

# Sexual Health in Humanitarian Emergencies

With a Special Focus on  
Preventing HIV/AIDS

## A Guide



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## Foreword

In the recent decades, natural and man-made disasters as well as complex humanitarian emergencies created by conflict, war, insurgency and militancy have worsened the risk and vulnerability of the disaster-affected communities in several countries across the world. This worsening of risk and vulnerability has been increasingly felt in economic, social, political and physical spheres. However, one of the most critical areas which has not received adequate attention of researchers, academics and policy formulators is that of the potential adverse impacts of these disasters on the risk and vulnerability of disaster-affected communities, specifically relating to sexual health. This publication, in the form of a Guide, titled 'Sexual Health in Humanitarian Emergencies' by Swasti and Oxfam International, published by Catalyst Management Services, addresses the need for guidance to development practitioners, voluntary activists, policy formulators and implementers on facilitating affirmative action to identify, assess and proactively respond to reduce the sexual health-related risk and vulnerability of disaster-affected communities.

Eighteen months after the Indian Ocean tsunami of 26<sup>th</sup> December 2004, Oxfam and its partners commissioned Swasti to carry out extensive field research in select locations in Kerala, Tamil Nadu, Andhra Pradesh, Pondicherry and the Andaman and Nicobar islands on the impact of the tsunami on the sexual health of the tsunami-affected communities, with a special focus on their risk and exposure to HIV/ AIDS. This study assessed the tsunami impact on the levels of vulnerability of the affected communities, their risk and exposure to HIV/ AIDS, reviewed the causal chain of factors that contribute to these vulnerabilities, and analysed how they varied across geographic and demographic profiles. This Guide has benefited from the insights gathered during the extensive interactions with grassroot communities in the course of the field visits. The contributors to this Guide felt the critical imperative to use these field-level insights to provide the

foundation for the programming of post-disaster response strategies with special attention to the concerns of sexual health of vulnerable communities.

This Guide is in three parts: Part I presents an overview of sexual health in humanitarian emergencies and identifies the critical gaps in existing toolkits; Part II provides ten useful tools to equip multiple stakeholders concerned with improved quality of life of communities in disaster-prone areas for more effective programming; and Part III provides brief annexures with links to additional sources of information. I hope that this publication would compel many organizations which restrict their programming interventions only with concerns of Reproductive Child Health to expand the scope of their response to incorporating the wider concerns of improved sexual health of grassroot communities at risk.

I am sure that this Guide will be an extremely useful resource for all those concerned with improved programming in the humanitarian sector. I hope that this publication will receive the attention it deserves, not only within the country but also in many other emergency hotspots of the world, and will enrich the work of professionals in the humanitarian sector in policy formulation, training, capacity building and overall programming to improve the lives of disaster-prone communities.

**N Vinod Chandra Menon**  
Member

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## Foreword

India is frequently hit by natural calamities like floods, droughts, earthquakes, cyclones and the like. This often leads to displacement and loss of livelihood creating a vulnerable environment for HIV to add to the crisis. The study done by Swasti with support of Oxfam in the Tsunami affected coastal belts of Andhra Pradesh, Tamil Nadu, Kerala and Andaman and Nicobar Islands has established credible evidence to showcase the link between disasters and increased vulnerability to HIV. I am happy to introduce this guide “Protecting Sexual Health in Humanitarian Emergencies, a Guide” as a useful tool for programmes aimed towards mitigating HIV induced disaster in an already catastrophic situation. This guide provides step by step guidance on how to mainstream HIV prevention, treatment and care programmes within a humanitarian response. This guide provides critical entry points to humanitarian workers to intervene effectively for mitigation of increased vulnerability to HIV following a natural disaster. In its present form, it can easily be integrated with standard humanitarian guidelines, tools and field manuals. Through this publication, Governments and civil society partners can effectively mainstream HIV issues into humanitarian response programmes and can contribute to mitigating the risk of HIV as well as its impact following a disaster. This will equally be useful to donors, policy makers and multilateral organisations to advocate strongly and provide resources for integration of HIV into humanitarian programmes launched in the wake of natural disasters in India.

I congratulate all those who have contributed to preparing this guide and hope that it will be put to best use for an integrated humanitarian response.

**J.V.R. Prasada Rao**

Regional Director, UNAIDS Regional Support Team Asia Pacific

[www.unaids.org](http://www.unaids.org)




## Foreword

**T**he link between vulnerability to HIV and humanitarian disaster has long been recognized and yet there is much work needed to address them together in humanitarian situations. Around 25 million people have died and about 30 million are living with HIV today. AIDS is the fifth major cause of death in middle-income countries, the third in low-income countries (WHO, 2007) and the leading cause in sub-Saharan Africa. And that should signify a disaster, albeit, a slow onset one. The WDR reports states that “for many marginalized groups, HIV is a disaster. “Given that the essence of the actions of humanitarian organizations is the protection of vulnerable and marginalized people, working to enhance the resilience and capacities of people and communities to prevent HIV/AIDS suitably meets this express mandate.

HIV has had devastating impacts on high prevalence areas by affecting growth, productivity, employment, stretching or breaking down health care and education, influence food shortages and leaving a trail of orphaned children. The relation of conflicts and natural disasters with HIV is broadly understood but tenuously known. The World Disaster Report (WDR) 2008 notes that among countries with high rates of HIV, about half have been affected by major conflict between 2002 and 2005, with mass rape, forced displacement, breakdown in basic health care, disruption of social programmes and educational systems all increasing the risk of infection. However, little is available on spread of HIV and natural disasters but what is known is that disasters can drastically disrupt the minimal care and support requirements and facilities. What is definitive is that humanitarian sector has started to understand the impact of HIV on people living through and emergency situation. People living with HIV and AIDS in protracted and complex emergencies more than often get lost as targeting and focusing humanitarian response becomes a huge challenge. Hopefully this guide to Sexual Health in Humanitarian Emergencies will help humanitarian professionals and agencies deliver their responsibility towards the some of the most vulnerable affected by disasters.





The evolving nature and increasing frequency of disaster events along with conflicts, impact of global warming and fragile states is increasing displacement and insecurity among many population groups. This is not only furthering vulnerability to HIV and AIDS but along with the epidemic and its complexities is raising crucial challenges on reducing vulnerabilities for the humanitarian community. While there is strong agreement on overcoming the complex challenge posed by HIV and AIDS in the protection and assistance of affected communities a vacuum exists on how this can be done in emergency operations.

Maybe the nature of the HIV prevention or care and support programmes would be subject to how widespread the epidemic is in the affected region and surrounding regions or maybe not. Maybe demographic information and epidemiological information would be able to inform the nature of targeting that is to be undertaken for the HIV and AIDS programme. Would the interventions need to differ depending on which stage of the emergency –immediate relief, rehabilitation, recovery etc. and how would they differ? These among others must be questions that perplex humanitarian actors and managers in integrating HIV and AIDS into their response and preparedness programmes.

This toolkit is one effort towards bridging this information and knowledge gap by providing some answers that could help humanitarian actors design programmes that integrate HIV and AIDS related interventions. The toolkit helps answer strategic planning concerns, provides inputs on preparedness and, helps intervention planning and implementation for managers of humanitarian organizations. For many of us humanitarian actors this toolkit is a good way to start looking at concrete steps and actions towards addressing HIV and AIDS through our emergency response and preparedness programmes.



**Sarbjit Singh Sahota**

Director, RedR India

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## Preface

### Building Humanitarian Capacities

**D**isasters take place in a society that is plagued by poverty, inequity, inadequate infrastructure, gaps in health services, and lack of preparedness and so on. The scale of disaster depends on the depth and diversity of society's vulnerabilities. Community and individual vulnerability conditions don't stay same all the time. Vulnerability conditions change over a period of time due to changing socio-economic status, changing life style, changes in external environment. Therefore, it is important for the disaster managers to consistently renew their understanding of society's vulnerability and accordingly pursue disaster risk reduction

The first ever organized humanitarian force for cross country operations was initiated by Red Cross during the First World War. Humanitarian expertise in those days essentially consisted of medical relief and trauma care. In the decades that followed several international humanitarian NGOs and United Nations organizations have expanded the humanitarian work all over the world. Different vulnerability settings in different parts of the world prompted these humanitarian organizations to develop stronger institutional capacities to address practical needs of the communities such as water and sanitation, public health, food security, livelihoods, housing and so on. These organizations today have created a global assurance of humanitarian response where ever it is required. These organizations continue to monitor changing humanitarian needs and renew their capacities to address them. While organizations like RedR and Emergency Capacity building project of five major humanitarian organizations have been conducting regular trainings to build humanitarian capacity, organizations like IFRC, Oxfam, CARE, etc. have brought a number of manuals, hand books and toolkits to help humanitarian workers enhance their knowledge and capacity according to changing and evolving humanitarian situations.





Among the greatest humanitarian concerns of the last one decade has been rapid climate change. According to a report by Environment News Network, the average number of disasters throughout the 1980s was 400. It increased to 630 in the 1990s and to 730 in the past ten years. The highest recorded number of natural disasters, 960, occurred in 2007. Scientists attribute these phenomena to climate change. Another major concern is the spread of HIV AIDS in African and Asian nations like a wild fire. According to a latest report by UNAIDS, currently (2008-09) there are 33 million people living with HIV AIDS. The fact that can't go unnoticed is that natural disasters are increasing in the regions that are already crippled by HIV AIDS epidemic.

According to UNAIDS report, there are over 2.4 million people living with HIV AIDS in India. Geographical review of the people living with HIV AIDS in India tells us that most of those living with HIV AIDS are living in big cities and coastal towns which are also the disaster hotspots. What is concerning however is the lack of inter face between HIV AIDS and humanitarian organizations who need to work together to reduce compounding vulnerabilities. In 2006, some of the leading HIV AIDS organizations and humanitarian organizations requested Oxfam America to conduct a thorough research and establish HIV AIDS risk among disaster affected population. The research conducted by SWASTI for Oxfam in Tamilnadu, Andhra Pradesh, Kerala, and Pondicherry & Andaman Islands identified the trends that compound HIV AIDS risk among disaster affected communities. This hand book builds on the knowledge emanated from the research and provides simple tools for step by step self learning of humanitarian workers to understand basic facts about HIV AIDS and to understand and address HIV AIDS Risk among disaster vulnerable and disaster affected communities. We hope that both HIV AIDS organizations and humanitarian organizations find this publication useful in their work.

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## Acknowledgement

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We would like to thank Prof. Vinod C Menon, Member NDMA; Left. Col. Dr. JR Bharadwaj, Member, NDMA; and Ms. Sujata Rao, Special Secretary and Additional Director General, National AIDS Control Organization, Mr. Sarbjit Singh Sahota Director, RedR India, for their valuable encouragement and support in the development of this toolkit

Special thanks to the members of the Oxfam family, particularly N. Hari Krishna, Technical Advisor, Disaster Risk Reduction, Oxfam International for coordinating with us in completing this document. A special word of thanks and appreciation to all the members of the technical panel who participated in the initial workshop and provided excellent feedback on the structure and content of the guide. We are particularly grateful to Tanaji Sen, Red R India, Zubin Zaman and Rajesh Kaushik, Oxfam India, and Rahul Pandit, UNDP.

Thanks are also due to my colleagues who worked on different aspects of this guide - Mr. Joseph Julian K G for his leadership and coordination in the development of this guide and writing key chapters of the document; Dr. Angela Chaudhuri and Dr. Mahesh Srinivas for writing main chapters; Jamie Frederick for compiling a major part of the annexures; Siddhi Mankad and Rima Kashyap for reviewing and editing; Shama Karkal for supporting the publication process and Mallika Badrinath for design and layout.

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## Abbreviations

AIDS	Acquired Immuno Deficiency Syndrome
ART	Anti Retroviral Therapy
BCC	Behaviour Change Communication
CSO	Civil Society Organization
DAPCU	District AIDS Prevention and Control Unit
DDRC	District Disaster Response Committee
FSW	Female Sex Workers
HIV	Human Immunodeficiency Virus
HRG	High Risk Groups
IASC	Inter-Agency Standing Committee
IASU	Inter-Agency Support Unit
ICTC	Integrated Counselling and Testing Centre
IDU	Injecting Drug User
IEC	Information Education Communication
KPG	Key Population Groups
MSM	Male having Sex with Male
NACO	National AIDS Control Organization
NACP	National AIDS Control Programme
NGHOs	Non-Government Humanitarian Organisations
NGO	Non Government Organisations
PLHIV	Person Living with HIV
PPTCT	Prevention of Parent to Child Transmission
S&D	Stigma and Discrimination
SACS	State AIDS Control Society
STI	Sexually Transmitted Infection
TI	Targeted Intervention
UNAIDS	The Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
WDR	World Disaster Report
WHO	World Health Organization

## About this guide

**D**isasters – natural or otherwise lead to an environment in which the risk of sexual health vulnerabilities, particularly transmission of HIV is increased. In December 2004 after the tsunami devastated coastal areas around the Indian Ocean, many humanitarian agencies, funding organisations, governments, NGOs and private individuals came forward to support relief and rehabilitation initiatives. In India, the coastal areas of Southern India and the Andaman and Nicobar islands were the most affected. Eighteen months after the tsunami, Oxfam and Swasti conducted a study to understand the vulnerability of communities to HIV in the tsunami-affected coastal regions of India. Research indicated that vulnerability to HIV increased in 20 out of the 30 communities studied primarily because the physical, social, and psychological conditions of the people after the tsunami led to a significant increase in unprotected sex with non-regular sexual partners, especially among people living in temporary shelters. The study also found that despite mainstreaming and capacity building efforts, HIV prevention during emergencies has not been very successful. Sexual health issues in general, do not receive adequate attention within any of the public health initiatives of relief agencies. Given the relatively higher incidence of sexually transmitted infections, as found in the study, the current sexual health-care focus is inadequate in humanitarian responses.

Mainstreaming sexual health, particularly HIV related issues into disaster response has emerged as one of the strategic ways of averting new infections after a natural disaster. The existing guidelines and policies (e.g. SPHERE) have clearly laid out the processes to be followed under humanitarian emergencies; but none directly address the needs of communities with regard to sexually transmitted infections including HIV, in the form of guidelines or minimum standards that can be incorporated as part of relief and rehabilitation programmes.

The purpose of this guide is to help in addressing sexual health related issues and in mainstreaming HIV prevention and AIDS care in humanitarian emergencies, especially natural disasters, by providing clear guidelines, recommendations and plans for action in disaster relief and rehabilitation. The design and the approaches in the guide are based on the study 'Vulnerability to HIV following a natural disaster in the tsunami affected areas in India' done by Swasti with the financial support of Oxfam.

