessarily address a wide and diverse audience and users are asked to bear with the information that is not relevant to their particular needs.

2. WHY IS HIV/AIDS A PRIORITY IN EMERGENCIES?

HIV spreads fastest in conditions of poverty, powerlessness and social instability – conditions that are often at their most extreme during emergencies. Moreover, in situations of war and civil strife there is a strong likelihood that AIDS control activities, whether undertaken by national governments or NGOs, will have been severely disrupted or have broken down altogether. Thus people are left with very little scope for protecting themselves – no matter how well-informed or well-intentioned they are – at a time when they are especially vulnerable.

The following are some of the factors that encourage the spread of HIV during emergencies:

- In situations of war and civil strife particularly, women and children are at increased risk of violence, including rape. In some conflicts rape is used as a method of persecution in systematic campaigns of terror and intimidation against certain population groups, and indeed may be the root cause of flight from home. But even where this is not the case, displaced women and girls are vulnerable to sexual abuse at every stage of their flight, and many find themselves coerced into sex to gain access to basic needs such as food, water, shelter or security. If either partner in the sex act is HIV-infected, the risk of passing on the virus to the other is especially high since coercive sex is likely to result in tears or other injuries to the genitals.
- Displaced men and boys may also be powerless and therefore vulnerable to physical abuse. They may be subjected to similar forms of sexual violation as well. Prisoners and captives are at special risk.

- The disintegration of community and family life means the break-up of stable relationships and the loss of mutual support, as well as the loosening of cultural and familial controls on behaviour. Fleeing populations generally have a high proportion of unaccompanied minors, particularly single females. According to UNHCR, roughly 75% of the world's refugees are women and children.
- Experience from refugee camps shows that children with too little to occupy themselves, uncertain of their future, and often with no one to account to for their behaviour, tend to become sexually active at an earlier age than they would under normal conditions.
- People cut off from their normal sources of income and basic needs, may find that selling sex is one of very few survival strategies open to them. The experience of many refugee camps has been that the sex industry has flourished, becoming part of the interaction between the refugee population and the local people in the host country.
- Forced migration often entails people from rural areas moving to heavily-populated areas on the outskirts of towns. Rural areas generally have a significantly lower HIV prevalence than urban areas; as rural populations are less aware of means of prevention, the risks of infection increase dramatically.
- Drug injecting as a vector for the spread of HIV is rivalling sexual transmission in some countries. If a population containing many drug injectors flees an area, traffickers and dealers will flee as well, taking any portable wealth (i.e. drugs) with them. Experience suggests that injectors without the drug of their choice will inject anything – from opium to disinfectant.
- In emergency settings, the risk of HIV transmission through the transfusion of contaminated blood may be high. More transfusions than usual may be needed, especially in situations of war and civil strife and given the poor nutritional status of women and children; the displaced people may come from a high-prevalence area; and resources and infrastructure for screening may be lacking. Despite the difficulties, ensuring a safe blood supply is a priority in these settings.

These factors are part of the complex dynamic of HIV/AIDS in emergency situations and need to be understood by local authorities and the donor community, when they are deciding where and how to intervene.

To the extent possible, new activities should be integrated into what is already being done and local resources should be used. This is an early priority: failure to establish trust and a working relationship with those in authority has so often led to obstruction and delays – to vital supplies being held up at ports for want of customs clearance; to duplication of activities; or to materials being shipped in from outside when they are available locally.

3. THE IMPORTANCE OF ADVOCACY

Emergencies do not occur in a political vacuum and for the smooth running of any relief or humanitarian operation there must be good communication and cooperation with national and local authorities if they still exist, especially the military.

Food – or the need for it – is one of the major reasons for sex being used as a currency of exchange. Ensuring the availability of adequate, appropriate food would reduce vulnerability.

Among the elements of advocacy that are important are:

- Reassuring governments, especially those hosting refugees, that the international community is aware of the extra burden being imposed on them and will do what is possible to help them shoulder it. As far as HIV/AIDS is concerned, this means listening to their concerns and collaborating with them on dealing with the issues that arise; also ensuring that interventions planned are in line with the national programme.
- Reassuring host countries or communities that the needs of those living with or alongside refugees will not be ignored. When planning HIV/AIDS interventions it should be recognized that there will be considerable interaction between communities, and providing services for one and not the other is not only counterproductive in terms of preventing the spread of HIV, but is likely to cause ill-feeling and friction.

- Coming to agreement on who should coordinate the activities, and forming partnerships with others working in the same field.

4. STAGES OF AN EMERGENCY

The action taken to prevent the spread of HIV will depend on the type of emergency being addressed. As a general rule, natural disasters such as earthquakes, droughts and floods do not destroy the national AIDS prevention and care infrastructure, even if they do disrupt activities at the local level. Under such circumstances, the focus should be on strengthening the existing capacity to cope with the emergency. In situations of war and civil strife, however, there may be very little to build on.

For planning purposes, emergencies can be divided into stages. Though not all emergencies follow the same pattern and some stages will be missed altogether, this does at least provide a framework for considering appropriate HIV/AIDS interventions. Because the situation is dynamic and changing all the time, there is a need for as much flexibility as possible in the response. There are also considerable grey areas between the stages, and responding agencies will need to rely on people in the field to make judgements as to when needs and circumstances change.

Stage I The destabilizing event

This is the event that threatens the lives, physical integrity or well-being of a population and “triggers” the emergency.

Action indicated: Except for ensuring an HIV-free blood supply, few, if any, HIV/AIDS activities can be carried out during this chaotic stage, which should be used to plan the response as far as possible. Prospective donor or coordinating agencies can start mobilizing funds and resources, including background information on HIV in the affected areas, that will greatly assist those planning to go into the emergency situation with technical and humanitarian aid. If an agency has a staff member responsible specifically for HIV/AIDS, he or she should be developing or refining protocols and guidelines in local languages for use by those going into the field and translating/adapting IEC materials on STD/HIV prevention, into appropriate languages.

Stage II Loss of essential services

This is the acute stage during which there is a breakdown of political, social and/or physical infrastructure. This breakdown limits or cuts off altogether the vulnerable population's access to basic needs, such as food, safe water, shelter, security, and health care. Conditions may force people to flee. On the other hand this may not be an option and people will be living amidst the chaos. At this stage mortality and morbidity are high, and hunger may be acute.

Action indicated: During this phase, when implementing agencies are primarily focused on saving lives, only the most basic HIV prevention activities are feasible. Here the priorities are to ensure:

- (a) coordination on HIV/AIDS-related interventions with all international, governmental, and nongovernmental agencies working on the emergency,
- (b) safe blood transfusion,
- (c) access to condoms,
- (d) availability of materials and equipment needed for universal precautions, and
- (e) availability of basic HIV/AIDS information.

Stage III Restoration of essential services

This is the stage in which the national and international responses to the emergency begin to have an impact. Essential needs are increasingly being met. Mortality and morbidity remain high, but implementing agencies are beginning to address a wider range of health problems.

Action indicated: With a degree of stability and reconstruction, relief organizations can begin to design more sophisticated and proactive HIV/AIDS interventions. The following is a potential sequence of activities:

- (a) Conduct a situation analysis:
 - Assess the infrastructure of the health system. What equipment, supplies and skills are needed for HIV/AIDS work? Where can interventions begin – food distribution sites, supplementary feeding centres, health centres, maternal and child health clinics?

- Establish baseline data. Gather and assess existing information on HIV prevalence and patterns of transmission in the population groups affected; this should include information on the country, region or area of origin, and the host country, region or area since there will be considerable interaction of populations. Information relating to the pre-emergency situation and new data that emerge during the emergency are all useful.
 - Undertake formative (qualitative) research, using focus groups and in-depth interviews with key informants; to gather information on potential role behaviours, target groups for intervention, acceptability of preventive measures, etc.
 - If possible, design a knowledge, attitude, behaviour and practice (KABP) survey on HIV/AIDS and a survey on the prevalence of sexually transmitted diseases.
 - Assess the existing infrastructure of the blood transfusion facilities, i.e. buildings, equipment, technical skills of staff, budget and consumable supplies, in order to continue to build on previous interventions to ensure an adequate and accessible supply of blood and blood products.
- (b) Identify HIV/AIDS programme coordinator(s), other staffing requirements, prepare short-term plan for HIV/AIDS work with partner host country authorities, international organization(s), and NGOs. Establish working relationship with refugee community leaders as well as local community leaders. Identify the officer responsible for the blood transfusion services who will undertake to act as the focal point for ensuring that safe blood and blood products are available.
- (c) Refine the basic package of HIV/AIDS activities described in stage II, plan and implement additional activities based on what is learnt in the assessment. These might include, for example:
- IEC (information, education and communication) activities in the community aimed at encouraging safer sexual behaviour and the use of condoms;
 - Establishing a regular programme for condom supply and distribution to replace the emergency system;

- Identifying the support still required to ensure a supply of safe blood and blood products, which will include maintaining a regular and unbroken supply of materials, reagents and testing assays.
- A programme for the control of STDs including syndromic management and education;
- Clinical care for people with HIV/AIDS, based on established case management protocols.

Stage IV Relative stability

Services to the affected population, whether in their home country or in refugee settlements outside, are being restored or established. Mortality may be dramatically reduced and leading causes of morbidity will have changed. For example, when safe water supplies and shelter are restored, the leading causes of ill-health are likely to shift from diarrhoeal diseases and acute respiratory infections, to more chronic conditions such as tuberculosis but also HIV/AIDS/STD, and the usual range of surgical and obstetric emergencies seen in the community.

Blood transfusion services should develop and implement plans of action for: the collection of blood from low-risk blood donors; testing of blood for HIV; optimal preparation and storage of blood and blood products.

Action indicated: Activities already initiated will continue. Mechanisms should now be established to monitor them, and adjustments made as necessary. The five steps essential to this phase are:

- (a) continuation of activities already initiated;
- (b) strengthening programme infrastructure (local staff, equipment, buildings, procedures);
- (c) surveillance and monitoring of these activities;
- (d) attention to logistics – i.e. the procurement, storage, and distribution of equipment and supplies;
- (e) evaluation of the interventions.