This guide is aimed at programme managers and decision makers and provides inputs on approaches to mainstreaming HIV within emergency response programmes at the field level. The guide is a step by step approach to address vulnerability to HIV during emergencies and provides direction to programme managers on what should be their response and where they can access resources to facilitate mainstreaming HIV





## Using this guide

This guide is a resource manual for addressing sexual health issues, particularly, HIV and AIDS interventions in emergency settings. It is meant primarily for programme managers and decision-makers to help them with guidelines on how to mainstream HIV into humanitarian response programmes.

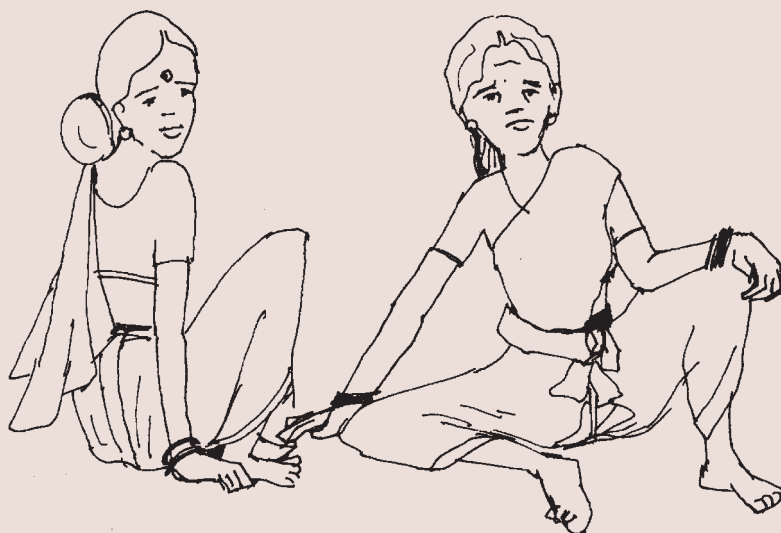
### Those who can benefit from this guide are:

- Non-government humanitarian organisations (NGHOs);
- Aid agencies who provide funds to humanitarian action during natural disasters;
- Government departments and mechanisms involved in rescue, relief and rehabilitation operations;
- Academic institutions/development organisations training professionals in humanitarian operations;
- National and Provincial AIDS Control Societies and Civil Society Organisations implementing HIV prevention programmes in disaster prone zones.
- Public health professionals and organisations

## The guide provides information on:

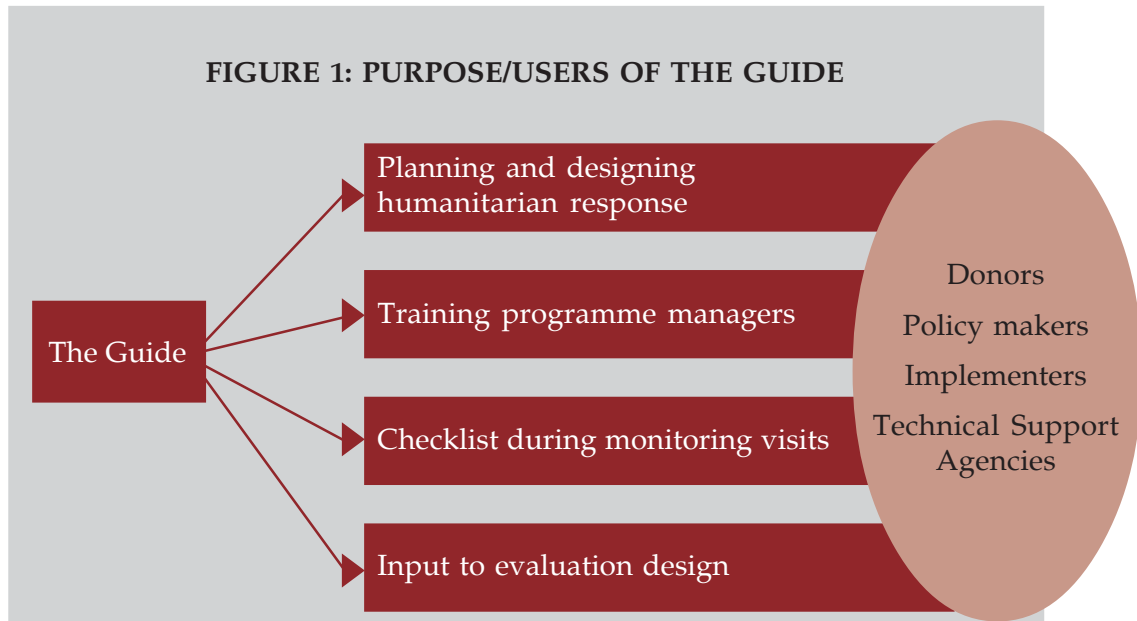
- The need to address sexual health issues while designing humanitarian response programmes
- Mainstreaming HIV during the preparedness phase of emergency response
- Collecting HIV related data through rapid assessment and situational needs assessment, after a disaster strikes
- Addressing key vulnerabilities to STI and HIV like, displacement, multi-partner sex, collapse of social structures and norms, easy availability of cash, poor access to health care system, migration and unaddressed needs of persons living with HIV (PLHIV)

This guide provides direction on what needs to be done to address vulnerability to HIV during different phases of humanitarian response – preparedness, relief and rehabilitation. A total of ten guides have been provided. Each can be used independently according to need and context. The guides are also useful for training programme managers and can be used as a checklist during monitoring and for evaluation.





**Diagram 1**



**The Guide is divided into three parts.**

**Part 1:**

Background- about the research study, purpose of the Guide and other contextual information


**Part 2:**

‘Understanding sexual health vulnerability and responding – approaches during humanitarian emergency’ – contains 10 tools. The purpose and usage of the guidelines, actions or processes are explained in each part. Since several manuals and guidelines exist on many of these topics, where relevant, the guide provides references to other sources. A ‘Roles and Responsibility matrix’ underscores the importance of co-ordination between agencies

**Part 3:**

Annexures

The icon  points to places where references are suggested.

The icon  points to aspects that the reader should take note of.





# Part 1

## Background to the guide





## Humanitarian emergencies, sexual health and HIV

An emergency can take many forms, ranging from natural disasters and health epidemics to chemical outbreaks and conflict situations. According to the Inter-Agency Standing Committee, "...an emergency is a situation that threatens the lives and well-being of large numbers of a population in which extraordinary action is required to ensure the survival, care and protection of those affected."<sup>1</sup>

Due to global warming, unpredictable weather-related disasters are becoming increasingly common. Some of these weather-related disasters include cyclones, tsunamis, droughts, floods and earthquakes. Oxfam reported that such disasters have quadrupled in the past 20 years, from 120 disasters a year in the early '80s to as many as 500 this year till date.<sup>2</sup> And while, between 1985-1994, 174 million people per year were affected by weather-related disasters, from 1995-2004, 254 million people were affected every year. In 2007, flooding in Asia alone affected 248 million people.<sup>3</sup>

Humanitarian aid is invariably necessary to remove the devastating effects disasters bring to an affected area and population. While covering the most basic needs first – food, water and shelter – other human needs are sometimes not prioritised by relief programmes, and this includes sexual health related care, including HIV prevention

services. The unstable social conditions induced by emergencies sometimes increase the vulnerability – directly or indirectly- to HIV. Therefore, it is important that humanitarian aid also focus on the continuation and maybe scaling-up of HIV services during their response –during its relief and rehabilitation phases.

### 1.1 Sexual health vulnerabilities and HIV scenario

Sexually Transmitted Infections (STI) increases the risk of HIV transmission. Detection and treatment of STIs is an important part of HIV control strategy as STI still remains a global public health challenge. In the US, CDC reports that 19 million new infections occur every year and almost half of them are reported among young people aged 15 to 24.<sup>1</sup> STI prevalence is estimated to be 5 - 6 percent in the adult population in India<sup>2</sup> and it is estimated that 40 percent of women have STI/RTI at any given point of time in the country.<sup>3</sup> This is an alarming data, in light of the link between STI and HIV.

According to a 2008 report by UNAIDS, 33 million people are living with HIV/AIDS globally. Every day over 6,800 people become infected with HIV. Approximately 0.3 percent of the population of South Asia is currently living with HIV, while India has the second largest population of people living with HIV globally, that is, approximately 2.5 million people.<sup>4</sup> Areas in South Asia, as seen above, are highly vulnerable to the spread of HIV and an emergency situation can further aggravate and fuel the growth of epidemic.

<sup>1</sup> "Guidelines for HIV/AIDS in Emergency Settings" Interagency Standing Committee. (2004). UNAIDS. [http://data.unaids.org/Publications/External-Documents/IASC\\_Guidelines-Emergency-Settings\\_en.pdf](http://data.unaids.org/Publications/External-Documents/IASC_Guidelines-Emergency-Settings_en.pdf)

<sup>2</sup> 2005 Disaster in Numbers. (2005). United Nations: International Strategy for Disaster Reduction. <http://www.unisdr.org/disaster-statistics/pdf/2005-disaster-in-numbers.pdf>

<sup>3</sup> 500 Weather-Related Disasters A Year. Planetary Rescue Operations. Accessed 8 November 2008. <http://msrb.wordpress.com/2007/11/27/500-weather-related-disasters-a-year/>

<sup>4</sup> Centers for Disease Control and Prevention (homepage on the Internet). Trends in reportable sexually transmitted diseases in the United States, 2005. Available from: <http://www.cdc.gov/std/stats/trends2005.htm>. [Last accessed on 2007 Feb 19]

<sup>5</sup> <http://www.nacoonline.org/upload/Basic%20Services/national%20Guidelines%20on%20Prevention,%20Management%20&%20Control%20of%20Reproductive%20Tract%20Infection%20Including%20Sexually%20Transmitted%20Infections.pdf>. P vi

<sup>6</sup> Ibid. P vi

<sup>7</sup> 2.5 million people living with HIV in India. UNAIDS. Accessed 8 November 2008. [http://www.unaids.org/en/KnowledgeCentre/Resources/FeatureStories/archive/2007/20070704\\_India\\_new\\_data.asp](http://www.unaids.org/en/KnowledgeCentre/Resources/FeatureStories/archive/2007/20070704_India_new_data.asp)

## 1.2 The link between HIV/STI and Humanitarian Emergency

Although there are limited statistics on increase in 'HIV/STI in post-emergency affected populations', it has been well documented that a relationship exists between the impact of emergencies and increase in HIV/STI infections.

In 2006, Oxfam and Swasti conducted an empirical study to understand the vulnerability of the tsunami-affected communities in India to HIV. The findings of the Oxfam-Swasti study established that disaster and emergency situations increased disaster victims' vulnerability to HIV/STI considerably due to several factors. The study found that more than 20 percent<sup>8</sup> of the respondents surveyed (using the polling booth<sup>9</sup> methodology) reported that they engaged in multi-partner sex behaviour. 20 of the 30 villages studied, where vulnerability was established, reported that their vulnerability to HIV increased after the tsunami. Social stigma of contracting a sexually transmitted infection prevented many people from accessing treatment, information and testing facilities. In most cases of sexually transmitted infection, the study found that, doctors often prescribed medicine without giving any advice regarding prevention or recurrence of infection. Post-disaster clinics often did not offer any privacy, affecting proper care and treatment for STI. (Summary of the study in Annexure 1)

A similar study on gender aspects by Oxfam<sup>10</sup> in 2008 highlighted the fact that many women and girls suppress the urge to defecate or urinate because of poor toilet conditions and absence of any privacy in temporary shelter complexes. This led to many of them suffering from urinary tract infection, vaginal infections etc. Due to absence of adequate health facilities these

infections were left untreated, making patients vulnerable to other infections.

According to the study conducted by Oxfam-Swasti in 2006, the following are some of the key reasons for increased sexual health vulnerability, particularly of HIV, after a disaster.

**Loss of livelihood:** One of the key post-disaster issues is the loss of livelihood of people due to destruction of their land, building, tools and equipments etc. Displacement leads to loss of jobs. Loss of a regular income has several negative repercussions. Women and girls become especially vulnerable, as they may find themselves coerced into engaging in sex as a survival mechanism—for food, shelter, and physical security. In some emergencies, increased powerlessness and insecurity make this group more vulnerable to rape and other sexual violence. The study showed that the highest post-tsunami vulnerability was found to be among unmarried women, followed by married women<sup>11</sup>. Vulnerability of unmarried women increased as they had to stay alone in temporary shelters most of the time while their parents went out to work.

**Migration:** Fishermen, and others, who lost all their assets in a disaster often migrated to faraway places seeking jobs. This migration led to separation between married couples leading to both, men and women, engaging in extramarital relationships.

**Breakdown of social norms:** Displacement often leads to the breakdown or weakening of traditional social norms and systems that control social behaviour and activities, including sexual relationships. The breakdown of families and communities and exposure of the uprooted population to unfamiliar social and livelihood situations increases their vulnerability to HIV infection.

**Challenges to health care:** Disaster situations invariably tax the existing health-

<sup>8</sup> Understanding the Effect of the Tsunami and Its Aftermath on Vulnerability to HIV in Coastal India, Oxfam and Swasti, P.6

<sup>9</sup> [http://www.swasti.org/main/index.php?option=com\\_content&task=view&id=12&Itemid=18](http://www.swasti.org/main/index.php?option=com_content&task=view&id=12&Itemid=18)

<sup>10</sup> Gender Sensitive Disaster Management, Oxfam and Naban Trust, Chaman Pincha, 2008. P.26

<sup>11</sup> Understanding the Effect of the Tsunami and Its Aftermath on Vulnerability to HIV in Coastal India, Oxfam and Swasti, P.7



care infrastructure. The result can be gaps in the supply and distribution of condoms and efforts to treat STIs and other diseases increasing vulnerability to HIV. The risk of transmitting HIV through transfusion of contaminated blood might also arise due to inadequate screening services at health centres.

**Disruption of HIV control activities:**

During disasters, HIV-and AIDS-control activities like awareness campaigns tend to be disrupted or eclipsed by other priorities, like the provision of basic food, water, shelter and the treatment of wounds and more acute diseases and infections. Institutions like schools and shopping centres, where awareness campaigns are often conducted, are sometimes closed or used for other purposes of emergency relief. This also leads to challenges in accessing care services for the PLHIV—especially those on ART treatment and other essential drugs for opportunistic infections.

**General trauma:** Trauma related to an emergency may sometimes lead to problems like alcoholism and high-risk sexual behaviour.

**Relief efforts:** Paradoxically, relief and rehabilitation efforts by aid providers may sometimes contribute to the risk of HIV and AIDS. In the case of the tsunami, for example, the structure and location of the new temporary shelters were major contributing factors. The Oxfam-Swasti study showed that in 10 out of 11 temporary shelters and in 8 out of 16 habitations there was an increase in HIV vulnerability due to increase in unprotected sex with non-regular partners<sup>12</sup>. The study also found that close physical proximity in the temporary structures within the settlements increased the vulnerability. Besides, the shelter design, restricted to a single cubicle, prevented even regular marital sex.

Along with all these issues, lack of proper information on sexually transmitted infections and HIV, use of condom etc have contributed to the heightened vulnerability of this population to HIV. In fact, the Study reported that more than 70 percent of the fishing community affected by the tsunami were either misinformed about HIV or had never heard about it.<sup>13</sup>

Another major contributory factor to increased HIV vulnerability is the sudden infusion of cash through cash compensation from relief organisations/ government. High compensations often led to increased consumption of alcohol and engaging in risky sex behaviour. This situation was most prevalent in the period between the emergency and rehabilitation phases of the disaster response.

The tsunami prompted concerns that rates of HIV infection and transmission would rise in the affected areas. While assessing the role of health systems in disaster mitigation, the World Health Organization (WHO) e.g. observed, that the conditions that define complex emergencies - conflict, social instability, poverty, and powerlessness - are also the conditions that favour the rapid spread of HIV and other STI.<sup>14</sup>

After the tsunami, the United Nations Development Program (UNDP) warned the affected countries about the need to guard against increased HIV transmission in devastated areas, because of high-risk behaviour and greater vulnerability among the affected populations. The main risk factors UNDP identified were similar to those identified by WHO (above). The Tearfund Disaster Management Team<sup>15</sup> also observed that, as in the tsunami, post-emergency situations increased both, people's vulnerability, and the impact of HIV and AIDS. The International Agency Support Unit (IASU)<sup>16</sup> of the UN office in Thailand

<sup>12</sup> Ibid. P 8

<sup>13</sup> Ibid P 8

<sup>14</sup> Ibid. P 2 in Disasters Work Book." Available at [tilz.tearfund.org](http://tilz.tearfund.org)

<sup>15</sup> Tearfund Disaster Management Team. 2005. "Building Back Better in Thailand Tsunami-Affected Area." Available at [www.un.or.th](http://www.un.or.th)

shared these sentiments. It also added that, after the tsunami, another vulnerable group emerged: reconstruction workers, who were at high risk of infection because of the mobile nature of their work.

In her review of existing policies and guidelines vis-à-vis responses to HIV and AIDS in emergencies, Ann Smith<sup>17</sup> of the Overseas Development Institute identified two major links between HIV and emergencies. First, humanitarian crises, whether resulting from conflict or natural disaster, are more likely to occur in countries where rates of HIV infection are already high. Second, emergencies may cause changes in sexual behaviour, disrupt medical facilities, and lead to sexual violence and loss of livelihoods—all factors that increase vulnerability to infection.

The Inter-Agency Standing Committee (IASC) made a similar observation. In its handbook, which provides elaborate guidelines on emergency response and addresses the specific needs of HIV infected and affected people, the IASC notes that in areas affected by natural disasters, the rate by which HIV infections increased depends on existing HIV prevalence rates. Regardless, as the tsunami response illustrated, concerns about tracking, preventing or treating HIV and AIDS are usually eclipsed by other, seemingly more immediate, priorities - with the probable result that thousands of people were left increasingly vulnerable to HIV and other STIs.

While weather-related emergencies cannot be stopped, if HIV services are continued, coordinated or even scaled-up during emergency situations, the threat of HIV can be contained.

## Existing toolkits – gap analysis

The need to mainstream sexual health programmes, particularly HIV/AIDS interventions during humanitarian response was clearly understood by humanitarian and development agencies. Currently, internationally, the following guidelines/resource materials (apart from the SPHERE manual) offer valuable insights to HIV/AIDS preparedness and planning in emergency settings:

**Guidelines for HIV/AIDS interventions in emergency settings** – This has been developed by Inter Agency Standing Committee (IASC) through contributions from UN and non-UN agencies, NGOs and International organisations. These guidelines were designed for use by authorities, personnel and organisations operating in emergency settings at international, national and local levels. The guidelines are applicable in any emergency setting, regardless of whether the prevalence of HIV/AIDS is high or low. These *Guidelines* give emphasis to the *minimum* required actions needed in order to manage HIV/AIDS in the midst of an emergency, and there is scope for further detailing of actions to aid field-level personnel.

**Clinical guidelines for ART management for displaced populations (2007)** – developed by UNHCR in collaboration with South African HIV Clinicians Society. The document provides guidelines on clinical management of HIV cases in an emergency context, including ART, PPTCT and PEP. This is extremely useful for planners and policy makers.

**Trainers' guide- Workshop on HIV/AIDS interventions in emergency settings** – Developed by IASC this is a guide for conducting workshops for persons in

<sup>16</sup> Inter-Agency Support Unit of UN Office, Thailand. 2005. "Building Back Better in Thailand Tsunami-Affected Area." Available at [www.un.or.th](http://www.un.or.th)

<sup>17</sup> Smith, A. 2002. "HIV and AIDS and Emergencies: Analysis and Recommendations for Practice," Humanitarian Practice Network, Overseas Development Institute. Available [www.odi.org.uk/hpg/papers/networkpaper038.pdf](http://www.odi.org.uk/hpg/papers/networkpaper038.pdf).





programming positions at National, Regional and Headquarter level, on planning HIV/AIDS interventions in emergency settings with a multi-sectoral approach. Detailed references to training methodologies and training materials are also provided.

### **Key gaps in existing resources and scope**

The existing resource materials are very useful guidelines for mainstreaming HIV/AIDS interventions during humanitarian response.

At the time of crisis, a field manual which provides practical guidance to planning and implementing HIV/AIDS interventions is critical, particularly at the field level (village; relief/rehabilitation camp, primary health centre). Some of the important **gaps** in the present resource material include,

- Limited reference to a Comprehensive and Inter-sectoral approach to HIV/AIDS interventions, which can be used as a field guide.

- Integration of Reproductive health, adolescent health and STI management in HIV/AIDS interventions.
- Addressing community involvement and capacity building in emergency situations.
- Needs assessment, Planning, Information management, Monitoring and Evaluation of HIV/AIDS interventions in emergency settings.
- Care and support interventions, and tackling stigma & discrimination in emergency settings
- Addressing human trafficking issues in emergency settings

Resource material addressing all of the above is not available adequately, especially for natural emergency settings. In South Asia no known materials are available, as very limited work has been done in this area.

**The preparation of this guide is not aimed at duplicating any of the existing toolkits on the subject. It hopes to add and strengthen the existing tools.**



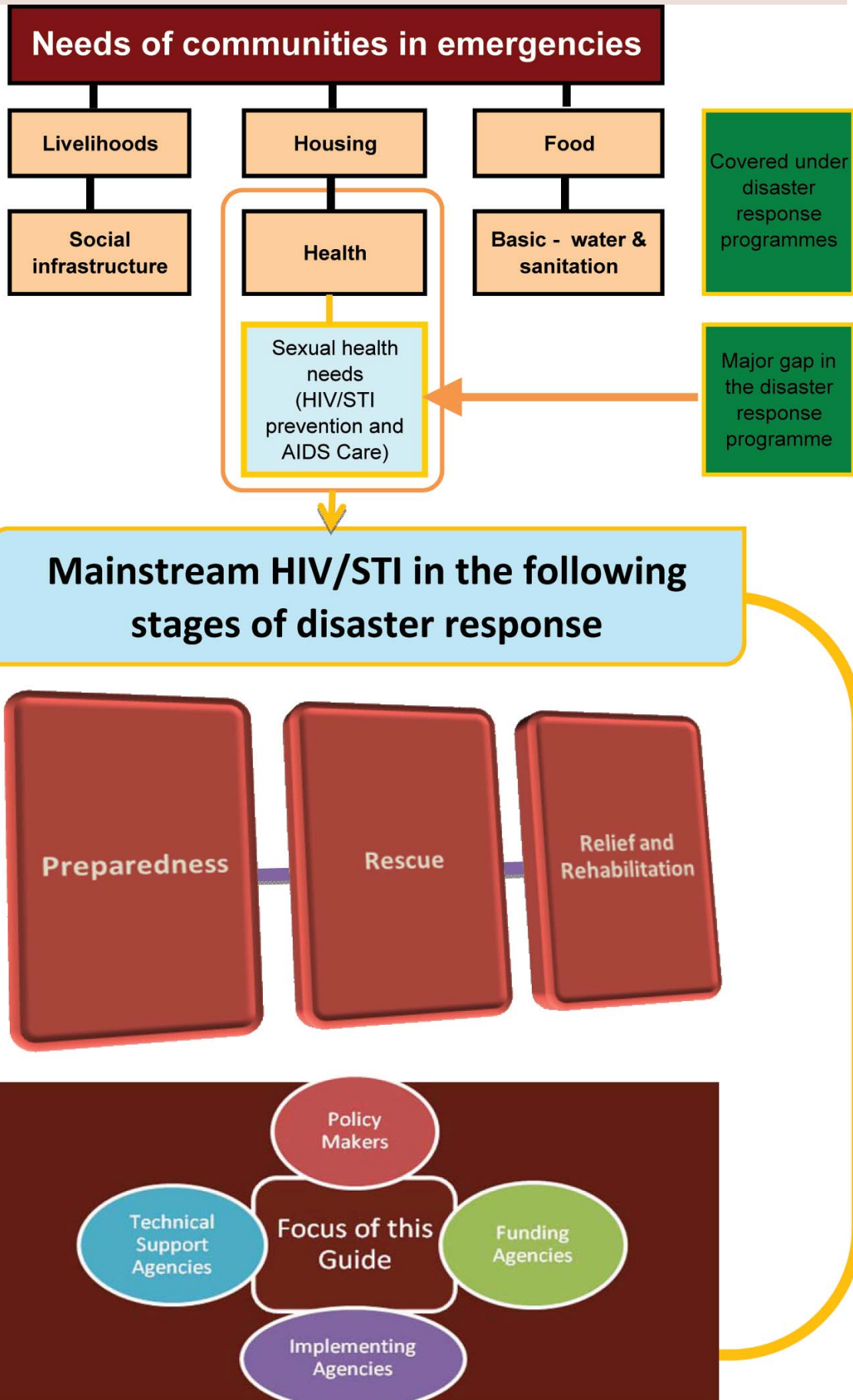


# Part II

Understanding sexual  
health vulnerability and  
responding – approaches  
during humanitarian  
emergency



Diagram 2



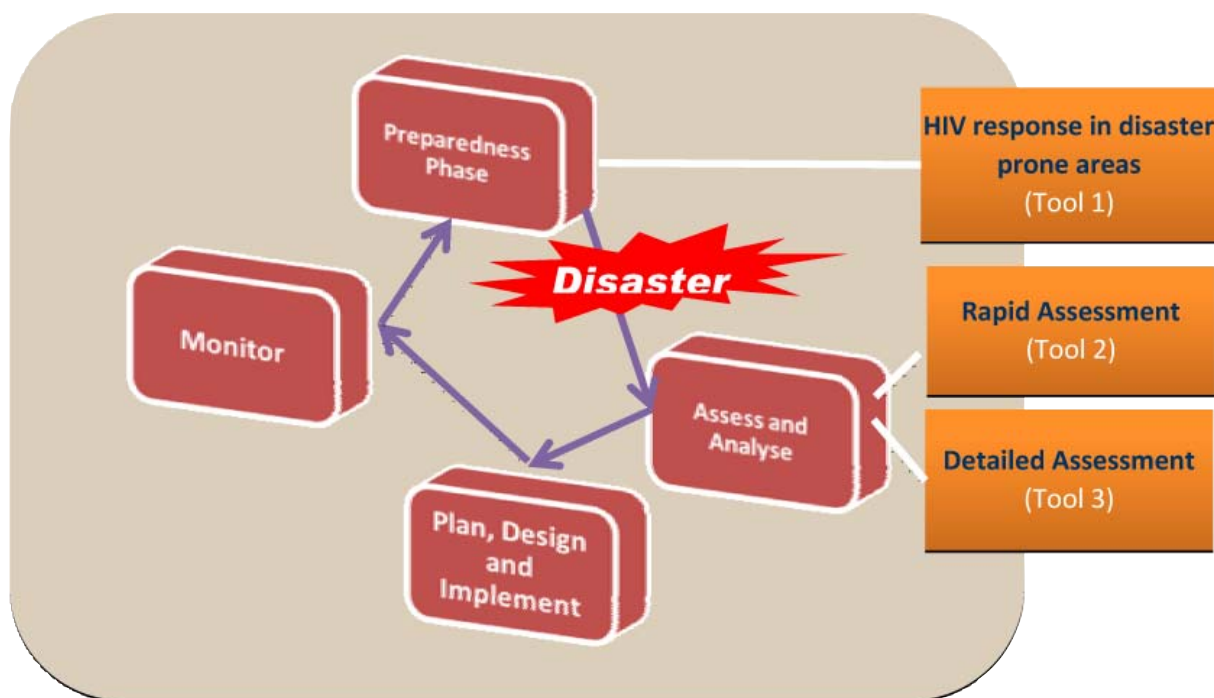
# Introduction

Communities in emergency situations have several needs. The basic needs are: water and sanitation, food, livelihood, housing, social infrastructure and health. These are largely being met in current disaster response programmes. Sexual health, one of the key needs of the displaced communities, has not been prioritized by the humanitarian response programmes. This can prove to be life-threatening due to increased chance of spread of HIV infection and untreated STIs after a disaster. The Oxfam-Swasti study, as described in the earlier part of this guide shows that there is increased vulnerability to STI and HIV following disasters, due to several factors. This guide proposes to

provide guidance and references to address these vulnerabilities in primarily three stages of humanitarian response: **Preparedness Phase, Relief Phase and Rehabilitation Phase.** (see Diagram 2)

Diagram 2 depicts the key focus of this guide. Given the current gap in focus on sexual health as part of humanitarian response, this guide suggests practical guidance and references to mainstream sexual health services, in particular HIV, into humanitarian response programmes. The guide also highlights the roles of the four key stakeholders i.e., policy makers, funding agencies, technical support agencies and implementing agencies in this regard.

**Diagram 3: Framework for this guide<sup>18</sup>**



The diagram above provides an outline of this guide.

The Preparedness Phase, provides guidance and tools to assess vulnerability to disaster

and HIV and references for designing response plan.

In the case of a disaster, a Rapid Assessment Study (Tool 2) is helpful to assess

<sup>18</sup> Framework adapted from Disaster Management Cycle concept



vulnerability to HIV/STI in the locality where the disaster has occurred.