Stage V Return to normality

At this stage, the destabilizing event has been resolved or is moving towards resolution. A degree of political/social/economic stability has been achieved in the area of displacement and/or conditions in the country of origin have improved to the extent that the displaced population can consider going home. In either case, people can begin to pick up the threads of normal daily life.

Action indicated: At this point, the degree of stability and reconstruction will dictate what interventions are appropriate and where they should be focused.

NOTE: It should be recognized from the start that relief agencies will, at some stage, depart, leaving local people to carry on the work. Every effort should be made to avoid creating dependency, to implement sustainable programmes and, wherever possible, to use local staff or train local counterparts during relief operations.

5. THE ESSENTIAL MINIMUM PACKAGE

The nature of the emergency being addressed will dictate what HIV/AIDS interventions are called for and what is feasible. The following are recommendations for what should be included, **as basic elements of a response to any emergency**, whatever the circumstances, **per 10,000 persons**, over a time period of one month. The guiding principles are:

- to ensure that the concerned population has access to knowledge about how to protect itself from HIV transmission, as well as the means to do so (i.e. condoms);
- to enable, empower, and provide the means;
- to maintain respect for the individual rights of people with HIV infection or AIDS;
- to prevent nosocomial transmission of HIV.

Prevention of HIV transmission through blood transfusion

The efficiency of HIV transmission through transfusion of infected blood is close to 100%. Measures to ensure the safety of blood transfusion in emergency situations, when regular transfusion services may have broken down, are extremely important.

In such situations, the main recommendations for preventing HIV infection through blood transfusion are:

- Transfuse only in life-threatening circumstances and when no other alternative is possible, (see references: *Guidelines for the appropriate use of blood*).
- Use blood substitutes whenever possible, e.g. simple crystalloids (physiological saline solutions for intravenous administration) and colloids (see references: *Use of blood plasma substitutes and plasma in developing countries*).
- Collect blood from donors identified as being least likely to transmit infectious agents in their blood. Selection of safe donors can be promoted by giving clear information to potential donors on when it is appropriate or inappropriate to give blood; by using a blood donor information leaflet (see Appendix 1). Blood from voluntary, non-remunerated donors is safer than paid donors.

Those who give blood under pressure or for payment are least likely to reveal reasons why they may not be suitable donors and therefore present a potentially greater risk of transmitting infection. This applies also to family members under pressure to give blood for a relative. Personal information given by the donor must be treated as strictly confidential.

- Test all donated blood. Screening for HIV and other infectious agents should be carried out using the most appropriate assays. In acute emergency situations these will be simple or rapid tests. Rhesus testing and simple ABO compatibility testing before transfusion should also be carried out.

Implementation

For use in the field, clear policies and protocols/guidelines should be developed on the appropriate use of blood for transfusion; the recruitment and care of donors; and the safe disposal of potentially dangerous waste products such as used blood bags, needles, and syringes.

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

- assess needs and organize delivery of essential supplies for the collection and screening of blood (see Appendix 2 for suggested blood transfusion supplies, per 10,000 persons to be cared for, per month);
- indicate conditions in the field – i.e. ambient temperature and humidity; available storage facilities for consumables and non-consumables, security of the storage facilities, refrigeration etc; describe the criteria for receiving blood and blood products;
- indicate quantities and specifications – i.e. size of blood bags (N.B. At present some of the supplies and equipment are not standardized, so it is essential to find out what people use in the local setting);
- indicate the site and time of delivery of supplies and details of contact person(s) at the receiving end (including addresses, telephone and fax numbers etc.);
- confirm receipt of supplies, state and condition on receipt and ensure delivery to the correct field site;
- monitor and evaluate the process to ensure that supplies are meeting needs;
- reorder in time for future deliveries, and plan ahead.

Appeals for blood donors should be made through the most appropriate channels of communication that exist. In the first instance this is likely to be the radio. The message should educate and inform those who should and

should not come forward and where and to whom they should report. If possible, trusted community leaders, who have been persuaded of the need, should endorse the appeal and give blood as an example to the community.

Further reading

1. *Guidelines for the appropriate use of blood*, Geneva, 1989, WHO Global Blood Safety Initiative (document WHO/GPA/INF/89.18 - WHO/LAB/89.10).
2. *Use of blood plasma substitutes and plasma in developing countries*, Geneva, 1989, WHO Global Blood Safety Initiative (document WHO/GPA/INF/89.17 - WHO/LAB/89.9).
3. “WHO policy on selection of blood donors”, in *Weekly Epidemiological Record*, 1993, 44:321- 3.
4. International Federation of Red Cross and Red Crescent Societies. “Blood needs in disaster situations: practical advice for emergencies”, in: *Transfusion International*, No. 59, March 1993.

Prevention of HIV transmission through universal precautions

“Universal precautions” are a simple, standard set of procedures to be used in the care of all patients at all times to minimize the risk of transmission of bloodborne viruses, including HIV. They consist of: handwashing; use of protective clothing such as gloves; safe handling of sharp instruments; safe disposal of medical waste including sharps; and decontamination of instruments and equipment.

Universal precautions are as important in emergency situations as at any other time to prevent the transmission of HIV between relief workers and the affected population. Because people working under pressure are more likely both to have work-related accidents and to use short-cuts in the precautions they take, infection control measures adopted during crises must be as practical as possible to implement and enforce.

The guiding principles for HIV infection control in emergency settings is that **all blood should be assumed to be potentially infectious**. (Though

HIV has been isolated from many other body fluids including saliva, tears, urine, and breast milk, experience shows that blood is the only fluid associated with HIV transmission during health care procedures.)

The main risks to relief workers are:

- injury with a needle or sharp instrument which has been contaminated with blood;
- exposure of open wounds to infected blood (HIV is not transmitted through unbroken skin);
- splashes of infected blood or body fluids on to mucous membranes and eyes.

The main risks to the patients are:

- contaminated instruments – e.g. needles, syringes, scalpels etc. that are reused without being adequately disinfected or sterilized;
- transfusion with contaminated blood;
- exposure of open wounds to infected blood.

Health care workers, patients and the general population should be reassured that there is no risk of transmission through casual contact between people, such as sharing eating utensils or washing facilities. Under certain circumstances, people without experience (e.g. aid agency officials, politicians, peacekeeping forces, journalists) may find themselves drawn into the relief effort because there is an urgent need for extra hands. They, too, should be given the information and wherewithal to protect themselves from infection as appropriate.

In the post-acute emergency phase, health care workers and other service personnel should be trained in more detail in infection control, especially those working in areas of risk for occupational exposure, e.g. attending childbirths and working in laboratories.

Elements of universal precautions and good hygiene

- **Handwashing** with soap and water. If hands are dried with a re-usable towel, it should be washed regularly. Handwashing is particularly important after contact with body fluids or wounds.

- **Gloves** should be worn for all procedures involving contact with blood or other potentially infected body fluids. (Gloves are not necessary, however, when the amount of blood is small enough to be contained in a swab – e.g. injection site). If gloves are in short supply, priority should be given to procedures involving contact with blood. Gloves should be discarded after each patient, or else washed or sterilized before re-use as appropriate. Heavy-duty gloves should be worn when materials and sharp objects are taken for disposal. Hands should be washed with soap and water as a matter of routine after the removal of gloves in case of tiny perforations.
- **Protective clothing** such as waterproof gowns or aprons, masks and eye shields should be worn only where there is likely to be exposure to large amounts of blood.
- **Safe handling of sharps.** This is the single most important consideration in preventing HIV transmission in emergency situations. All sharps should be handled extremely carefully, they should never be passed directly from one person to another, and their use should be kept to a minimum. Workers should never try to bend or break needles, nor attempt to recap needles in their sheaths – a manoeuvre associated with needlestick injury. Puncture-resistant containers for their disposal must be readily available, close at hand and out of the reach of children. Sharps should never be thrown into ordinary waste bins or bags.
- **Disposal of waste materials.** It should be recognized that people (including small children) struggling to survive will scavenge, so safe disposal is a vitally important consideration. All waste materials should be burnt and those that still pose a threat, such as sharps, should be buried in a deep pit (at least 30 feet from a water source).
- **Cleaning and disinfection.** Cleaning of medical instruments between patients is essential. Special attention must be paid to instruments that are contaminated with body fluids. Disinfection and cleaning are recommended (see Appendix 3). HIV will be inactivated through boiling or the use of chemical disinfectants. Non-reusable equipment such as disposable needles and syringes should not be reused. Reusable equipment should first be dismantled and cleaned and then boiled for at least 20 minutes. For those instruments that are heat-sensitive, the following agents may be used:

- chlorine-based agents (e.g. household bleach)
- 2% glutaraldehyde
- 70% ethyl and isopropyl alcohol.

Accidents at work

In cases of injury with a sharp instrument, the wound should be encouraged to bleed for a few moments and then washed thoroughly with soap and water. It should then be covered with a waterproof dressing.

If a person receives splashes of blood or other body fluid into the mouth, the mouth should be rinsed out thoroughly with water. If the splash occurs to the eyes, these should be bathed with saline solution or plain water.

Any accident should then be reported to a health officer in charge to ensure appropriate follow-up.

Implementation

Guidelines should be adapted or developed that give workers in the field clear and concise information about the potential risks of their environment, how to protect themselves, and what to do in the case of accidents such as needle-stick injuries, cuts or blood splatterings. For workers' peace of mind and the rational use of infection control measures, it is equally important to give clear information about what does **not** constitute a risk. The guidelines should spell out when it is, and when it is not, appropriate to use the various items of protective clothing and why. Health workers should also be given guidance on how to avoid unnecessary injections and other procedures involving sharp instruments.