If there is an established vulnerability, a Detailed Assessment (Tool 3) is done to gather information to plan for interventions.

Remaining tools, as seen in Diagram 4 in the next page, address scenarios that 'increase a population's vulnerability to HIV/STI'. The main focus of tools 4 to 10 is to address key

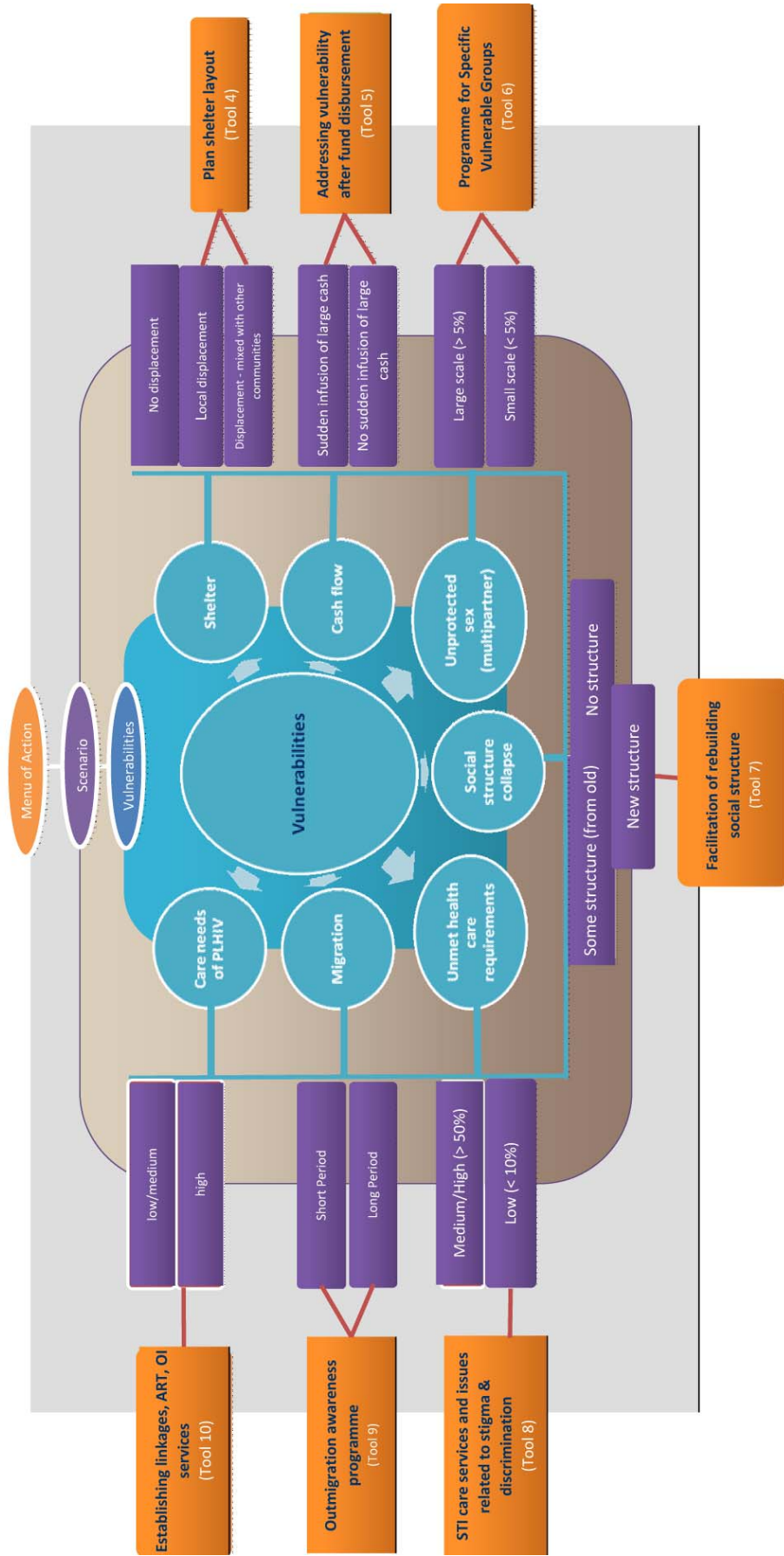
vulnerabilities to HIV which were identified as part of the study in the tsunami hit regions of India (which was quoted earlier).

The diagram 4 captures the key vulnerabilities, resulting scenarios and menu of actions which are the basis of this document.

Guidance provided in this document may be applicable to any country or region, but the references and examples quoted here are mostly from India



Diagram 4



## Roles and responsibility matrix

Relief and Rehabilitation efforts involve varied stakeholders:

- The **Government** which is the principal co-ordinating agency
- **International and National Aid agencies**
- Local agencies including **Non-governmental agencies (NGOs) and Community based organisations (CBOs)** who could be the bridge between the community and the relief efforts
- The **community** who is at the heart of all relief and rehabilitation efforts.

Having role clarity between these different stakeholders will ensure that relief and rehabilitation efforts are effective in tackling crises. This is an outline of the possible roles that could be taken up by various agencies.

### Summary of Roles

Areas	Government	International/ National Aid agency	Implementer (NGOs/CBOs)	Organisations working in HIV /AIDS (Both Government and donor agencies)
<b>Policy and Advocacy</b>	Policy formulation	Support policy researches through funding that will feed into policy formulation	Provide ground level intelligence. Work with local administration to improve surveillance and treatment services	Develop HIV related policies in the country
<b>Rapid and Situational Needs assessment</b>	Allocate resources for carrying out the assessment	Lead in designing the vulnerability assessment study	Prepare a detailed field plan for undertaking the study, in consultation with Aid agency	Share existing information on vulnerable locations to HIV where the disaster has happened
	Ensure co-operation of all related line departments in conducting assessment	Funding support in conducting the assessment study	Provide personnel and other logistical support for data collection, including liaison with community	Share methodology and experience of having done similar mapping exercise
<b>Implementation of interventions to reduce STI/ HIV vulnerability</b>	Prepare macro level plan for implementation of interventions – including resource plan and selection of implementing partners	Support govt. agency in planning strategies and mobilize resources	Key role in carrying out planned interventions	Support in making the macro plan for interventions. Provide funds and resources to facilitate implementation of services.

Areas	Government	International/ National Aid agency	Implementer (NGOs/CBOs)	Organisations working in HIV /AIDS (Both Government and donor agencies)
<b>Training/ Capacity building</b>	Providing resources for trainings	Identifying consultant resource pool for technical guidance	Logistical support for trainings, including organ- ising training venues, food, trans- portation etc. Mobilise personnel for the training.	Make available existing training modules and guidelines Provide resource persons to conduct appropriate trainings
<b>Networking</b>	Setting up of a co-ordination committee/ task force to monitor and ensure effective main- streaming of HIV/STI inter- ventions  Ensuring effective co-ordination between various Aid agencies	Active participation in consultative committee meetings.  Facilitating representation and participation of the community in important forums including gover- nance structures	Active participation of agencies that represent various NGOs/CBOs.	Taking part in the coordination committees through its provincial or district level representatives
<b>Referral</b>	Identify list of referral services follow up at the community level	Support in establishing referral linkages with its existing services		



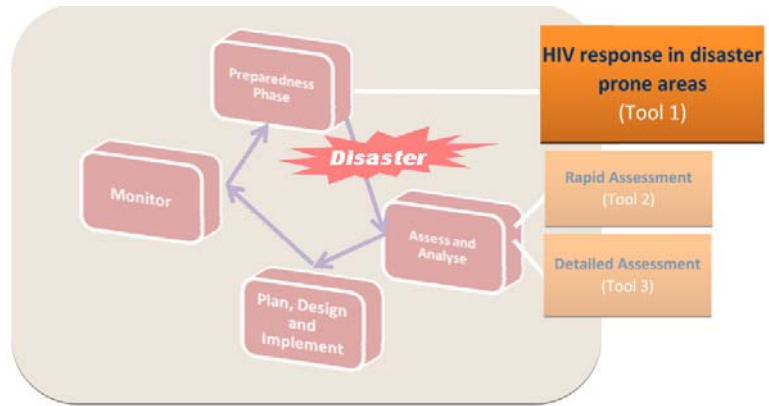






Tool

1



## Getting prepared HIV in disaster-prone areas

### What the tool is about:

The tool provides information and approaches on mainstreaming HIV into humanitarian responses in disaster-prone areas. Preparedness is the first phase of the response. It reduces the degree of vulnerability when disaster strikes and reduces post-disaster efforts towards mitigation. It also contributes to building the capacity of agencies working in disaster response programmes, who are not exposed to HIV issues.

**The section is useful** to initiate the process of mainstreaming HIV while planning for disaster preparedness programmes and specifically while doing the situation analysis by

- District-level Disaster Response Committees or authorities – formed in disaster-prone areas under the chairmanship of the District Administrator.
- District Level Health Committees and action groups
- District level AIDS Prevention and Control Units/team



How to mainstream HIV in disaster prone areas:

### Step 1: Identify vulnerable districts

Based on:

1. Degree of vulnerability to natural disaster
2. Degree of vulnerability to HIV

Data on disaster risk and HIV prevalence should be gathered as part of a **pre-disaster needs assessment** and gathered by a team of two persons preferably with disaster and community health related experience. Focus of the study should be on the following areas:

- List of geographical locales on the disaster map<sup>19</sup> with 'highest level of risk' of HIV – prepare the final list of selected districts for HIV response
- HIV prevalence in the selected districts (data should be available with province/states level implementing unit of country HIV programme<sup>20</sup> or the country programme itself): Areas where HIV surveillance data shows high prevalence of HIV – i.e. more than 5 percent among key population groups (Sex workers, male having sex with male (homo sexuality among males) and injecting drug users) and more than 1 percent among the general population (data from the antenatal clinics)<sup>21</sup>

Data from India available in the following link:

- STI prevalence in the selected districts (data should be available with province/states level implementing unit of country HIV programme or the country programme itself<sup>22</sup>)
- Presence of Key Population Groups<sup>23</sup> in the selected districts (Mapping study findings from Provincial/State level AIDS programme office)
- Data on PLHIV reported in the selected districts – the compiled data will be available with Voluntary Counselling and Testing centres within the district or the Provincial/State level AIDS programme office.
- Current HIV related interventions and services available in the selected districts – this information will be available with Provincial/State level AIDS programme office or NGOs involved in HIV programmes locally.

<sup>19</sup> For more details on disaster map in India click the link: <http://ndma.gov.in/wps/portal/NDMAPortal>

<sup>20</sup> State AIDS Control Society (SACS)– as it is called in India [http://www.nacoonline.org/Quick\\_Links/Publication/ME\\_and\\_Research\\_Surveillance/](http://www.nacoonline.org/Quick_Links/Publication/ME_and_Research_Surveillance/)

<sup>21</sup> India Data available in the following link: [http://www.nacoonline.org/Quick\\_Links/Publication/ME\\_and\\_Research\\_Surveillance/](http://www.nacoonline.org/Quick_Links/Publication/ME_and_Research_Surveillance/)

<sup>22</sup> India data in the following link:<http://www.nacoonline.org/upload/NACO%20PDF/District%20Categorisation%20for%20Priority%20Attention.pdf>

<sup>23</sup> Key Population Groups – persons with high risk behaviour (multipartner sex/sharing of needles for injecting drugs) that increases their vulnerability to

HIV. Eg. Sex Workers, Male having sex with male, injecting drug users.

<sup>24</sup> Focused HIV prevention programme implemented among the Key Population Groups. More details as implemented in India - [http://www.nacoonline.org/Quick\\_Links/Publication/NGO\\_Targeted\\_Interventions/](http://www.nacoonline.org/Quick_Links/Publication/NGO_Targeted_Interventions/)

<sup>25</sup> Note on Anti Retroviral Therapy – available in the annexure

<sup>26</sup> Preventing Mother to Child Transmission. [document on the Internet.] Avert, 2008. [cited 2008 Nov. 19]. Available from <http://www.avert.org/motherchild.htm>

## Step 2: Planning response

Based on the established vulnerability, the following services can be planned:

Vulnerability Level	Indicators	Programmes
High	High chances of natural disaster High HIV/STI prevalence Presence of key population groups	Prevention services – sexually transmitted infection services, condom/information education communication programmes, targeted intervention <sup>24</sup> programme, anti retroviral therapy services <sup>25</sup> , integrated counselling and testing centre, prevention of parent to child transmission programme <sup>26</sup> , legal aid etc
Low	High chances of natural disaster Very low HIV/STI prevalence No key population groups reported	IEC programme to improve awareness on HIV

Once the type of programme is identified an action plan can be drawn for implementing the programme. While planning programmes for Persons Living with HIV (PLHIV), PLHIV network groups should be involved. Resources for planning, prevention or care programmes are available with the national and provincial/state level HIV/AIDS programmes in the country.

### Resources for initiating HIV programmes

In India, a National AIDS Control Programme Phase III (NACP III) is already being implemented across the country in all the states. There is an established State AIDS Control Society (SACS) in each of the states (provinces) that spearheads the HIV response and it is a resource for providing services and technical support. As part of NACP III there is a strong focus on establishing District AIDS Prevention and Control Units (DAPCU) in high prevalence districts. If already established, these units can be accessed for support. The Programme Manager of DAPCU could be co-opted as part of the District Disaster Response Committee. The National AIDS Control Programme has a host of prevention services being implemented through NGOs and public health departments. Information on these NGOs and the kind of services provided by them are available with the SACS. For more information on the SACS and NGOs visit the NACO website – [www.naonline.org](http://www.naonline.org)

Besides the above, whenever disaster preparedness awareness programmes are conducted in the district, HIV related messages should be incorporated in the programme.

It is also important to sensitise members of the District Disaster Response Committee, staff and volunteers from the community on the risk of HIV during disasters.



### Step 3: Monitoring

It is important to establish common mechanisms for monitoring the response plan. There are established systems within the provincial level bodies (like State AIDS Control Societies in India) for monitoring HIV related programmes. Information sharing mechanisms by participation in various committees should be established to ensure that the plan to mainstream HIV is implemented. District HIV programme officers should be included in the coordination meetings of district disaster response committees so that information regarding monitoring the response programmes is shared.