For a population of 10,000 persons, over a time period of one month, the following supplies are recommended as a minimum to prevent the transmission of bloodborne viruses such as HIV:

- 900 disposable needles
- 900 disposable syringes
- 500 reusable gloves (pair)
- 100 sterile gloves (pair)
- 60 sleeved gloves (pair)
- 30 aprons (gowns)

- 30 masks
- 20 heavy duty gloves (pair)
- soaps
- disinfectant (20 l)
- 5 rubber sheets

Monitoring and evaluation

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

Handling corpses

HIV can live and reproduce only in a living person. Therefore, shortly after an HIV-infected person has died the virus will also die. However, when handling corpses in an emergency situation it is advisable for relief workers to protect their hands with gloves, if possible, and to cover any wounds on the hands or arms with a plaster or bandage. This is especially important if body fluids such as blood or diarrhoea stools are involved. Relief workers should wash thoroughly with soap and water afterwards.

Further reading

1. *Guide of kits and emergency items: decision-makers guide*. Médecins sans Frontières, MSF Logistique, 33700 Mérignac, France (May 1994).
2. *Preventing HIV transmission in health facilities*. Geneva, World Health Organization (document GPA/TCO/HCS/95.16).
3. *Guidelines on sterilization and disinfection methods against human immunodeficiency virus (HIV)*, 2nd ed. Geneva, World Health Organization, 1989 (WHO AIDS Series No. 2).
4. *AIDS home care handbook*. Geneva, World Health Organization, 1993 (document WHO/GPA/IDS/HCS/93.2).
5. *Injections: pledge for safety*. Presentation package of materials on injection safety, WHO/UNICEF, 19 October 1994.

Prevention of HIV transmission through provision of condoms

Acute phase

Condoms offer effective protection against the sexual transmission of HIV if they are consistently and correctly used. Since most of the world's people have already been exposed to this message in some way, the most urgent task facing emergency relief agencies during this acute phase is to make condoms freely available to those who seek them.

The main considerations are:

- **Supply and distribution.** In the AIDS era, condoms should be considered an essential item in emergency relief supplies. They should be on the checklist of every agency responsible for providing relief supplies, from the World Food Programme and UNHCR, to small NGOs. Decisions should be made as to whether it is most appropriate to pre-package condoms with other items such as emergency medical or food supplies, or whether to package them separately but deliver them to the field at the same time and using the same channels as other relief supplies. To some extent this will depend on the quantity of condoms to be sent to the field in any given emergency.

Agencies need to decide, too, how best to distribute the condoms to the public, and how to ensure that they reach vulnerable groups, including women and youth. This will have some bearing on the route used to deliver them to the field. For example, if it is decided that condoms should be made available at health clinics, it makes most sense to include them with medical supplies; if at food distribution points, then they should be sent with food supplies.

Culturally appropriate instructions (e.g. pictorial) on how to use condoms, and how to dispose of them safely, should be included with the consignments. The public should be informed of how and where to obtain condoms through whatever communication channels are available, e.g. radio, posters.

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

- **Needs assessment.** During the acute phase of an emergency there is no time to seek the detailed information about sexual behaviour on which condom supplies are calculated in more normal situations. The decisions about quantities to send to the field will have to be based on whatever information is available. The estimated size of the affected population is important, as is any indication available of the gender and age make-up of the group. In addition, national AIDS programmes, if they are still functional, may have useful information on the sexual behaviour of the affected group.

Formulae common to family planning programmes may give a general idea of the requirement, i.e. about eight condoms per month per sexually active male. Add to this figure 50% for “safety stock” and 20% for wastage and loss.

Generally, there are 3500 men in the reproductive age groups per 10,000 population, of whom about half are sexually active. A baseline calculation for procuring one months’ supply of condoms per 10,000 population would then be:

$$\begin{aligned}(3500 \times 1/2) \times 8 &= 14,000 + 50\% \text{ safety stock} \\ &= 21,000 + 20\% \text{ wastage/loss} \\ &= 25,200 \text{ (about 25,000)}\end{aligned}$$

Follow-on supplies should be modified according to the field situation (e.g. demographic profile in refugee camps may be very different from the normal demographic profile; there may, for example, be a disproportionate number of women and children). An example of instructions on condom use are given in Appendix 4.

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

- **Procurement and quality.** Good quality condoms are essential both for the protection of the consumer and the credibility of the relief programme.

The two main factors that influence condom quality are: (a) quality at time of manufacture; and (b) their treatment while in the distribution pipeline. If the condoms are of good initial quality, are protected with impermeable foil packaging and are properly stored (protected from rain and sun, in particular), they are likely to retain much of their original quality. Moreover, in emergency settings the turnover of condoms is likely to be relatively fast, and they are less likely than usual to be exposed to sun and humidity on market stalls.

The procurement office responsible for bulk purchases in emergencies should require a certificate with each shipment of condoms verifying that they have been quality tested on a batch-by-batch basis by an independent laboratory.

There is a huge variety of condoms on the market, and if an emergency relief agency's experience of condom procurement is weak it may be desirable for the programme to buy them through an intermediary supplier such as UNFPA, IPPF or WHO², which can buy bulk quantities of good-quality condoms at low cost. It should also be noted that WHO keeps a stock of condoms in Marseille which can be used in emergencies.

Post-acute phase

During the acute phase of an emergency, as part of its prevention of HIV transmission strategy, a relief programme will focus on issues of immediate concern such as obtaining a sufficient quantity of good-quality condoms and integrating their distribution into existing channels such as health clinics and food distribution points. As the situation normalizes, it will be important to build on this foundation in order to respond to the full range of needs that are associated with STD/HIV prevention in a more stable community.

² The following are the contact addresses on condom supplies on file in WHO:

1. IPPF: Dr H. Mahler, Regent's College, Inner Circle, Regent's Park, GB-London NW1 4NS, Fax No. (44) 71 487 7950
2. UNFPA: Dr Nafis Sadik, 220 East, 42nd Street, New York, N.Y. 10017, USA, Fax No. (1) 212 297 4915
3. WHO: Chief, Supplies, CH-1211 Geneva 27, Fax No. (41) 22 791 41 96

To maximize condom use among individuals at risk of HIV/STD infection, a series of interrelated activities must be undertaken in a coordinated way. **Condom programming** is the recommended management approach that incorporates the key elements of demand, supply and support.

The condom programming concept links product *supply* as a response to the growing *demand* for barrier protection with *support* activities. If condom promotion, for example, is not based on the epidemiology of STD/AIDS in the community and is not accompanied by work that addresses the policy environment, appropriate distribution outlets, low prices and good quality, etc., the condom promotion effort will be wasted.

The team responsible for planning the condom programming component of the post-acute phase in an emergency setting must conduct a thorough assessment of the condom promotion and distribution situation followed by a planning exercise. The following action-oriented recommendations are intended to serve as a guide to help the team understand the actual and potential condom demand, supply and support dimensions in the community. The steps they then take to build on the existing situation will flow naturally from that understanding.

Actions

1. Identify the main public, private and NGO partners which can implement condom promotion and distribution activities. Analyse the levels and proportion of funding for condom programming and condom-related activities, by cooperating sector, agency and NGO.
2. Conduct an analysis of the specific sexual behaviours that transmit STD/HIV by type, frequency and use of condoms.
3. Determine the sizes and locations of the main groups of people to target for condom promotion and distribution.
4. Assess the main constraints (and opportunities) pertaining to condom promotion and distribution.
5. Analyse the existing condom “market”, i.e. brands, promotion/distribution strategies, packaging, instructions, prices, sizes, lubrication, accessibility and quality.

6. Determine the quantity of condoms in the pipeline, i.e. sources (including, if applicable, local manufacture), shipments (en route and pending), in transit and in stock.
7. Make an estimate of the quantity of condoms needed by populations who will be targeted for condom promotion and distribution for the coming year and the coming five years. Using service statistics, demographic and/or behavioural data, one can accurately forecast requirements and thus avoid overstocks or stockouts.
8. Explore ways to procure condoms either from donors, intermediary suppliers or directly from manufacturers (foreign or domestic) and weigh the cost-effectiveness and sustainability of existing sources. Condoms that satisfy the requirements of the WHO Specification can be procured from UNFPA, IPPF and WHO.
9. Identify the most appropriate channels and outlets for condom distribution for each target group.
10. Identify/develop the most appropriate messages and media for condom promotion for each group.
11. Identify ways to obtain consumer feedback (especially complaints) on condom acceptability, including size, lubrication, breakage, slippage, packaging and other factors that affect acceptance.
12. Establish ways to assess the adequacy of existing logistics systems for the ordering, receipt, handling, storage and distribution of condoms.
13. Decide upon ways to evaluate the quality of condoms stored for long periods, including ways to obtain national, regional or international quality-testing laboratory services.
14. Develop strategies to strengthen or establish positive policy, laws and regulations in support of condom programming, including constraints affecting import, distribution and advertising. Positive policies which support the goals of the STD/AIDS prevention effort need to be established at national and community level. The support of government and community leaders is vital if the programme is to overcome the many

constraints associated with condom promotion and distribution. Educating legislators about the social and economic impact of AIDS and lobbying opinion leaders about the threat posed to youth are only two of the ways in which the programme can solicit and gain the support of decision-makers in the community.

15. Design and use simple monitoring and evaluation criteria.
16. Develop the necessary training activities to establish or strengthen staff skills and enhance motivation.

Further reading

1. *Managing condom supply manual*. Geneva, World Health Organization, 1995 (document WHO/GPA/TCO/PRV/95.6).
2. *Logistics management; forecasting and procurement*. Condom Programming Fact Sheet No. 6 (document WHO/GPA/TCO/PRV/95.12).
3. *WHO specification and guidelines for condom procurement*. Geneva, World Health Organization, 1995 (document GPA/TCO/PRV/95.9).

Prevention of HIV transmission through provision of information

The acute phase of an emergency is not the time for launching, de novo, information and education programmes aimed at changing attitudes and behaviour. The challenge at this point is to give back a measure of power to people who have lost control over their lives. All opportunities should be explored for giving the affected population basic information pertaining to HIV/AIDS.

People who are preoccupied with more immediate dangers need to be reminded of the fact that HIV/AIDS remains a threat in emergency situations. They need also to be reassured about what does not constitute a threat. And they need to be given appropriate and basic information on how best to protect themselves from infection under the circumstances, or look after themselves if they already have HIV/AIDS. This means information on how and where to acquire free condoms, where and how to get medical attention if necessary, and information on basic hygiene.

In emergencies, when normal communication networks are disrupted, people tend to congregate round any available radio sets for information on what is happening. The radio is therefore one of the first options to consider for anyone with a public announcement to make, and should be used too for appropriate HIV/AIDS messages. Besides providing the messages to be broadcast, agencies should consider supplying radio announcers with basic fact sheets on HIV/AIDS as background material and handy reference.

In addition, emergency relief agencies should ascertain what information and education materials, if any, are still available locally and make use of them as appropriate. Brochures (Appendix 5) on safer sexual behaviour may be particularly relevant, for example, and they could be distributed at all health and other facilities including feeding centres, or wherever else condoms are on offer. About 4000 brochures per 10,000 persons/month may be the minimum requirement. Posters bearing basic HIV/AIDS messages may also be useful, and agencies should consider what can be prepared in advance of a crisis. Mobile demonstration teams could provide simple, basic, culturally appropriate information on HIV prevention in situations such as refugee camps.

Finally, much of the information on HIV/AIDS is sensitive, and thought should be given to who are the best “messengers”. The central questions to answer are: who does the target audience most respect? And from whom will they accept this particular message?

In the post-acute phase of an emergency situation, while various aspects of the AIDS programme are being reactivated, contacts with the various sectors (e.g. public information, education, health, social affairs, youth, women) which were involved in the IEC activities before the emergency should be re-established in order to assess the following:

- status of current IEC activities
- availability of school materials, training materials, promotional materials, audiovisual equipment used in IEC activities, and the magnitude of damage that has occurred in relation to these activities
- loss of human resources, facilities, services
- material and human resources required to rectify the damage
- intentions, plans and feasibility of restarting activities.

Reactivating the various IEC programmes will involve making training and promotional materials available, reprogramming IEC activities and budget in view of the loss and damage, replacing staff and re-establishing committees.

Programmes that were produced before the emergency, can be re-broadcast, reminder messages and articles can be published in key newspapers and magazines, and key people in the field of HIV prevention and care can be interviewed and encouraged to advocate for the necessity of reviving the IEC activities at the community level and in various sectors. It is also important to use the media to assure people that prevention and care services are or will be available.

During emergencies, adults are likely to be fully occupied, dealing with their families' basic survival needs. Until schools are fully operating again, young people may be idle and can be mobilized to do community volunteer work in prevention and care. They can be particularly useful in peer education but can also do valuable sensitization work with the general population.

Prevention of HIV transmission through STD care

Access to STD care

Because the risk of HIV transmission is greatly increased in the presence of other STDs, early establishment of STD-related services is a priority. STDs and their complications are a major cause of ill-health and are usually grossly under-reported. The prevention of STDs involves the promotion of safer sex as well as early and effective case management and case finding.

Early and effective STD case management

STD services should be user-friendly, private and confidential. STD patients should be managed at the first encounter of the patient with any health worker. Special arrangements may be necessary to make STD care accessible to women and young people.

Appropriate and effective case management involves the following:

- Guidelines for case management: case definition and management protocol
- Training health care providers
- Consistent availability of appropriate drugs

- Consistent supply of condoms
- Referral facilities
- Monitoring

Training health care providers

All health care providers, including volunteer workers, should receive some training in prevention, be provided with information materials and serve as channels for the distribution of condoms. A professional health worker should be trained in the syndromic approach to STD management. A training module should be selected which includes the following:

- Diagnosis and syndrome recognition
- Effective treatment based on observed syndromes
- Education/counselling focused on specific target groups
- Condom promotion and provision
- Partner notification and management
- Monitoring
- Importance of confidentiality.

STD drugs

Treatment should be standardized on the basis of syndromes and not dependent on laboratory analysis. A treatment protocol based on syndromic case management should be prepared and adopted (*See Further reading, next page*). The most effective drugs should be used at the first encounter. In all cases, the national treatment protocol should be considered.

Initial drug requirements should be based on available data from the country of origin and estimated accordingly. Monitoring of the activities will then serve to review real needs. Note that if IEC efforts are effective, if services are user-friendly and out-of-camp people are attending the clinics, the needs for drugs may increase rapidly.

Laboratory services

Cost, inconsistent availability of supplies and lack of expertise severely limit the practicality and availability of laboratory investigations in refugee

situations. A syndromic approach to STD case management should allow effective care without recourse to laboratory support. The exception to this is diagnosis of syphilis which can be done on-site using simple, serological screening tests. Syphilis testing is recommended for case finding in pregnant women and screening of blood donors.

Partner notification and management

Partners of patients with an STD are likely to be infected themselves and should be offered treatment. Each patient should be provided with contact slip(s) to be given to their sexual partner(s). On the basis of these slips, partners should be provided the same treatment as the “index” patient in any health facility. The process should be confidential, voluntary and non-coercive and include all sexual partners of each “index” STD patient.

Monitoring

Data on the number of STD cases presenting for treatment or detected in health services are essential for planning services and as an indicator of trends in STD incidence in the community. Always suspect an under-reporting of STDs.

STD case finding

Syphilis in pregnant women is particularly harmful to the unborn child. Whenever possible, screen all pregnant women for syphilis including this as part of routine antenatal care. If such systematic screening is not possible and there is a known high prevalence (equal or superior to 10%) of syphilis in the population, consider prophylactic treatment of all pregnant women with a single injection of benzathine penicillin at the first antenatal contact.

Further reading

1. *Management of sexually transmitted diseases*. Geneva, World Health Organization, 1994 (document WHO/GPA/TEM/94.1).

6. MOBILIZATION OF THE MINIMUM PACKAGE

Preparedness

The key to an efficient and effective response to emergencies is preparedness. Preparedness means having identified in advance the human, material and financial resources required to respond to an emergency situation, and being able to draw on these resources as rapidly as possible. This implies having already established or identified the mechanisms for the release of the resources needed.

A needs and resources assessment should be conducted as early on during the emergency as possible. It is important to bear in mind that the assessment is not a one-time event, but a continuous process which should be undertaken throughout the emergency response operation.

The minimum package

Since in the initial, acute stage of an emergency only limited HIV prevention activities are feasible, it is proposed that the following should be priorities:

- (a) safe blood transfusion;
- (b) access to condoms;
- (c) availability of materials and equipment needed for universal precautions to prevent the spread of HIV infection between relief workers and victims of the emergency, and;
- (d) availability of basic relevant HIV/AIDS information.

This minimum package is designed to address these priorities for a population of 10,000 persons per month.

Requirements for accessibility/availability of the package

Having immediate access to the minimum package is vital and several options exist to ensure this:

- the materials and equipment in the package can be stockpiled;
- the agency can pre-negotiate agreements with suppliers in advance; or
- if there is no risk of delay in procurement and delivery, the items may be bought on the open market.

The choice of any of these options will depend on the concrete procurement and delivery conditions for each of the items in the package.

Mechanisms for release

According to which option has been chosen for ensuring the rapid availability of the minimum package, procedures and mechanisms for the release of the equipment and materials should be developed. The responsibilities involved should be clarified in advance, e.g. who activates the package (e.g. should it be one specific agency or should several/all agencies/organizations have direct access to the package?), who within the agency/organization should authorize the release? What procedures should be established to ensure effective and rapid release?

Implementation/dissemination

The process of implementing the activities related to HIV interventions in an emergency situation involves addressing fundamental issues of management and coordination which include:

- identification of the agents of implementation (UN agencies, NGOs, regional and local authorities, regional and local health structures)
- development of understanding with the agents of implementation for the acceptance of the minimum package and its incorporation into their standard packages which have already been developed for emergency situations.

As stressed, the key to a rapid and effective response is that all above arrangements are planned, and put in place beforehand.

7. HIV/AIDS-RELATED HUMAN RIGHTS AND ETHICS DURING EMERGENCIES

During any emergency when political, social and security structures break down, human rights may be violated in ways that either increase the risk of infection with HIV or increase the impact that HIV/AIDS has on infected people and their families, or on people merely suspected of infection.

In terms of increased risk of infection, people are able to avoid infection to the degree that they have access to HIV/AIDS prevention information, education, health (STD and reproductive) services and means of prevention (condoms); and are able to use these to avoid infection. During emergencies, people will have less access to such information and services, either because they are not available or accessible or because they are denied by those in power at the time. The degree of access will of course change over time as the emergency moves from the acute phase to phases of increased stability. Thus, in the context of the provision of assistance during emergencies, the provision of HIV/AIDS education and services should be seen as a part of meeting people's basic rights to life, health, education and information.

Marginalized or disadvantaged groups will have less access than they usually do to such information and services. In the context of the activities described in this guide, special measures, such as providing targeted outreach programmes, should be taken so as to ensure that particularly vulnerable and disadvantaged groups have access to HIV/AIDS prevention information and condoms during emergencies. Among emergency populations and refugee populations, such groups include women, children, minorities, indigenous peoples, migrants, the illiterate, the poor, men having sex with men, sex workers and injecting drug users.

People should also be able to avoid sex that threatens them with infection. With the breakdown of family, social and security structures that occurs during emergencies, this is more difficult than usual because of the increase in sexual and gender violence. Such violence includes all coerced or non-consensual sex, including rape inside and outside marriage, sexual abuse, exploitation of prostitution, trafficking in women and children, sexual bartering, and female genital mutilation. Such sexual violence involves a higher likelihood of infection because the person coerced cannot protect him/herself from unsafe sex and because the virus can be transmitted more easily if bodily tissues are torn during violent sex.

Thus, measures taken during emergencies and armed conflict to protect those vulnerable to sexual violence will also protect them from increased risk of HIV transmission. Those particularly vulnerable are women, children, the elderly, detainees and prisoners.