*Following case study on East Godavari District in Andhra Pradesh, India, demonstrates the process followed in mainstreaming HIV prevention and care programmes within emergency contingency planning.*

#### Case Scenario of East Godavari District in Andhra Pradesh, India.

##### Vulnerability Assessment of East Godavari District in Andhra Pradesh, India

Lead Questions	Data	Assessment of Vulnerabilities	Year and source
Is the district on the Disaster Map?	Risk Zone B	Very High Damage - frequent cyclones	NDMA <sup>27</sup>
Is the district on the Disaster Map?	Red Zone	Risk of Flooding - very high	NDMA <sup>28</sup>
What is the HIV prevalence in the district - ANC data?	1.75 %	High	2006 HIV Sentinel Surveillance (HSS)
What is the HIV prevalence in the district's High Risk Groups (sex workers, male having sex with male and injecting drug users)?	14 %	High	2006 HSS
Is the district one of the category A or B districts as per NACO guidelines?	Category A	High	2006 HSS
Number of STI cases identified and treated (5 locations)	2914		April-Oct 2008

The above table places East Godavari<sup>29</sup> district on the risk map of both disaster as well as HIV prevalence. Given the fact that East Godavari district is prone to both

<sup>27</sup> <http://ndma.gov.in/wps/portal/NDMAPortal>. Accessed last on 17 Feb. 09

<sup>28</sup> <http://ndma.gov.in/wps/portal/NDMAPortal>. Accessed last on 17 Feb. 09

<sup>29</sup> East Godavari district is in Andhra Pradesh a state located in southern part of India. EG district is having a coast line of 177 KM is among most hazard prone areas. The district has been devastated by major cyclones and floods in 1977, 1982, 1990, 1996, 2000 2003 & 2005 and also by Tsunami in 2004.

cyclones and floods, the need for preparedness plan for disaster mitigation is very high. The fact that HIV prevalence in the general community depicted by the prevalence in the ANC clinic is more than 1 percent and among the high risk population it is more than 5 percent, makes the district **HIV high prevalent**. This scenario has continued



consecutively for the previous three years and therefore the district is in A category according to NACO. Given this scenario, a contingency plan for mainstreaming HIV into disaster preparedness plan is critical.

### **Response Plan 1 – Setting up a prevention programme**

HIV prevention programmes are broadly classified as **prevention among high risk groups** (sex workers, male having sex with male and injecting drug users) and **prevention among the general community**.

Prevention among the high risk groups is more intense and focused and employs strategies like Behaviour Change Communication (BCC)<sup>30</sup>, STI treatment programmes, condom programmes, advocacy and enabling environment, community participation etc. General community programmes are focused on building awareness on HIV prevention, reduction in stigma, on key services related to HIV etc. Being a highly vulnerable district with high prevalent HIV reported both among the general community and high risk groups a comprehensive prevention package is crucial in East Godavari district. Following is the prevention implementation model suggested for the district:

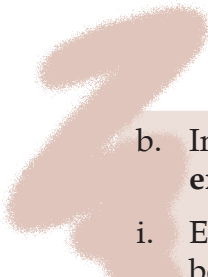
- a. Targeted Intervention Programmes. Being a high prevalent district and being in the A category, the national programme on HIV would have initiated several prevention activities in the district. As a first step what is critical is to ensure that these services are also extended to those parts of the district which are vulnerable to disaster. If no programmes are running in these area, NGOs can facilitate, with the support of District Disaster Response Authority getting in touch with Andhra Pradesh State AIDS Control Society (APSACS) to start new interventions in these areas to cover the high risk population or extend the area of intervention of an existing NGO implementing targeted intervention nearby.


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<sup>30</sup> Details in the Annexure





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- b. Initiate following programmes in the disaster prone areas, **if services are not existing**:
- i. Establish STI clinics in the government hospital, Primary Health Centre. This can be initiated with the support of NGOs working in HIV prevention programmes.
  - ii. Blood Safety Programmes<sup>31</sup>: In order to ensure availability of safe blood, the blood banks should be involved in the contingency plan and their roles are clarified.
  - iii. Ensure condom services are initiated in the government hospitals and private clinics, and messages on condom usage are displayed. (NGOs involved in HIV prevention and care can work with government hospitals to strengthen the condom supply as well as information on condoms )
  - iv. Gather information on STI service providers in the area and train them in syndromic case management<sup>32</sup> of STI and HIV related issues with the support of local NGOs working in HIV, so that they are available for treatment/ care in case of an emergency.
  - v. In order to improve the knowledge level of the community on HIV, initiate Information Education and Communication (IEC) campaigns in the locality among the general community. This would include street plays, poster campaign, World AIDS Day commemoration on December 1<sup>st</sup>, awareness classes in the community etc.
  - vi. Include HIV related subjects as part of training for volunteers who are being mobilized to support emergency response activities
  - vii. Provide information on Integrated Counselling and Testing Centre (ICTC) and encourage people to get tested and know their status.
  - viii. Involve the NGOs working in HIV programme in all the contingency planning activities for disaster preparedness.
  - ix. If the disaster prone location is in the rural areas, link up with the 'link worker programme' of NACO.<sup>33</sup> The link worker programme has been designed specifically to address vulnerable populations, like key population groups (sex workers, MSM) and young people in the rural areas.
  - x. Initiate Adolescent Education Programmes (AEP) in schools existing in the disaster prone areas. (The programme is being implemented in India through the education department —link up with the District Educational Officers' Office)



(For more information on Adolescent Education Programmes check the following link:- [http://www.nacoonline.org/Quick\\_Links/Youth/School\\_Age\\_Education\\_Program\\_SAEP/](http://www.nacoonline.org/Quick_Links/Youth/School_Age_Education_Program_SAEP/) )

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<sup>31</sup> [http://www.nacoonline.org/Quick\\_Links/Publication/Blood\\_Safety\\_\\_Lab\\_Services/](http://www.nacoonline.org/Quick_Links/Publication/Blood_Safety__Lab_Services/)

<sup>32</sup> STI treatment protocol based on symptoms. For more details refer to annexure.

<sup>33</sup> Link worker programme guidelines: <http://www.nacoonline.org/upload/IEC%20Resources/link%20Worker%20Scheme%20Operational%20Guidelines.pdf>

## Response Plan 2 – Setting up care and support programmes

HIV prevalence in East Godavari district being very high, the need for care and support programmes for People Living with HIV (PLHIV) will also be very high. Following are some of the actions that can be initiated to ensure care and support services reach the PLHIV.

- a. Anti Retroviral Therapy (ART): Ensure PLHIV in the disaster prone areas are linked to the ART programme in the district. The ART centre in the Godavari district is currently at the Government General Hospital, Kakinada. Involvement of District Level Network of Positive persons in the contingency plan will help in ensuring continued support in accessing ART medicine in case of disasters. Service providers at the ART centre and DLN should be linked to the contingency plan so that their services can be immediately accessed.
- b. Prevention of Parent to Child Transmission (PPTCT)<sup>34</sup>. PPTCT programmes are being implemented across the country in India for pregnant women who are HIV+. This programme helps in prevention of transmission of the virus from the mother to the child. It is important to link with the existing programmes and involve them in the contingency plan so that if there is an emergency PPTCT staff know the specific roles they have to play.
- c. Other care and support programmes: Inform the community care centres (CCC)<sup>35</sup> of the contingency plans and define their role so that in case of emergency, staff of CCC can step in and support the PLHIV especially in the management of Opportunistic Infections<sup>36</sup>



<sup>34</sup> PPTCT: [http://www.nacoonline.org/Quick\\_Links/Directory\\_PTCT/](http://www.nacoonline.org/Quick_Links/Directory_PTCT/)

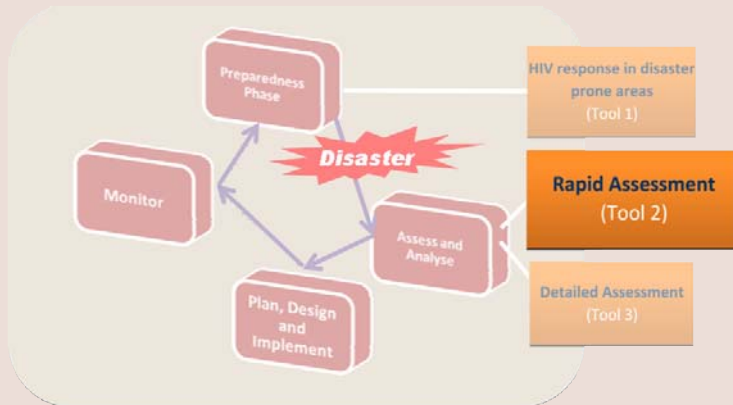
<sup>35</sup> Community Care Centre: [http://www.nacoonline.org/Living\\_with\\_HIVAIDS/Care\\_and\\_Support\\_Centers/](http://www.nacoonline.org/Living_with_HIVAIDS/Care_and_Support_Centers/)

<sup>36</sup> Opportunistic Infection: <http://www.nacoonline.org/upload/Publication/Treatment%20Care%20and%20support/Guidelines%20for%20Prevention%20and%20Management%20of%20common%20opportunistic%20infections.pdf>



## Tool

2



## Rapid assessment study - of sexual health vulnerabilities - particularly HIV

### What the tool is about:

This section provides guidance on the various tools necessary to begin the Relief Phase to address vulnerability to STI/HIV during disasters. It begins with the process of conducting a **rapid assessment study in order to assess the extent** to which a particular disaster-affected area (where communities have been rehabilitated or are living, post-disaster) is vulnerable to sexually transmitted infections (STI) and HIV.

### Who can use the rapid assessment study:

Primarily funding agencies - to plan areas of intervention and, NGOs while planning intervention on the ground.

### When the rapid assessment study is to be used:

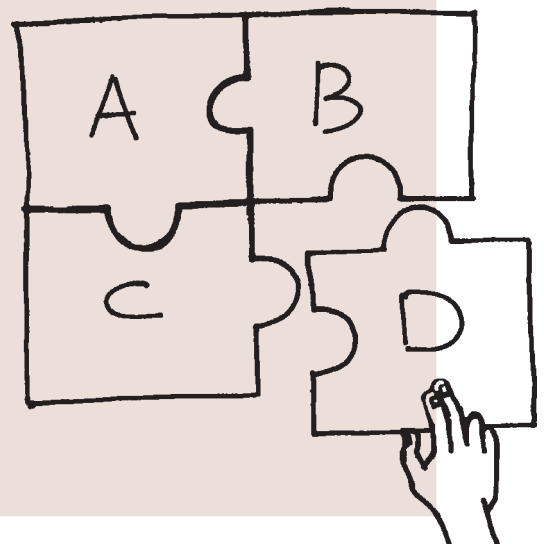
The rapid assessment study for sexual health/HIV vulnerability should be done along with the rapid assessment study for planning relief after the disaster. Rapid assessment, as per the SPHERE guidelines, is carried out one to three days after the disaster.

### About the rapid assessment study (for sexual health and HIV vulnerability)

The rapid assessment study is a quick study carried out to determine the **extent of vulnerability** of people to HIV and sexually transmitted infections in the disaster area.

Based on the assessment, an area is defined either as **highly vulnerable, moderately vulnerable area or low vulnerable**. *If an area is highly vulnerable, a detailed assessment of the site follows* (Refer Tool 3).

Three parameters are used to assess whether an area is highly vulnerable or not:





### Parameter 1: Risk profile based on HIV prevalence of the district/geographical locale

In most countries, the surveillance system identifies HIV prevalence and vulnerability in different provinces within the country. Using this data, vulnerability to HIV and STIs in the geographical locale where the disaster has



occurred can be established. An example of risk profiling based on HIV prevalence in India, is given in the following box.

#### India's National AIDS Control Organisation's Definition for categorisation of districts

**Category A:** More than 1 percent prevalence in Ante Natal Clinics (ANC) in the district and more than 5 percent in high risk groups, in any of the sites in the last 3 years.


**Category B:** Less than 1 percent prevalence in ANC in all the sites during last 3 years with more than 5 percent prevalence in any High Risk Group site (STD/FSW/MSM/IDU).

**Category C:** Less than 1 percent prevalence in ANC in all sites during last 3 years with less than 5 percent prevalence in all HRG sites, with known hot spots (Migrants, truckers, large aggregation of factory workers, tourist etc).

**Category D:** Less than 1 percent prevalence in ANC in all sites during last 3 years with less than 5 percent prevalence in all HRG sites with no known hot spots, or no or poor HIV data.

For more details on any district, visit the following link: <http://www.nacoonline.org/upload/NACO%20PDF/District%20Categorisation%20for%20Priority%20Attention.pdf>

*\*HIV Sentinel Surveillance<sup>37</sup>*

It is critical to note that, during emergencies, it is likely that communities from different geographical locations may co-habit on account of displacement. Therefore the categorisation should include the areas or districts to which the displaced, and the host, communities belong to. 

### Parameter 2: Presence of specific vulnerable groups

Presence of high-risk groups or Specific Vulnerable Groups (SVG) like female sex workers, Men having Sex with Men (MSM), Injecting Drug Users (IDU) and migrant workers lead to increased vulnerability to STI and HIV. There are two ways to assess their presence.

a. By Observation:

There are existing rapid methods and community experts who can very rapidly 

<sup>37</sup> HIV Sentinel surveillance means carrying out cross-sectional studies (also known as prevalence surveys) of HIV prevalence rates at regular intervals among selected groups in the population known as "Sentinel groups". For more details: [http://dsacs.delhigovt.nic.in/naco\\_pdf/guideline\\_11.pdf](http://dsacs.delhigovt.nic.in/naco_pdf/guideline_11.pdf)



assess presence of female sex workers and MSM. These experts can be accessed through the State AIDS Control Societies.

- b. By referring to mapping estimates and studies  
Mapping reports on High Risk Groups (HRG) or Specific Vulnerable Groups (SVG)<sup>38</sup> are available with the State or District AIDS Control Units. This data provides estimates and location of at-risk populations like female sex workers, MSM and injecting drug users. Some mapping studies also give information on risk profiles of migrant workers.

### Parameter 3: Access to health services and information

The availability and ease of access to health services is another key pointer of vulnerability to STI and HIV. Where there are services there is information, and commodities like condoms are available. In the absence of these services, health seeking behaviour is likely to be poor.

The team can observe/ascertain the following:

1. Distance to health care centre
2. Presence of public health outreach workers
3. Availability of primary care services for STI and HIV

If there are primary care services for STI & HIV **and** functioning health infrastructure located **near** the community, vulnerability is considered moderate/low, otherwise it is considered high.

Based on the above three parameters the following table captures key vulnerability markers.

### Vulnerability matrix

	Parameter 1 District HIV risk profile	Parameter 2 Presence of high-risk groups	Parameter 3 Access to health services
<b>High-vulnerability</b>	District classified as Category A or B (Parameters used as per NACO classification - see pg. 20)	Presence of more than <b>three</b> female sex workers per 500 population, <b>or</b> the number of single adult male migrants constitute more than 5% of the total population. (#Note 1)	Non-availability of primary care services for STI & HIV <b>or</b> non-existence of functional health infrastructure <b>close</b> to the displaced community (#Note 2)
<b>Moderate/Low vulnerability</b>	District classified as Category C or D	Presence of less than <b>three</b> female sex workers per 500 population <b>or</b> the number of single adult male migrants constitute less than 5% of the total population	Availability of primary care services for STI & HIV <b>and</b> functioning health infrastructure located <b>close</b> to the displaced community

<sup>40</sup> Integrated Counselling and Testing Centre (ICTC) – facility where HIV testing and counselling services are available. (This is a term largely used in India. Globally the term Voluntary Counselling and Testing Centre (VCTC) was used)

Categorisation of high-vulnerability for any one parameter must be considered the basis for classifying the displaced community as highly vulnerable to STI & HIV

#Note 1: Estimated sex worker population in India is 1 percent of adult women, approximately 0.6 percent of total population

#Note 2: In a normal situation, primary care services for STI management, HIV testing, OI treatment, condoms etc. are usually available. In a post-disaster situation, non-availability of these could lead to increased vulnerabilities and the area is classified as high-vulnerable area

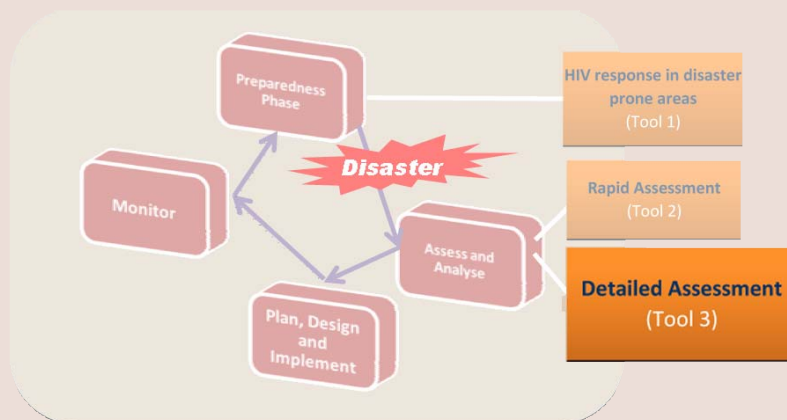
Add the above mentioned three parameters to the rapid assessment checklist as given in the International Emergency Assessment Checklist of Sphere Project

[http://www.sphereproject.org/component/option,com\\_docman/task,cat\\_view/gid,115/Itemid,203/lang,English/](http://www.sphereproject.org/component/option,com_docman/task,cat_view/gid,115/Itemid,203/lang,English/)



## Tool

3



## Detailed assessment study

### What the tool is about:

After the rapid assessment study, a detailed assessment study should be done. This section provides guidance on how to make an in-depth, detailed assessment around vulnerability factors in areas that have been established as high risk to HIV, through the rapid assessment process.

The detailed assessment is made generally in the 2nd to 4th week after the disaster has struck.

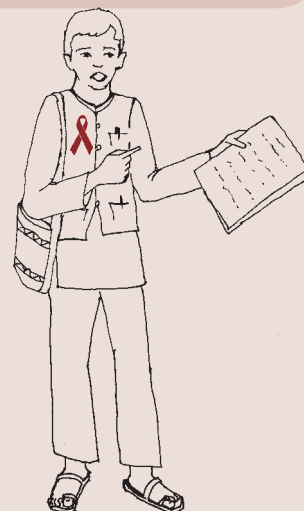
The information gathered will be useful for programme managers and staff of implementing agencies while making the implementation design.

**Detailed assessment** is a formative research methodology for gathering data using quantitative and qualitative techniques. The findings from the study are used for planning and designing intervention programmes.

A detailed assessment carried out as part of humanitarian response, collects information on livelihood, housing, food, social infrastructure, basic water and sanitation and health. Sexual health assessment must be part of this overall assessment as a subset of public health assessment.

The detailed assessment answers key questions like:

- What are the sexual health needs of people in the disaster hit area and how are they addressed?
  - o Knowledge on sexual health needs
  - o Access to information, treatment and care
  - o Access to sexual health products like condoms
  - o Sexual health seeking behaviour
- What are some of the strategies to address sexual health needs? Who are the key stakeholders in the locality who can be involved in sexual health programmes, particularly for the prevention and care of HIV?





- What are the key vulnerability factors to STIs/HIV post-disaster?

- o Multi-partner sex behaviour
- o Existing prevalence of STI/HIV
- o Presence of high number of specific vulnerable groups like sex workers, men having sex with men, and injecting drug users.



- o Location and time where the specific vulnerable groups can be found and provide services.

- Will displacement contribute to increased risk to STIs and HIV?
- Has loss of livelihood increased vulnerability to HIV?
  - o Women taking up sex work for additional income/livelihood
- Which are the high risk groups found in this area, and where can they be found?
  - o Sex workers
  - o Men having sex with men
  - o Injecting drug users
  - o Any other
- Is there any programme for sexual health and for HIV prevention and care, currently running in the locality?
- Is gender based violence or trafficking been reported in the locality? What are the potential risk factors for trafficking in the locality? Is there any movement of single women working , post-disaster?
- What is the total number of PLHIVs living in the affected district? (Details can be obtained from the state/provincial AIDS control units. Reported cases would be available from Integrated Counselling and Testing Centre (ICTC) or the Antiretroviral Therapy (ART) centre) in the locality.

Above mentioned key questions and suggestions can be added to the detailed assessment checklist as given in the International Emergency Assessment Checklist of Sphere Project

[http://www.sphereproject.org/component/option,com\\_docman/task,cat\\_view/gid,115/Itemid,203/lang,English/](http://www.sphereproject.org/component/option,com_docman/task,cat_view/gid,115/Itemid,203/lang,English/)

While doing a sexual health detailed assessment, key background documents and reports can provide useful information and perspectives. The right skills and attitude



of research staff should be ensured through an appropriate selection process and trainings and the findings organised in a report that can be used for decision making. It is important to provide some direction for strategies and ways forward in the report so that it can provide inputs for planning HIV programme implementation.

One of the key tools that can be used while planning interventions with the community for STI/HIV prevention is the **Situational Needs Assessment and Planning** tool (SNAP). Details about SNAP are given in the box below.

**Situational needs assessment and planning (SNAP)** is a research methodology used to design programme strategies for intervention based on the community's situation and needs. (The tool has been effectively used for designing sex worker HIV prevention programmes). Evidence-based planning and community participation are key objectives of SNAP which is organised around the strategic need of 'information for planning'. The primary focus of SNAP is to have a micro level plan that is owned by the local communities and available for immediate use in the field.

**Process and tools used:**

• **Step A: Location Familiarisation Exercise**

- Rapid Interviews with Secondary Stakeholders (Local shop owners, police, vendors etc)
- Rapid Interviews with Primary Stakeholders (Sex workers, Male having sex with male, Injecting drug users etc.)
- Transect Walk – observation walk across the affected area for data related to high risk spots (sex worker client pick up points, injecting drug users "shooting galleries"<sup>39</sup>)

• **Step B: Primary data collection for Planning**

- Depth Interviews with STI doctors (using interview guide)
- Depth Interviews with ICTC<sup>40</sup> staff (using interview guide)
- Direct Interviews with Secondary Stakeholders (using interview guide)
- Focus Group Discussion (FGD) with Primary Stakeholders

• **Step C: Social mapping and developing micro-plans with the community**

- Draw a social map of the geographical site together with the community (sex workers) capturing key information like, the pick-up points of clients, condom outlets, clinics, police station, sex activity spots etc.
- Based on the data gathered make outreach plan, Field Visit Scheduling, Condom Depot Locations, Condom Stock and Demand Index, Partnership and Networking Chart.

For more information on SNAP check:

[http://www.swasti.org/main/index.php?option=com\\_content&task=view&id=12&Itemid=18](http://www.swasti.org/main/index.php?option=com_content&task=view&id=12&Itemid=18)

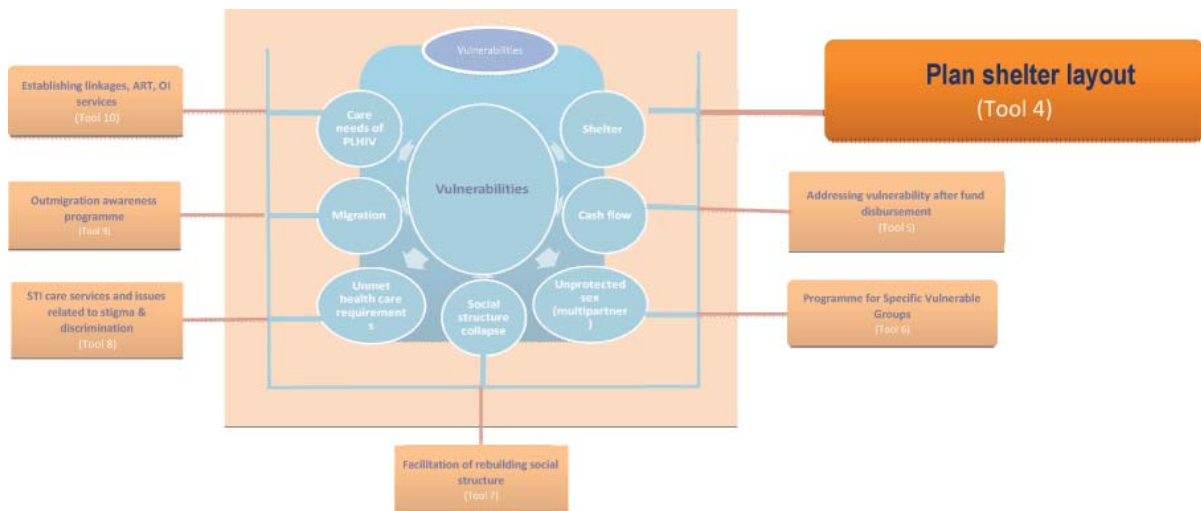
<sup>38</sup> Sex Workers, Male having sex with male, Injecting Drug Users.

<sup>39</sup> Place where injecting drug users come together and share drugs using syringe.

<sup>40</sup> Integrated Counselling and Testing Centre (ICTC) – facility where HIV testing and counselling services are available. (This is a term largely used in India. Globally the term Voluntary Counselling and Testing Centre (VCTC) was used)

## Tool

4



## Shelter and vulnerability during displacement

**This tool is about** shelter planning processes – so that they can be designed/planned to effectively reduce sexual health-related vulnerabilities of communities who are displaced.

The section would be useful for district-level authorities engaged in **planning/ designing of temporary or intermediate shelters for affected communities**. (NGOs working with the government on shelter planning can also use this tool to advocate shelter planning/design.)


### Shelter and HIV vulnerability

In an emergency situation, affected populations are housed in temporary/intermediate shelters till their permanent shelter can once again be safely accessed or a new one built. Though referred to as “temporary”, communities often end up staying at these shelters for a considerable period of time. Displacement of populations and resettlement in temporary or intermediate shelters have a direct influence on vulnerability to STI and HIV.

As observed in the Swati-Oxfam research conducted post-tsunami, some of the factors related to Shelters that result in increased vulnerability to STI/HIV include:

- Increased physical proximity and unsafe multi-partner sex.
- Establishing of new contacts which may result in unsafe, non-regular sex partners.
- Lack of privacy in intermediate shelters- which results in limited opportunities for sexual





relationship between spouses. Sometimes leads men and women to seek sexual contact with others.

- Inadequate space and congestion in intermediate shelters—which forces young men to sleep outside or away from home/ come back late thus providing opportunities to explore sexual relations outside.
- Abandoned and damaged buildings – provide space opportunities to engage in sex.
- The use of intermediate and abandoned shelters for sexual activity.

**Mainstreaming HIV while planning shelter layouts** depends on two scenarios:

1. Persons displaced from their homes, re-settled in temporary or permanent dwellings, without coming into contact with other communities, and
2. Those coming into contact with other communities.

**In case of Scenario 1:** Affected communities displaced from their original habitation, settled in temporary or permanent dwellings without coming into contact with other communities.

1. It is best to have a family-centric approach where each family lives together under the same roof, or in adjacent dwellings. Adolescents and unmarried youth in particular could be more vulnerable staying away from their families. Therefore it is necessary to provide adequate space for each family to live together.
2. Efforts need to be made to provide adequate privacy to married couples in every shelter.
3. Women must have access to separate bathing and sanitary facilities to safeguard their privacy.
4. The shelters must be located close to other facilities like drinking water, health services, prayer halls, food distribution centres etc. so that people, especially women and girls, do not have to travel for considerable distances to access these services.
5. Damaged and abandoned buildings must be razed or protected to restrict access by people. Intermediate shelters that are no longer in use also must be dismantled or protected to avoid misuse.
6. As far as possible, reconstruct the same social order (in terms of neighbourhood) as in the original location so that the existing social order is largely replicated. Whilst disasters are an opportunity to deal with social segregation, in a post disaster scenario, tackling these issues by changing social order could cause other tensions. Hence, help the community resettle as far as possible in the same social order that existed before.

**In case of Scenario 2:** Affected communities displaced from their original habitations, settled in temporary or permanent dwellings along with other communities


1. Within each community, ensure that intermediate shelters are appropriately designed to decrease vulnerabilities (points 1-6 of scenario 1).
2. Ensure that communities with similar socio-cultural backgrounds are




accommodated at different sites/locations, adequately spaced from each other.

3. Each such site/location should preferably have separate access to facilities like drinking water, sanitation, food distribution systems etc.

While designing inter-mediate shelters it is advisable to involve community representatives including women, so as to understand and accommodate socio-cultural and gender needs of affected communities.