Non-consensual sex includes people giving sexual favours in exchange for essential goods and services, such as food/water, shelter, fuel, security. Therefore, to the degree possible the loci in which women/children interact with authorities for access to these essential goods should be monitored, as should all places of detention, including local jails. POW detention centres and refugee camp detention centres. Furthermore, HIV/AIDS prevention education and issues of sexual abuse should be targeted to those in the community who have “authority”, such as refugee camp officials, refugee leaders, national military units and peacekeeping forces, staff of international and nongovernmental organizations, truck drivers, vendors of household goods and brothel owners. (For further steps to take, see UNHCR documents: *Sexual Violence against Refugees – Guidelines on Prevention and Response, 1995*; *Refugee Children – Guidelines on their Protection and Care, 1994*; *Guidelines on the Protection of Refugee Women, 1991*.)

The human rights of those infected or suspected of infection should also be respected both to protect their dignity and to enable them to cope with the disease. Coercive or discriminatory measures which may be taken (often in the name of public health) include mandatory testing of individuals or groups; publication of HIV status; isolation or segregation of people infected with HIV/AIDS; and denial of asylum, health care, employment and/or assistance because of HIV status. Such measures violate the rights of people living with HIV or suspected of it and do not prevent the spread of HIV/AIDS.

Mandatory testing is sometimes a reaction by authorities if they fear that a displaced or refugee population may infect a local population. However, mandatory testing in such situations does not stop the spread of infection from one population to another because:

- HIV/AIDS is already present in all populations; testing itself does not stop the spread of the disease; testing diverts resources from programmes for prevention education and information, STD management, and condom distribution, all of which are more effective in reducing the spread.
- Testing does not identify all those infected because of false results and/or because of the “window period” during which a person may be infected and highly infectious but the antibodies to the disease have not yet developed and do not register on the test; furthermore, a person who tests negative may become infected any time after the test.

Since testing cannot identify all HIV-positive people, every person receiving health care should be regarded as a potential carrier of HIV, hepatitis B and other bloodborne infections; and universal precautions by health workers should be observed at all times.

Mandatory testing not only has no public health justification; it also violates the rights of people, including the rights to privacy and security, as well as the ethical principles of autonomy, informed consent and confidentiality. If HIV status is made known, HIV-positive people may be subject to discrimination, stigma, ostracism, harassment and physical abuse. Thus, HIV/AIDS status should be kept confidential by health care workers and other authorities who may have access to it.

Furthermore, in the provision of health care during emergencies, medical tests and treatment, including those related to HIV/AIDS, should be conducted with the informed consent of the patient. All the positive and negative consequences of testing or treatment should be explained to the patient. With regard to pregnant women, there should be no routine or hidden testing of such women. Rather, as part of prenatal care, they should receive information and counselling concerning HIV/AIDS so that they may make informed and voluntary decisions, concerning testing, pregnancy, treatment and breast-feeding. Protocols to obtain informed consent and ensure confidentiality should be developed.

The establishment of voluntary testing and counselling programmes is not a priority during an emergency. Available resources for HIV testing should be devoted, first and foremost, to ensuring a safe blood supply for transfusions. As the emergency or refugee situation stabilizes, voluntary testing and counselling programmes should be made available to the affected population to the extent that they are available in the community at large. As with any voluntary counselling, pre- and post-test counselling should be provided, with informed consent being obtained during pre-test counselling.

In order to be able to cope most successfully with HIV/AIDS during emergencies, people who are infected with HIV or have AIDS should remain in their homes, communities, refugee camps and health care facilities, as appropriate, where they should have equal access to available care and support. They should not be segregated into special areas, nor should access to assistance and health care be denied due to HIV status. The right to seek and enjoy asylum should also not be denied on account of HIV/AIDS status, actual or presumed.

8. COMPREHENSIVE CARE FOR PEOPLE WITH HIV/AIDS IN THE POST-ACUTE PHASE

Comprehensive care for people with HIV-related illnesses should be seen as a essential component of basic curative care in any refugee situation. This is especially important when refugees come from an area where HIV-related illnesses have become a predominant cause of morbidity and mortality. As tuberculosis is one of the main presenting problems in people with HIV, serious consideration must be given to the feasibility of introducing a tuberculosis diagnosis, management and control programme.

The elements of comprehensive care include: clinical management – early diagnosis, rational treatment and planning for follow-up care; nursing care to promote and maintain hygiene and nutrition, provide palliative care, educate individuals and families on AIDS prevention and care; counselling to help individuals make informed decisions on HIV testing when available, stress and anxiety reduction, and promoting safer sex; and social support – information and referral to support groups, welfare services and legal advice.

The introduction of comprehensive care for HIV-infected persons in refugee situations involves:

- Sensitizing health workers to HIV-related illnesses and AIDS.
- Adapting existing clinical and nursing guidelines for case management in primary and secondary care in refugee settings. This should include guidelines on discharge and referral of people with HIV-related problems.
- Drawing up an essential drugs list for treatment of HIV-related illness and establishing mechanisms to ensure the procurement and supply of these drugs.
- Training health care workers in the use of the clinical guidelines and essential drugs list.
- Introducing counselling training for health and lay workers, and developing guidelines for the provision of counselling. This can be integrated into counselling for other stresses related to the refugee situation.

- Ensuring that HIV-related care is fully integrated into basic curative services, and that prevention components (e.g. supply of condoms) are part of the care.
- Developing community support for AIDS care by:
 - exploring community capacities and commitment;
 - encouraging the development and training of self-help and other community-based support groups;
 - starting community-based care and support activities, using the self-help groups that have been established.
- Developing a tuberculosis control policy which includes: case definition and diagnosis of tuberculosis in a refugee situation, appropriate regimens to be followed, supervised ambulatory care, mechanisms to ensure case-holding, especially where refugee populations are likely to move, management of complications and side effects of drugs, and tracing of contacts and case-finding.
- Collecting data on numbers of AIDS cases, using the WHO clinical definition.

Further reading

1. *Guidelines for the clinical management of HIV infection in adults*. Geneva, World Health Organization, 1991 (document WHO/GPA/IDS/HCS/91.6).
2. *Guidelines for the clinical management of HIV infection in children*. Geneva, World Health Organization, 1991 (document WHO/GPA/IDS/HCS/93.3).
3. *HIV prevention and care: teaching modules for nurses and midwives*. Geneva, World Health Organization, 1991 (document WHO/GPA/CNP/TMD/93.3).
4. Slide set on *Clinical aspects of HIV infection in adults* (document GPA/IDS/HCS/93.4).

5. *HIV/AIDS counselling: A key to caring: guidelines for policy makers and planners*. Geneva, World Health Organization, 1995 (document WHO/GPA/TCO/HCS/95.15).
6. *AIDS home care handbook*. Geneva, World Health Organization, 1993 (document WHO/GPA/IDS/HCS/93.2).
7. *Sourcebook for HIV/AIDS counselling training* (document WHO/GPA/TCO/HCS/94.9)

9. NEEDS ASSESSMENT FOR HIV INTERVENTIONS IN EMERGENCIES

In the acute phase of an emergency there is no time for a detailed situation analysis, and relief workers must be prepared to work on the basis of assumptions. However, certain sources of information can and should be tapped to ensure that the relief operation is as relevant as possible to the situation on the ground. HIV prevalence data and country profiles are available from the Joint United Nations Programme on AIDS (UNAIDS) and elsewhere. As discussed before, this will give an idea of the magnitude of the HIV threat and which population subgroups are especially vulnerable to infection. It is an important element in decision-making and setting priorities.

Information on the size of the population affected will be available from national governments in some cases, and from agencies such as UNHCR if refugees are involved. For the purposes of HIV interventions, the gender and age make-up of the affected population is important.

These details are rarely available early on, and opportunities should be identified, as a matter of urgency, for gathering such information during routine emergency relief activities, such as registering people for food distribution, visiting refugee camps, or providing emergency medical care.

During the immediate post-acute phase of an emergency, a health information system (HIS) coordinator and team for the emergency should be named, either specifically for HIV/AIDS/STD aspects of the emergency, in which case the HIS team should be under the STD/AIDS coordinator, or for all HIS needs for the emergency – under the overall coordinator for the emergency. The following are the minimum needs assessments recommended to be carried out:

Continuous data

- Monitoring of HIV and VDRL/RPR sero-prevalence in donated blood for transfusion.
- Monitoring of VDRL/RPR sero-prevalence in pregnant women attending prenatal care.
- Monitoring of reported new cases of: (a) active tuberculosis; (b) male urethral discharge; (c) vaginal discharge; (d) genital ulcers, in the populations affected by the emergency.

Discontinuous data

- Registration of all persons directly affected by the emergency, recording of age group, sex, language spoken, by camp and/or emergency area.
- Census of all agencies or groups (health ministry; national NGO; bilaterals; multilaterals; international NGOs; multilaterals) providing health services, by type of service offered.
- Site visits to camps or areas affected, to qualitatively assess: accessibility; fragility of camp or area; nature and extent of potential HIV/STD-associated risk behaviours/practices.
- Monitoring of condom, HIV/syphilis test kit availability in health facilities.
- Monitoring of condom, HIV or VDRL/RPR test kit, disposable needle, and ciproflaxin stocks available in the emergency area.
- Annual surveys of HIV sero-prevalence in pregnant women attending prenatal care.
- Prevention indicator surveys, the initial round, 12 months following the initiation of the above-mentioned points and subsequent rounds every 2-3 years, depending on the stability of the camp or area affected, and/or the duration of the emergency.

Detailed instructions for undertaking needs assessment using continuous and discontinuous data are provided in Appendix 6.

APPENDIX 1

- A. EXAMPLE OF A MEDICAL HISTORY QUESTIONNAIRE**
- B. EXAMPLE OF A DONOR INFORMATION LEAFLET FROM
A BLOOD TRANSFUSION SERVICE IN AFRICA**

APPENDIX 1

EXAMPLE OF A MEDICAL HISTORY QUESTIONNAIRE

I fully understand that any incorrect statement or concealment may be to the detriment of my health or the health of the patient who receives the blood donated by me.