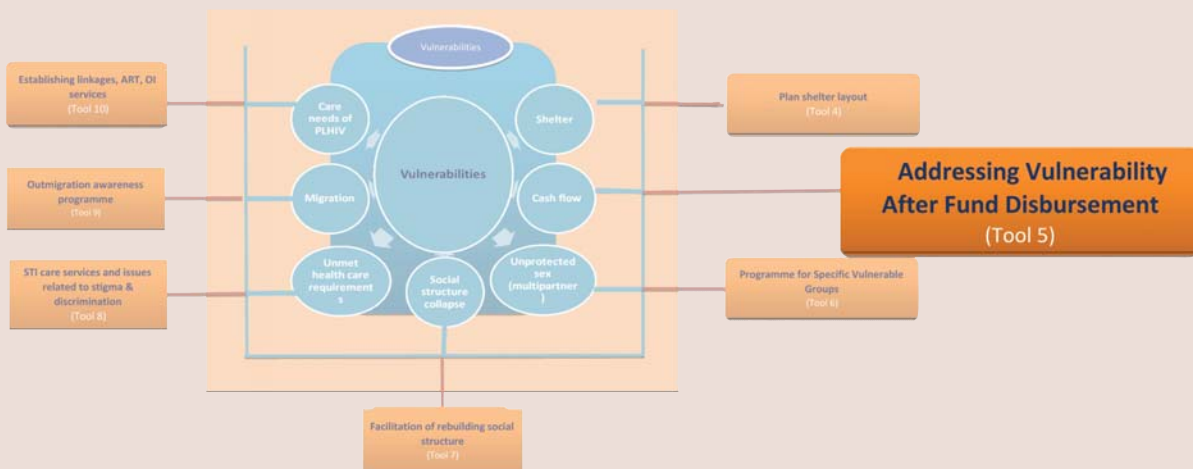
Ref: Participatory Planning Guide for Post-Disaster Reconstruction; EPC –TCGI-LLC;   
<http://www.tcgillc.com/tcgidocs/TCGI%20Disaster%20Guide.pdf>

For further guidance on shelter design refer to, Humanitarian Charter and Minimum   
Standards in Disaster Response – The Sphere Project; 2004 Edition;  
[www.sphereproject.org](http://www.sphereproject.org)



## Tool

5



## When funds are disbursed

### What the tool is about:

This tool addresses HIV vulnerabilities related to large inflows of cash and material aid to victims during disaster relief and rehabilitation. It provides guidance for planning of general awareness programmes among the affected communities with particular focus on youth, to decrease vulnerabilities leading to STI/HIV.

### Who can use this tool:

Implementing agencies — to plan HIV awareness programmes in all locations where increased income levels are noted.

### When the tool is to be used:

This tool is to be used while planning the relief and rehabilitation response programme after the disaster.

Following disasters there is usually an inflow of considerable aid in the form of cash as compensation for loss of life and injuries. Assistance in kind is also provided in forms of alternate shelters, livelihood related support, rations, bedding, clothing etc. All these may lead to sudden increase of disposable cash, which in some cases has lead to alcoholism, purchase of commercial sex and brinkmanship in terms of taking risks.<sup>41</sup>

<sup>41</sup> Understanding the Effect of the Tsunami and Its Aftermath on Vulnerability to HIV in Coastal India, Oxfam and Swasti

The following are guidelines that address increased levels of vulnerability on account of inflow of cash aid:

1. The target group for awareness programmes can be those in the age-group 18 – 50 years. Adolescents in the age group 10-18 years need to be addressed through Adolescent Education Programme<sup>42</sup>.
2. The awareness issues that need to be addressed include transmission and prevention of HIV/STI; condom usage; counselling and testing services; care and support for PLHIVs; stigma and discrimination.

#### References:

- HIV Education for Refugee Youth: A Window of Hope, UNHCR, 2001; <http://www.unhcr.org/protect/PROTECTION/403a0fd14.pdf> ;
- HIV Interventions for Young People in Humanitarian Emergencies. Inter-Agency Task Team, 2008.
- [www.teachaids.org](http://www.teachaids.org)

These are broad issues that need to be addressed and the actual needs of the campaign need to be decided based on the findings of the detailed assessment study (ref tool 3, pg. 28).

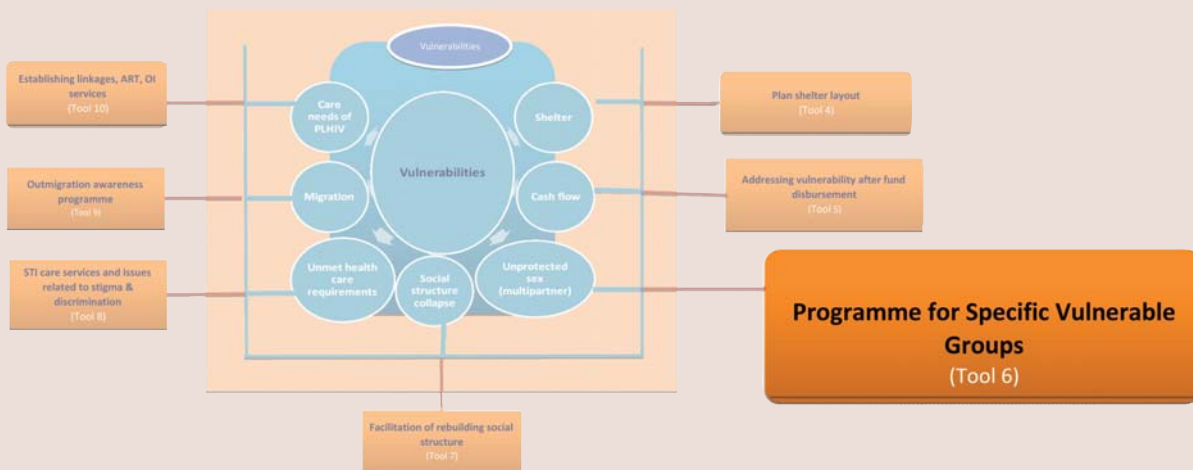


<sup>42</sup> Adolescent Education Programme refers to an interactive process of teaching and learning which allows learners to gain knowledge and develop skills which support healthy behaviours. Module has been developed particularly to cater to the youth and are taught in the school. For more details on the facilitators guide and teachers workbook etc - [http://www.nacoonline.org/Quick\\_Links/Youth/School\\_Age\\_Education\\_Program\\_SAEF/](http://www.nacoonline.org/Quick_Links/Youth/School_Age_Education_Program_SAEF/)



## Tool

6



## Planning programmes for specific vulnerable groups

### What the tool is about:

It provides guidance on addressing vulnerabilities related to, increase in unprotected sex behaviour with non-regular partners and, specific vulnerable groups (sex workers, male having sex with male, injecting drug users) and provides suggestions for designing programmes for the Specific Vulnerable Groups (SVG) and programmes to address high risk behaviour among the general population, to prevent the spread of HIV/STI.

While planning the relief and rehabilitation measures, the section would be useful for:

- District administrations coordinating the relief and rehabilitation effort
- Donor agencies
- Technical agencies providing capacity building support to field level agencies

### Factors facilitating unprotected non-regular partner sex:

In most countries with high prevalence of HIV, close to 80 to 90 percent of the route of transmission of HIV is through unprotected sex. Of this a key contributing factor is unprotected sex with non-regular sex partners. One of the key vulnerability areas to HIV post-disaster is unprotected non-regular partner sex. Some of the factors facilitating this behaviour include:

- Sex work as livelihood option,
- Injecting drug use, on account of sudden inflow of cash
- Shelter related issues (refer section 2.3 pg.32)
- Migration
- Trafficking/exploitation of women and children
- Low awareness of HIV



### Prevention of HIV/STI – among specific vulnerable groups

**Rapid Assessment Study :** Ideally the rapid assessment study carried out (see page 23) should also identify SVG in the disaster area, and provide information regarding existing STI/HIV prevention programmes in the locality.

**Response Plan:** The district administration involved in initiating overall disaster programmes in the district should plan HIV mainstreaming along with the national HIV programme implemented. Key strategy for prevention among these vulnerable groups is the Targeted Intervention Programme<sup>43</sup>



#### Targeted Intervention

In order to achieve overall reduction in the HIV epidemic one of the key prevention strategies being implemented across the globe is the 'targeted intervention programme'. Key focus of the targeted interventions is on specific vulnerable groups like sex workers, men having sex with men, and injecting drug users. The programme strives to achieve behaviour change among these groups – to safer practices of sex and injecting drug use — that will minimize the risk of HIV transmission. Key components of targeted intervention programmes are: behaviour change communication, condom programme, needle and syringe exchange programme and detoxification among drug users ; sexually transmitted Infection control programmes, reduction in stigma and discrimination against these communities through advocacy, community empowerment through increased community participation etc.

The targeted intervention programme is also being implemented among the 'bridge population' (*Bridge populations comprise people, who, through close proximity to high risk*

<sup>43</sup> <http://www.nacoonline.org/upload/Publication/NGOs%20and%20targetted%20Interventions/NACP-III.pdf>




groups are at the risk of contracting HIV. Quite often they are clients or partners of male and female sex workers. Truckers and migrant labour are major bridge populations.) . Intervention among these groups are aimed at increasing knowledge about sexually transmitted infections, HIV/AIDS and safe sex.

For more details on different models of targeted intervention programmes click on the following links:

1. A Manual on TI - <http://www.fhi.org/NR/rdonlyres/exjzjml54egjnyih4isxdklmrpferljk12xmwpfyxckwm3j77iu4kgtmouujrr5remdyi325jwh3gh/targetedintervstdcommsex.pdf>
2. Guidelines on TI - [http://www.nacoonline.org/Quick\\_Links/Publication/NGO\\_\\_Targeted\\_Interventions/](http://www.nacoonline.org/Quick_Links/Publication/NGO__Targeted_Interventions/)
3. TI Strategies - [http://www.apacvhs.org/What\\_TargetedIntervention.html](http://www.apacvhs.org/What_TargetedIntervention.html)
4. Toolkit on TI in Sex Work setting - <http://whqlibdoc.who.int/publications/2005/9241592966.pdf>

## Addressing vulnerability among the general population

 **Response Plan:** The national HIV programme in the region provides several initiatives as a package of services to reach out to the prevention and care needs of the general population: Integrated Counselling Testing Centre (ICTC)<sup>44</sup>, STI clinics, condom distribution (both public and private), general Information Education and Communication (IEC) etc. While addressing the general population, special attention needs to be given to addressing issues of women and youth.

**Women's** vulnerability is heightened by both biological and socio-economic reasons. In the South Asia context, the position of women in society is still very weak. Early marriage and sexual abuse and violence against women are still prevalent. Besides, their biological construct makes them more susceptible to HIV infection in any given heterosexual encounter.

**Youth** is an age of curiosity and experimentation, many times with limited or no information. This increases their vulnerability to STI and HIV. During a high level technical meeting on "HIV Prevention for Young People in Developing Countries" organised by USAID, Institute for Youth Development and FHI, at Washington DC, in 2003, Dr. Monasch noted that one half of new HIV infections worldwide occur in youth in the age group of 15 to 24.<sup>45</sup> In India the data shows that 31 percent of the AIDS burden is in the age group of 15 to 29.<sup>46</sup>

There are several risk factors for youth in an emergency situation. Risk increases because of break in parental control, break in protective environment, exploitation, trafficking etc. Therefore a comprehensive programme for HIV prevention is important for prevention of HIV/STI among the youth.

<sup>44</sup> ICTC – provides HIV testing and counselling services – In India this services is available in most of the districts across the country.

<sup>45</sup> <http://www.fhi.org/NR/rdonlyres/enxmmgpn6d2khkyduc2xrihuyspe7arbfkquwepzyr72sdc7dpd6bguxhdkqtq5aaagfuz6g7wafr5d/HIVprevenmtgreportWeb.pdf>, P. 5

<sup>46</sup> [http://www.nacoonline.org/Quick\\_Links/Youth/](http://www.nacoonline.org/Quick_Links/Youth/)



There are several existing models for prevention among women and youth. For more details visit the links below.

1. Prevention of HIV among women:-  
<http://www.nacoonline.org/upload/Publication/IEC%20&%20Mainstreaming/mainstreaming%20hiv%20and%20aids%20for%20women.pdf>

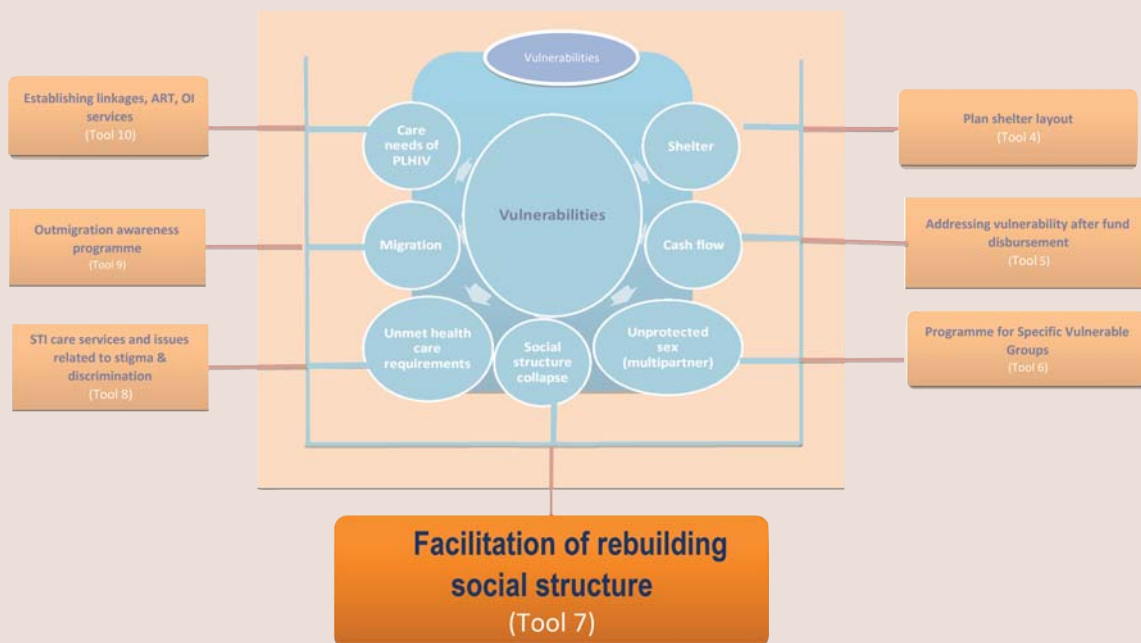


2. M&E Indicators for monitoring HIV prevention programme among youth:-  
[http://data.unaids.org/Publications/IRC-pub06/JC949-NAP-YoungPeople\\_en.pdf](http://data.unaids.org/Publications/IRC-pub06/JC949-NAP-YoungPeople_en.pdf)
3. Youth Peer Education Tool:- <http://www.fhi.org/NR/rdonlyres/er5r5l4cwghbr336eqs3z5c3q7xokveougqupqov5sqpadbftctjs434bwiged2norg2azfwrszbe/YPeerTOTfull.pdf>



## Tool

7



## Rehabilitation phase - Rebuilding social structures

### What the tool is about:

It highlights action to be taken by programme implementers, particularly disaster response personnel and those involved in rehabilitation, to help rebuild social structures so as to reduce vulnerability to sexually transmitted infections, HIV and AIDS

This tool is to be used while planning the relief and rehabilitation implementation programme by the programme implementers, particularly disaster response personnel and those involved in rehabilitation

Social structures are formed through norms of behaviour, hierarchy, information potential, obligations and expectations. After a disaster, lives are lost, individuals are displaced, environment and social standing changes. Social structures tend to disintegrate, dissipate or dissolve. Leadership may be displaced and the changing environment affects shifts in social priorities. The disintegration of social structures exposes several vulnerabilities— including food security, shelter, gender-based vulnerabilities, poverty etc. **Though disintegration of social structures is the least tangible reported loss during a disaster, it is critical to the speed of recovery and also to reduce the community's vulnerability to HIV and STI.**

This guide presumes that the social structure, albeit dynamic, is not the same as it was before the disaster.