Do you suffer or have you suffered from:

- | | | |
|--|--|---|
| <input type="checkbox"/> Lung disease | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Rheumatic fever |
| <input type="checkbox"/> Persistent cough | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Circulation problems |
| <input type="checkbox"/> Anaemia | <input type="checkbox"/> Nose bleeds (excessive) | <input type="checkbox"/> STD/VD |
| <input type="checkbox"/> Low/high blood pressure | <input type="checkbox"/> Dizziness | <input type="checkbox"/> HIV/AIDS |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Prolonged diarrhoea |
| <input type="checkbox"/> Unexplained weight loss | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Thyroid disorder |
| <input type="checkbox"/> Swollen glands | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Shingles | <input type="checkbox"/> Skin rashes | <input type="checkbox"/> Malaria |
| <input type="checkbox"/> Night sweats/fever | <input type="checkbox"/> Sleeping sickness | <input type="checkbox"/> Hepatitis/jaundice |
| <input type="checkbox"/> Brucellosis | <input type="checkbox"/> Asthma | |

Are you taking or have you taken any medicines:

- | | | |
|-------------------------------------|---------------------------------------|-----------------------------------|
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Antibiotics | <input type="checkbox"/> Steroids |
| <input type="checkbox"/> Injections | <input type="checkbox"/> Vaccinations | <input type="checkbox"/> Other |

Have you had any operations:

- | | |
|--------------------------------|--------------------------------|
| <input type="checkbox"/> Minor | <input type="checkbox"/> Major |
|--------------------------------|--------------------------------|

Have you had any:

- | | | |
|---|--|--|
| <input type="checkbox"/> Acupuncture | <input type="checkbox"/> Scarifications | <input type="checkbox"/> Blood transfusion |
| <input type="checkbox"/> Sexual contact with a prostitute | <input type="checkbox"/> Homosexual contacts | <input type="checkbox"/> Exposure to drugs by injection for non-medical uses |

Have you been in contact with any infectious disease?

Females only:

Are you pregnant or have you been pregnant within the last 6 months?

Are you breast-feeding?

Do you have any menstrual problems (excessive menstrual bleeding)?

Donor's signature Date

Health Worker's signature Date

Accept/Defer/Reject

**EXAMPLE OF A DONOR INFORMATION LEAFLET
FROM A BLOOD TRANSFUSION SERVICE IN AFRICA**

IMPORTANT INFORMATION ABOUT AIDS FOR THOSE WHO WISH TO GIVE BLOOD

WHAT IS AIDS?

AIDS is a disease which destroys the body's ability to protect itself against infections and other illnesses. It is caused by HIV, a virus that lives in blood and other body fluids. You can therefore get HIV infection if blood containing the virus enters your blood stream. You can also get HIV infection by having sex with someone who has HIV. This is particularly true if you have had a sexual contact which has resulted in you contracting a sexually trans-mitted disease (STD). More information about HIV and AIDS and how to protect yourself from getting the disease can be obtained from your doctor or your nearest health clinic.

IS THERE ANY RISK OF CATCHING HIV FROM BLOOD DONATION?

There is absolutely no risk to blood donors giving blood at any blood donor clinic. All the materials used for collecting blood are sterile and are only used once, so HIV or any other disease cannot be caught from giving blood.

WHAT TESTS ARE DONE ON DONATED BLOOD TO ENSURE THAT IT IS SAFE FOR TRANSFUSION?

The laboratory does tests for HIV, syphilis (an STD) and hepatitis B. The tests are the same as those used anywhere in the world. However, these tests may not show the early stages of infection. So people who may have been exposed to HIV infection must not donate blood. If the results of a test are positive, a donor is only informed if he or she requests the service to do so. People who think that they may have been infected by HIV must not use the Blood Transfusion Service as a place to find out if they are infected. This could be very dangerous to the patient who receives their blood.

WHO SHOULD GIVE BLOOD?

Please remember blood is required in order to save lives. Only healthy people who are not at risk from HIV and other transmissible infections should donate blood. If all the people in this category give blood regularly, our country will have sufficient supplies of blood which will greatly assist in saving lives.

WHO SHOULD NOT GIVE BLOOD?

Blood should not be given by people who have had a sexually transmitted disease or who are at risk of contracting HIV, including those with many sexual partners, homosexuals, prostitutes and injecting drug users. It should also not be given by anybody who has had sexual contact with anyone in these categories.

Blood transfusion services have a very high respect for people who give their blood to save a life. We are confident that nobody would knowingly donate blood if they thought that they could possibly transmit HIV and cause the recipient of the blood to develop AIDS.

Blood is required daily. Give blood and save a life with your safe blood. Your support is appreciated.

APPENDIX 2

ESSENTIAL ITEMS FOR BLOOD TRANSFUSION IN EMERGENCY SETTINGS

CHECKLIST OF ESSENTIAL ITEMS PER 10,000 POPULATION COLLECTION,
TESTING AND TRANSFUSION OF 1000 UNITS OF WHOLE BLOOD³

Item No	Item description	Usual presentation	Recommended quantity	Important remarks
	CONTAINER 1			
	Perishable must be refrigerated			
1	Anti-A Blood Group Reagent	10 ml vials	12 x 10 ml	Perishable "+2 to 8 °C"
2	Anti-B Blood Group Reagent	10 ml vials	12 x 10 ml	Perishable "+2 to 8 °C"
3	Anti-A+B Blood Group Reagent	10 ml vials	12 x 10 ml	Perishable "+2 to 8 °C"
4	Anti-D Rhesus (Saline)	10 ml vials	12 x 10 ml	Perishable "+2 to 8 °C"
5	HIV 1/2 Rapid Test	100 tests	12 x 100	Perishable "+2 to 8 °C"
6	HBsAg Test, rapid	200 tests	6 x 200	Perishable "+2 to 8 °C"
7	Anti-Human Globulin Polyvalent, Coombs	10 ml	12 x 10 ml	
8	Phosphate Buffered (Normal) Saline	1 L	12 L	
	CONTAINER 2			
9	Blood bag single, 450 ml, CPDA with taking set & needle	200 pieces	6 x 200 pieces	If bloodbag sizes differ please indicate size required i.e. 250ml/
10	Transfusion set, blood, sterile, with fixed vein needle 18Gx1.5" with inline filter and injection port	100 sets	12 x 100 sets	
11	IV catheter, 20Gx1.1/4", sterile, disposable, with wing	50 pieces	10 x 50 pieces	
12	Ditto, 22Gx1"	50 pieces	10 x 50 pieces	
13	Ditto, 23Gx3/4"	50 pieces	5 x 50 pieces	
14	Multiwell plates, polystyrene, 96 U-wells, without lid	50 plates	12 x 50 plates	
15	Vacutainer tube 10ml, siliconized	100 tubes	5 x 100 tubes	
16	Pasteur pipettes with integral bulb, disposable plastic non-sterile, 3 ml graduated in 0.5ml	500 pipettes	5 x 500 pipettes	
17	Blood lancets, sterile, disposable	200	10 x 200	
18	Gauze swab, 8-ply, 10x10cm	100 swabs	50 x 100 swabs	
19	Plaster, surgical, Tenso, 6x2cm	1000 pieces	5 x 1000 pieces	
20	Plaster, Albuplast, 9.14mx5cm	6 pieces	10 x 6 pieces	
21	Markers, fine point, permanent black glassware, etc.	10 markers	5 x 10 markers	

³ Consult agency supplies and equipment lists for potential suppliers and unit prices: a selection is also provided at the end.

Guidelines for HIV interventions in emergency settings

Item No	Item description	Usual presentation	Recommended quantity	Important remarks
22	Test tubes, round bottom, polystyrene, 75 x 10 mm	1000 tubes	25 x 1000 tubes	
23	Syringe 5 ml, hypo, disposable	100 syringes	12 x 100	
24	Needle hypo, disposable, 21Gx1.5", Luer, sterile	100 needles	12 x 100	
25	Ditto, 23Gx1"	100 needles	5 x 100	
26	Copper sulphate, male, SG 1.055	1 L	2 L	For rapid assessment of haemoglobin levels Ditto
27	Copper sulphate, female, SG 1.053	1 L	1 L	
28	Glove operation latex disposable, sterile, anatomically shaped, size 7.5	50 pairs	5 x 50 pairs	
29	Sharps container, disposable, 6 litre capacity	25 containers	5 x 25 containers	
	CONTAINER 3 Dangerous goods			
30	Isopropanol		5 litres	
	CONTAINER 4 Bulk items			
31	Sodium chloride 0.9%, 1l + set vacutainer for IV human use (item 11 can be used as cannula/catheter for this item)	20 vacutainers	200 x 20	This is a bulk item – each vacutainer set of 1 l weighs 1 kg i.e. 4,000 kg
	CONTAINER 5			
32	Spring balance for testing weight of donated blood, i.e. 250/600gm		12	If the pack is to be ordered several times this item should not be repeated: one-off order for each blood transfusion facility
33	Domestic body weighing scale 20/30 kg to 250 kg	1	2	Ditto

PACKAGING AND FORWARDING GUIDELINES

1. A forwarding agent should be identified in Europe (Brussels, Frankfurt, etc.) who can “group” the items listed on the attached checklist.
2. The lead time for all of these items to be made available to the forwarding agent from the different suppliers is 3-4 weeks.
3. A supply service can order the items and arrange for a forwarding agent and eventual shipment of the supplies.
4. The supplies have been arranged into “containers” in order to facilitate packing and receipt/storage/distribution at country level.
5. Test kits and reagents should ideally have expiry dates at least three months later than the expected date of delivery.

SELECTION OF SUPPLIES AND EQUIPMENT CATALOGUES FOR HIV INTERVENTIONS

1. UNICEF Copenhagen Warehouse: Standard stock items catalogue.
UNICEF Plads, Freeport, DK-2100 Copenhagen 0, Denmark.

Fax No. (45) 31 26 94 21
2. WHO Supplies and equipment list – basic standard items
WHO, CH-1211 Geneva 27, Switzerland.

Fax No. (41) 22 791 4187
3. Inter-Agency Procurement Services Office (IAPSO), UNDP
IAPSO, Gittervej 20, Freeport, P.O. Box 2530, DK-2100 Copenhagen 0,
Denmark.

Fax No. (45) 35 27 37 99
4. Médecins Sans Frontières Logistique: Logistics catalogue and medical catalogue
MSF Logistique, 14 avenue de l’Argonne, F-33700 Merignac, France.

Fax No. (33) 56 13 73 74

APPENDIX 3

**A. CONTENTS OF WHO/UNICEF PRESENTATION PACKAGE
OF MATERIALS ON INJECTION SAFETY**

B. INFORMATION ON CLEANING AND DISINFECTION

**CONTENTS OF WHO/UNICEF PRESENTATION PACKAGE
OF MATERIALS ON INJECTION SAFETY*****DOCUMENTATION****POLICY*

- WHO/UNICEF joint statement on the safety of injections
- Yamoussoukro declaration
- Safety of injections in immunization services – WHO recommended policy (document WHO/EPI/LHIS/94.1)
- Reducing the risk of unsafe injections in immunization programmes: the role of injection equipment (WHO/EPI/LHIS/94.2)
- The use of opened vials of vaccine in subsequent immunization sessions – WHO policy statement (WHO/EPI/LHIS/95.1)

TRAINING

- Safe injection practices (EPI Update, January 1995)
- Product Information Sheets – injection and sterilization equipment (reprint of sections 8-10)
- Immunization in Practice – A guide for health workers who give vaccines: syringes, needles and sterilization
- Instructions for the use of steam sterilizer and sterilizable plastic syringes
- Surveillance of adverse events following immunization (document WHO/EPI/TRAM/93.2)
- Worksheet for calculating disposable syringe needs.

SUPPORTING PAPERS

- Safety, effectiveness and ease of use of a non-reusable syringe in a developing country immunization programme (Bulletin of the World Health Organization, 1995, 73(1): 57-63)
- Risk of human immunodeficiency virus and hepatitis B virus transmission through unsafe injections – model-based estimates (draft document)
- Risk of transmission of hepatitis B virus or human immunodeficiency virus from jet injectors or needles and syringes (draft document)
- Report on injection practice research in Indonesia (excerpts from a draft report).

INFORMATION ON CLEANING AND DISINFECTION

HIV can be transmitted via needles, syringes and other invasive equipment contaminated with body fluids. To protect patients from infections, these items should be cleaned and sterilized, or appropriately disinfected before each use.

<i>Disinfection</i>	<i>Cleaning</i>
The inactivation of vegetative bacteria, viruses and fungi, but not spores	The physical removal of most microorganisms and contamination, using detergent and water

(a) Cleaning

Efficient cleaning with detergent and hot water removes a high proportion of any microorganisms present. Heavy-duty gloves should be worn for cleaning instruments. Additional protective clothing should be worn if there is a likelihood of splashing, e.g. plastic aprons and protective spectacles. All equipment should be dismantled for decontamination. The level of decontamination for instruments and equipment depends on what the equipment is used for.

<i>High risk</i>	<i>Medium risk</i>	<i>Low risk</i>
Instruments which penetrate the skin or sterile body areas	Instruments that come into contact with mucous membranes or non-intact skin	Equipment that comes into contact with intact skin, or items that do not come into contact with the patient
<i>Decontamination Method</i>	<i>Decontamination Method</i>	<i>Decontamination Method</i>
↓	↓	↓
1. Sterilize	1. Sterilize if possible e.g. dental instruments, vaginal speculae	1. Wash thoroughly with detergent and dry.
2. Single use disposal	2. Boil for 20 minutes 3. Chemical disinfection for equipment that is heat- sensitive	

(b) Disinfection

Disinfection will usually inactivate HIV. Two commonly used methods are boiling and chemical disinfection:

- Boiling is an effective way to disinfect equipment, e.g. needles and syringes, if autoclaving facilities are not available. Equipment, which has first been cleaned, should be boiled for 20 minutes.
- Chemical disinfection is used for heat-sensitive equipment that is damaged by high temperatures. Most disinfectants are effective against a limited range of microorganisms and vary in the rate at which they destroy microorganisms. Items must be fully dismantled and immersed in the disinfectant. Care must be taken to rinse disinfected items with clean water so that they do not become re-contaminated. Chemical disinfectants are unstable and chemical breakdown can occur. They may also be corrosive and irritant to skin and protective clothing may be required. Chemical disinfection is not as reliable as boiling or sterilization. However, the following will inactivate HIV:
 - ⇒ chlorine-based agents e.g. bleach
 - ⇒ 2% glutaraldehyde
 - ⇒ 70% ethyl and isopropyl alcohol

(c) Spillages/splashes of body fluids

Following a spillage of body fluids, gloves are worn (e.g. heavy-duty rubber gloves) and as much of the body fluid as possible is removed with some disposable absorbent material, e.g. paper towels. This is then discarded safely into a leak-proof container and incinerated. The area of spillage is cleaned with a chlorine-based disinfectant and the area is thoroughly washed with hot water and detergent.

APPENDIX 4

**EXAMPLE: HOW TO USE THE RIGHT CONDOMS
THE RIGHT WAY⁴**

⁴ Extracted from GPA briefing document for United Nations Peacekeeping Forces (document WHO/GPA/DIR/95.3).

HOW TO USE THE RIGHT CONDOMS THE RIGHT WAY

1. First pick the right condoms

- The best ones to use are made of latex rubber. These are less likely to break or leak than animal-skin condoms or the thinner “more sensitive” condoms.
- If you have a choice, pick condoms with lubrication (slippery liquid or gel) already on them. This makes them less likely to tear during handling or use. **NEVER USE AN OIL-BASED LUBRICANT WITH A CONDOM.**
- Some condoms are packaged with spermicide (such as nonoxyl-9), a chemical designed to kill sperm. Most spermicides also kill viruses. Although they are not available everywhere, condoms that include a spermicide may provide an additional barrier against the AIDS virus.
- New condoms are stronger than old ones. If you keep a condom for too long, the rubber loses its strength. Store them in a cool, dry place out of direct sunlight. Heat quickly damages rubber, so do not store condoms in hot spots such as the glove compartment of a car. Many condom packages will have either a manufacturing date or an expiry date on them. This is helpful since it provides an indication of age. Older condoms are likely to be weaker, and should be thrown out. A condom should also be thrown out if it feels brittle, dried out or very sticky, or if it looks discoloured or was in a torn or damaged package – so take a look at them as you use them.
- Condoms should never be re-used – use a new condom each time you have sex. So, keep a supply of condoms on hand.
- Carry some condoms whenever you go out. Even if you do not use them, you can give a spare one to a friend who may have forgotten his.

2. Next, using condoms should be discussed with the person you are planning to have sex with

- Waiting to pull out a condom until the moment before you have sex is the WORST possible time to bring up the subject. Your partner may get angry that you have waited so long and may feel tricked, or not trusted.
- The best time to introduce the subject of using condoms is the first time you think about having sex with someone. Planning to protect yourself and your partner from getting a sexually transmitted disease, especially AIDS, shows that you care about your health and about your partner's health. It also shows that you are aware of the risks of unprotected sex at a time when AIDS is a serious epidemic all over the world.
- The person you are thinking about having sex with may not agree at first when you say that you want to use a condom when you have sex. You may need to offer some arguments about why you feel that way, using facts you learned from this brochure. If the person still resists, then the smart thing to do is not to have sex. If that person cares so little about his/her health – or yours – then you should find someone else who does care.

3. Once you and your partner are comfortable with the idea of using a condom and are ready to have sex, here is how to use a condom the right way:

- Only open the package containing the condom when you are ready to use it. Otherwise, the condom will dry out. Be careful not to tear or puncture the condom when you open the package. If it does get torn, throw it away and open a new package.

- Condoms come rolled up into a flat circle. They can only be unrolled onto an erect (“hard”) penis.
- Before the penis touches the other person, place the rolled-up condom, right side up, on the end of the penis.
- Hold the tip of the condom between your thumb and first finger to squeeze the air out of the tip, or teat. This leaves room for the semen to collect after ejaculation (“cumming”).
- Keep holding the top of the condom with one hand. With the other hand (or your partner’s hand), unroll the condom all the way down the length of the erect penis to the pubic hair. If the man is uncircumcised, he should first pull back the foreskin before unrolling the condom.
- Always put condom on before entering partner.
- If the condom is not lubricated enough for you, you may choose to add a “water-based” lubricant, such as silicone, glycerin, or K-Y jelly. Even saliva works well for this. Lubricants made from oil (cooking oil or shortening, mineral or baby oil, petroleum jellies such as Vaseline, most

lotions) should NEVER be used because they can damage the condom.

- If you feel the condom slipping off during sex, hold it at the base to keep it in place DURING THE REST OF THIS SEXUAL ACT. It would be safest for the man to pull his penis out and put on a new condom, following all the steps again.
- 4. After sex, you need to take the condom off the right way:**
- Right after the man ejaculates (“cums”), while still inside his partner, he must hold onto the condom at the base, near the pubic hair, to be sure the condom does not slip off.
 - Now, the man must pull out WHILE THE PENIS IS STILL ERECT. If you wait too long, the penis will get smaller in size, and the ejaculate (“cum”) will spill out of the condom.
 - When the penis is completely out, take off the condom and throw it away.
- 5. If you are going to have sex again, use a *new* condom and start the whole process over again!**

APPENDIX 5

EXAMPLE OF A BROCHURE ON SAFER SEXUAL BEHAVIOUR

World Health Organization: Global Programme on AIDS RECOMMENDATIONS

About Safer Sex

- Whether you are a man or a woman, you can become infected with HIV through the sexual secretions of an HIV-infected partner, especially if you engage in unprotected sex.
 - Mutual fidelity between two uninfected partners protects both people from HIV.
 - The more sex partners you have, the greater the risk that one of them will be infected and will infect you and the greater the risk that you will infect others. The more partners your partner has, the greater the risk that he or she will be infected and can infect you.
 - The presence of sexually transmitted diseases increases the risk of HIV infection.
 - Even if a condom is used, some sexual practices are more risky than others.
- If you and your sex partner are HIV-seronegative and maintain a monogamous relationship, do not inject drugs, share needles, or receive transfusions of infected blood – and have never done so – you are not at risk of HIV infection. If you are unsure about any of these factors, it is important for both of you to practise safer sex.

Tips for Safer Sex

The four key tips for safer sex, as summarized below, will reduce the risk of HIV transmission through sexual behaviour.

- 1.** Always use a condom during vaginal or oral intercourse (see details on next page).
- 2.** Anal intercourse is one of the riskiest practices. If you engage in anal intercourse, use a good-quality, well lubricated condom. The extra lubrication will reduce the likelihood that the condom will be damaged during this form of sex.
- 3.** To be even safer, engage in imaginative non-penetrative sex, such as caressing or massaging any part of the body, masturbation (provided that sexual secretions do not come into contact with exposed mucous membrane or with cuts or sores on the partner's skin) and kissing that does not involve exchange of blood.
- 4.** The safest course of all is abstinence.

World Health Organization: Global Programme on AIDS
R E C O M M E N D A T I O N S

How to use a condom

- Be sure to have a condom *before* you need it.
- Use a condom with every act of vaginal, oral or anal intercourse unless you are absolutely sure that you and your sexual partner are both uninfected. This means that you have both had a negative HIV test result or that neither of you has had other partners, received a transfusion of infected blood or used intravenous drugs for at least 10 years, or since your negative test results. If you are not sure, use condoms.
- Before the penis touches the partner, place the condom on top of the erect penis. Hold the condom so that the rolled rim is on the side away from the body. If uncircumcized, pull the foreskin back. It should unroll easily and not need to be stretched.
- After ejaculation, hold the condom rim to the base of the penis while pulling the penis out. This makes sure that the condom will not slip off.
- Take off the condom without spilling semen.
- Throw the used condom away into normal rubbish receptacles. Do not use a condom more than once.
- Use another condom if the one you have:
 - has torn or damaged packaging;
 - bears a manufacturing date more than five years past;
 - is uneven or changed in colour;
 - feels brittle, dried out, or very sticky.

Tips for Condom Care

Heeding these tips will help keep condoms breaking or leaking.

1. Store condoms in a cool dark place, if possible. Heat, light and humidity can damage condoms.
2. If you have a choice, choose prelubricated condoms that come in square wrappers and are packaged so that light does not reach them. The lubrication may make them less likely to tear during handling or use. Protection from light slows deterioration.
3. Take care handling condoms. Fingernails and rings can tear them.
4. If you want a lubricant, use silicone or other lubricants that do not contain oil. These include glycerin and specially products such as K-Y Jelly. Spermicidal jelly and foam are also good lubricants and add more protection against pregnancy and STDs. Do not use cooking oils or shortening, baby oil, mineral oil, petroleum jellies (such as Vaseline), skin lotions, suntan lotions, cold creams, butter, or margarine.
5. Do not unroll condoms before using them. You may weaken them, and an unrolled condom is difficult to put on. Keep extra condoms on hand if you want to practise.

APPENDIX 6

**NEEDS ASSESSMENT: CONTINUOUS
AND DISCONTINUOUS DATA**

Continuous data

Disease, or syndrome-specific, data should be collected by the health information system (HIS) for HIV/AIDS/STD surveillance purposes for new cases of the following conditions:

1. HIV/AIDS-associated diseases:
 - clinically diagnosed new cases of active tuberculosis, with or without radiological confirmation.
2. Newly diagnosed cases of STD-associated clinical signs:
 - male urethral discharge;
 - vaginal discharge;
 - genital ulcers.
3. HIV and/or VDRL/RPR sero-reactivity in selected populations:
 - VDRL/RPR sero-reactivity in pregnant women, and blood donated for transfusion;
 - HIV sero-reactivity in blood donated for transfusion.
4. Denominator data:
 - number of persons consulting, or admitted to, clinics/health facilities/hospitals each month.

Laboratory facilities for smear microscopy (for acid-fast bacilli (AFB), suggestive of *M. tuberculosis*) should be available. Where possible, surveillance data on tuberculosis cases reported should be stratified by: (a) pulmonary tuberculosis, AFB smear positive; (b) pulmonary tuberculosis, AFB smear negative; (c) extrapulmonary tuberculosis.

Surveillance data should be analysed separately for each camp/emergency area (i.e., all new cases reported by a health facility in a camp/emergency area are counted, even if the person is not from the camp). Rates should be calculated on the basis of all newly diagnosed cases reported of the above

conditions in a camp/area (the **numerator**), divided by the reported number of attendances for all clinics/health facilities/hospitals in the camp/area (the **denominator**). The data should be analysed as two-monthly moving averages.

Using “moving averages” helps to obtain trends that are more easily interpretable as changes in disease frequency, and not due to other phenomena such as changes in clinic attendance.

EXAMPLE. Surveillance of new cases of active tuberculosis is started in January. For January, a rate for the month alone is calculated, and graphed; in February, the average (**mean**) of the February and January rates is calculated, and graphed; for March, the average rate for February – March is plotted; for April the “moving” average rate for March – April; for May, the moving average will be the mean of the April and May monthly rates, and so on.

Laboratory testing for HIV should use kits that detect both HIV-1 and HIV-2. For emergency needs assessment purposes, distinguishing HIV-1 infection from HIV-2 is not a priority, as prevention measures against both HIV serotypes will be the same.

Continuous (routine) monitoring of data separately by camp/emergency area is important, since these data are to be used for rational targeting and selection of priority areas/camps in which to take public health action. For example, a rise in the apparent HIV sero-prevalence in blood donated for transfusion in one camp/area may lead to the following actions: (a) site visits to both blood donation site and laboratory, to determine whether or not clerical, procedural, and/or technical errors have occurred; (b) reinforcement of blood donor motivation, recruitment, and deferral procedures; (c) review and/or 3 months) reinforcement of the donor screening questionnaire; (d) intensified HIV/AIDS/STD prevention efforts in the camp/area. If these measures are effective, HIV/syphilis sero-prevalence in donated blood should remain low, decrease, or rise more slowly than in the population as a whole.

Discontinuous data

1. An estimate of the age/sex profile of the camp/emergency area, should be obtained when a census of the camp/emergency area is conducted; the repetition of such surveys depends on the duration of the emergency,

or stability of the camp/emergency; generally they should be repeated as often as once a year (or less frequently). As a minimum, age may simply be collected as: **newborn/toddler; child; prepubertal adolescent; postpubertal adolescent/ young adult; adult; elderly.**

Age/sex data help to define supply/logistics needs, by providing a crude estimate of the of the number of persons at risk of HIV/AIDS/STD (i.e. the total of postpubertal adolescents/young adults, plus adults)

2. The overall coordinator for the emergency should compile an annual census of: (a) all agencies or groups (health ministry; national NGOs; bilateral aid agencies; international NGOs; multilateral agencies) providing health services to the population/area affected by the emergency. These data should be shared with the STD/AIDS coordinator, and the HIS coordinator. Such data should include the name of the chief-of-party of each agency, and the types of health-related activities in which they are involved.

The HIS coordinator, or HIS staff, should make regular supervisory tours (at least every 3 months) of the camps/areas affected by the emergency. From the first of such visits, the HIS team should develop a profile of the different camps, including its location/accessibility (on main road, near large town, etc.). Such qualitative data will also help make a preliminary assessment of the HIV/STD risk profile of the populations.

The data will also help in assessing the distribution and spread of diseases; for example, if two camps, 10 km apart, are on the same road whereas the other camps are not, then if for example, an epidemic affects one of these two camps, then the other camp on the same road may be next to be affected, even if other camps are closer by distance “as the crow flies”.

On supervisory tours by either the HIS team, or the STD/AIDS coordinator, the clinics/health facilities/hospitals should be checked to see if they have adequate supplies of: condoms; HIV test kits; and VDRL or RPR test kits. The simplest way would be to ensure that local stores have enough stocks of such items to cover at least the previous month’s utilization rate.

EXAMPLE. Records indicated that 5,000 condoms were requested/supplied to local clinics last month. The local storehouse had 10,000 condoms remaining in-stock. The STD/AIDS coordinator concluded that local stocks were adequate to meet expected demands.

3. Once a year, the HIS team should coordinate an unlinked anonymous survey of HIV seroprevalence in pregnant women coming to selected health facilities for antenatal care, who have blood taken for VDRL/RPR testing. In this unlinked anonymous testing, residual blood originally taken for VDRL/RPR are tested for HIV after all data which identify the source person are removed. This method, recommended by WHO for HIV surveillance purposes, makes it possible to obtain the best possible data on HIV penetration into the population (here, of pregnant women), while protecting the anonymity of the person.
4. The central warehouse should be monitored by the HIS team, or STD/AIDS coordinator, to ensure that there remains in-stock at the central warehouse supplies of: (a) condoms; (b) HIV or RPR/VDRL test kits; (c) disposable needles; (d) ciproflaxin, sufficient to cover three times the demand for the above-mentioned items in the preceding month.

Stocks of all other items should also be monitored, but by a logistics, or stock control, officer, whose duty it would be to ensure an uninterrupted and adequate supply of all equipment and supplies. The above-mentioned items are proposed as indicator items, to be monitored in addition by the STD/AIDS coordinator, and/or the HIS team, to monitor the adequacy of supplies.

5. Once the first round of the previously-mentioned needs assessments have been completed, and/or the routine collection and analysis of continuous data are in-place and functional, consideration should be given to conducting a baseline prevention indicator (PI) round of surveys within the first 12 months following the start of the needs assessments. This is especially so if the camp is likely to exist for some time (as a rule of thumb, 2 years or more), and/or the emergency will remain unresolved for some time (2 years or more). The PI are a series of indicators developed by GPA to help assess the effectiveness of public health HIV/AIDS/STD prevention and control programmes against heterosexually transmitted HIV/STD. Such PI surveys should be repeated every 2-3 years, to look at trends in these indicators of HIV/AIDS/STD prevention.

References

1. Training module: surveillance of HIV infection (draft document GPA/TCO/SEF 1993)
2. *Unlinked anonymous testing for the public health surveillance of HIV infections: proposed international guidelines*. Geneva, World Health Organization, 1991 (document GPA/SFI/89.3).
3. *Field guidelines for sentinel HIV surveillance: A manual for national AIDS programmes* (document GPA/TCO/SEF 1991).