### **Guidelines on facilitation of rebuilding of social structures after a disaster:**

Social capital is created when relationships are changed to facilitate positive action. The stages to be rebuilt are:

- |                |   |
|----------------|---|
| Preparedness   | → enhancement of social structures      |
| Relief         | → utilisation of social structures      |
| Rehabilitation | → re-establishment of social structures |



### **Guidelines on how to facilitate the rebuilding of social structures:**

1. Preparedness Phase: Ensuring involvement of community in preparing for the disaster will contribute to mitigation of negative impacts of a disaster on that community. While addressing larger issues of disaster preparedness, it is also important to focus on the sexual health issues at the preparedness stage. Make the community leadership aware of the social structure collapse that could take place and the particular vulnerability related to HIV as a result of that.
2. Relief and Rehabilitation Phase: During the time of disaster, the affected people and their families and friends are the first responders, and it is the local community and their involvement and preparedness that will make the difference in the success of relief efforts.
  - Engage with decision makers, and current and emerging leaders, to help protect those already identified with HIV and AIDS
  - Create support groups with the help of leaders to enable/facilitate smooth access to health care services for all, especially the weaker sections of the community (aged, elderly, pregnant, chronically ill, those with no other support systems).
  - Create support groups for PLHIV; widows; orphaned adolescents etc. Support group creation requires close facilitation and several tools are available that can be used to facilitate support group formation. For more details visit the following web link:

[http://www.swasti.org/main/index.php?option=com\\_content&task=view&id=12&Itemid=18](http://www.swasti.org/main/index.php?option=com_content&task=view&id=12&Itemid=18)



**Reference:** The importance of Social Capital in disaster response, Russel R Dynes, Disaster Research Center, University of Delaware, 2000.

Social Capital and Disaster Management: Building Community Capacity Interim Report: February 2003. Available at [http://info.wlu.ca/~wwwbrant/pages/people/walkerton-first\\_interima.pdf](http://info.wlu.ca/~wwwbrant/pages/people/walkerton-first_interima.pdf)

Ichiro Kawachi, S.V. Subramanian and Daniel Kim, Social Capital and Health, Part II, pages 273-285, chapter on Disaster Preparedness and Social Capital . Also available at <http://www.springerlink.com/content/x325351876817746/>

### Checklist for assessing social structure

While preparing a plan for the restoration of ,or strengthening, social structures in a community, the following information can be gathered as part of the detailed assessment process (Refer tool 3 pg. 42)

1. Population characteristics: Gather data on socio-cultural and economic characteristics of the displaced group, major occupational background, religion, role of women in the society, migration pattern etc
2. Community structures: Community leadership and capability, decision-making process, interest groups, pressure groups, value system, crime and punishment – traditional practices, political structure

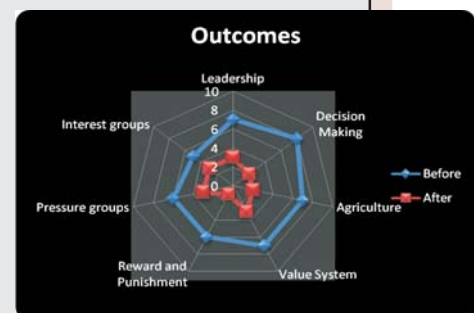
Assessment can be carried out in different community groups. Analysis can be on a before-after scenario and solutions for restoring the social structures and norms can be arrived through a consensus process. The data gathering can be done using **Cobweb analysis tool** (Refer to the box below), which is an effective participative tool that will provide information for a before-after scenario with regard to key parameters related to social structures.

### Cobweb Analysis

This is a PRA tool used for qualitative assessment of a scenario within the community. The Tool can be used through mixed group interaction, wherein leaders of the community, community members and other key stakeholders from the same community are brought together to discuss the issue of social structures collapse. Following areas can be examined in a discussion:

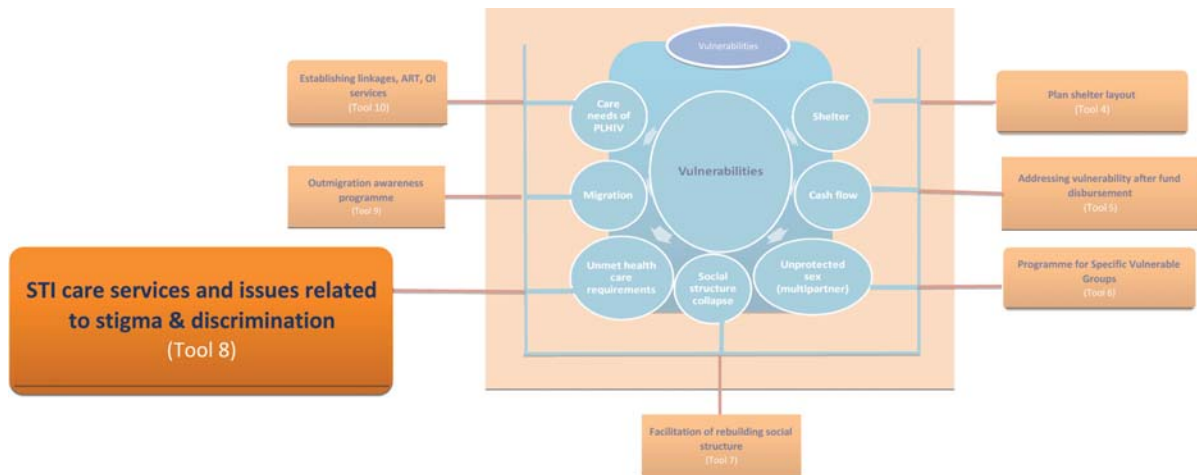
- Leadership,
- Decision making process
- Social value system
- Reward and punishment etc.

In each of the above areas, community members will jointly assess the status on a scale of 1 to 10. The following diagram which is in the shape of a cobweb can be used for interaction with the community. The community's discussion and scoring can be on a before-after scenario. Scoring is indicative and what is important is the depth of discussion around the score which will provide lots of information on the status of social structures before the disaster, and what has happened after, and this will help in providing information for restructuring.



## Tool

8



## Strengthening STI/HIV treatment and care services in the existing health system, post-disaster

### What the tool is about:

Responding to increased vulnerability to HIV due to poor access to health care systems during a disaster, and suggest ways to integrate STI and HIV related services into the health care systems post-disaster while planning the relief and rehabilitation implementation programme.

### Who can use the tool:

- Government health authorities — to integrate STI and HIV related services into existing health services.
- NGOs involved in direct provision of health services or complementing government services – to ensure integration of STI and HIV related services.
- Technical agencies that provide training to humanitarian workers





## Sexual health care services and humanitarian emergencies

The vulnerability to STI and HIV, of disaster-affected communities in relief and rehabilitation camps, is heightened due to poor access to, or lack of, the following health and related services:

- STI Management including identification and treatment
- Counselling individuals to identify increased vulnerabilities/risk and for making informed choices especially in relation to sexual health issues
- HIV testing for early identification
- Blood safety, including collection and transfusion services during disasters— one of the important modes of transmission of STI and HIV
- Awareness/education programmes
- Access to condoms

### **Health and related services in any emergency should ensure availability of the above services.**

#### Integration of STI and HIV services with existing health services

All services related to STI and HIV need to be integrated into existing health services established as part of the humanitarian response programme or those already available locally and, preferably, not as a stand-alone service. Integration will help avoid stigma associated with most of these services and reduce infrastructure, space and resource needs which are precious in emergency settings. It is important to ensure privacy (separate room for the doctor – separated at least with a screen or curtain) while designing the clinic. It is also important to ensure training on STI and Syndromic Case Management (refer to annexure for syndromic management of STIs) given to health care providers. Technical agencies involved in training humanitarian workers could include, STI and HIV in the training curriculum for health care providers. Following are some links for training manuals for STI:



#### **References:**

1. WHO Training manual on STI for facilitators: <http://www.wpro.who.int/NR/rdonlyres/2E4A6567-7F1F-484F-8C5D-A1DE3AF4C050/0/FacilitatorsVersion.pdf>
2. WHO training manual on STI for participants: <http://www.wpro.who.int/NR/rdonlyres/73F8E5F9-BFEA-4895-AAF8-3079AD4F104F/0/ParticipantsVersion.pdf>
3. STI Guidelines of NACO (India): <http://www.nacoonline.org/upload/Basic%20Services/National%20Guidelines%20on%20Prevention,%20Management%20&%20Control%20of%20Reproductive%20Tract%20Infection%20Including%20Sexually%20Transmitted%20Infections.pdf>

### **STI related services**

STI services are aimed at prevention, early identification and prompt treatment.




**Screening for STIs:** Is a proactive effort and involves asking questions related to



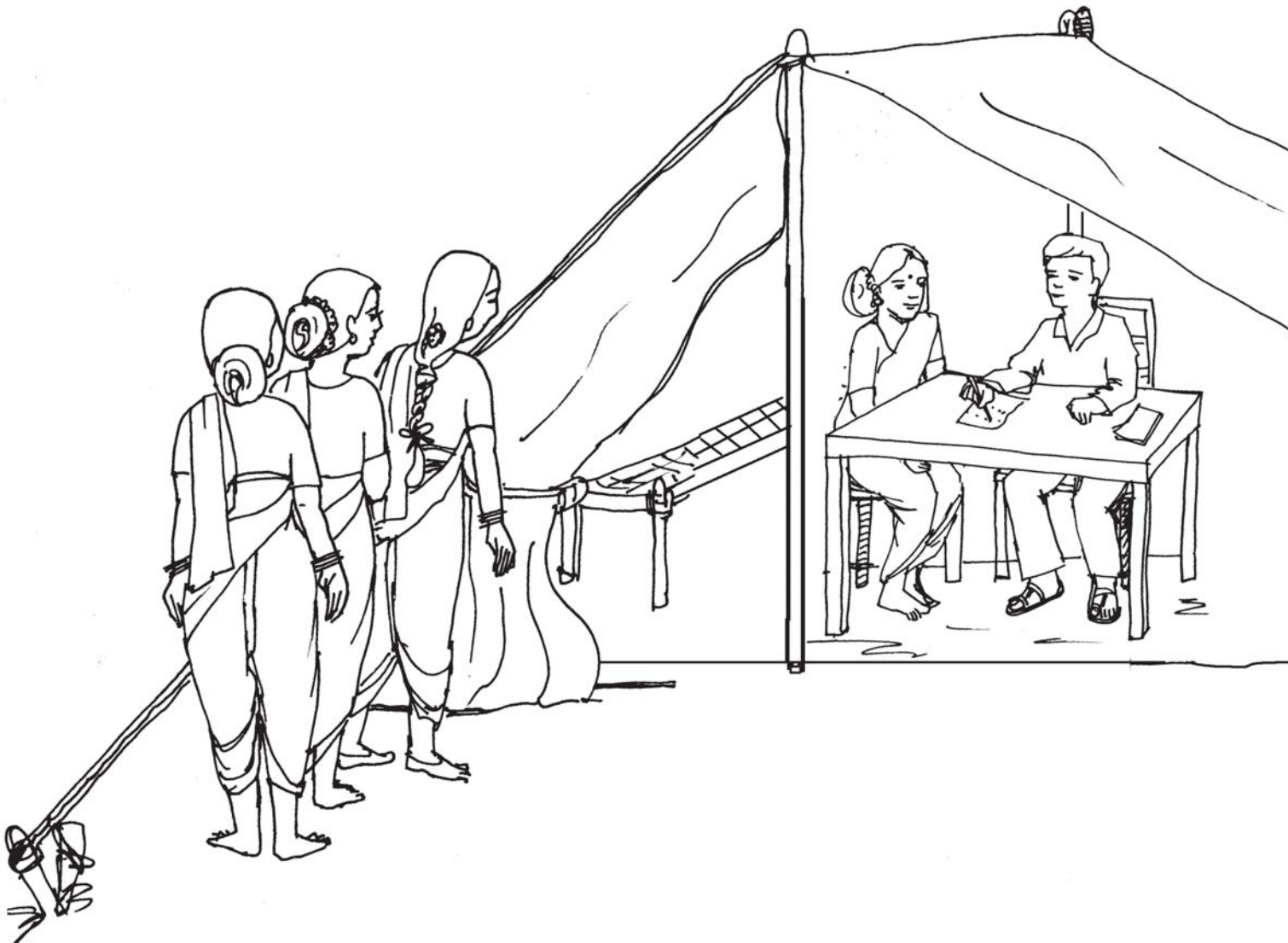
symptoms of STI. This requires that the clinics are designed with adequate privacy. It is not advisable to have separate STI clinics, as this could discourage individuals with STI to visit the clinic for treatment. STI services should be integrated with regular clinical services.

### **Diagnosis and treatment of STIs:**

In emergency situations, laboratory facilities are hard to come by. Syndromic approach to treating STI is a well accepted protocol and can be easily adopted by doctors and health care workers in an emergency.

While treating STI, it needs to be emphasised that treatment of the partner is essential and patients need to be encouraged to bring their partner in for treatment. 

In case the STI is a result of sexual violence, then referrals to agencies and programmes dealing with such issues (e.g. women's groups) need to be activated.



## Counselling services

Counselling in emergency situations is provided to help people cope with the aftermath of disaster. Counselling for other needs should also include counselling regarding their vulnerability to STI and HIV, and help them to make informed choices. Counsellors need to be oriented to handle general health issues, including sexual health and HIV. This will avoid stigmatisation of counselling and the counselled.

Counselling can also be provided in an outreach mode through outreach/mobile health clinics.



### References:

- Operational guidelines for Integrated Counselling and Testing; NACO July 2007; Pages 15 & 16; [http://www.nacoonline.org/Quick\\_Links/Publication/Basic\\_Services/Operational\\_\\_Technical\\_guidelines\\_and\\_policies/Operational\\_Guidelines\\_for\\_Integrated\\_Counseling\\_and\\_Testing\\_Centres/](http://www.nacoonline.org/Quick_Links/Publication/Basic_Services/Operational__Technical_guidelines_and_policies/Operational_Guidelines_for_Integrated_Counseling_and_Testing_Centres/)
- Integration of HIV/STI Prevention, Sexuality, and Dual Protection in Family Planning Counselling: A Training Manual; Engender Health; Working Draft 2002; <http://www.engenderhealth.org/files/pubs/hiv-aids-stis/integration-manual.pdf>
- Programme guidance on Counselling for STI/HIV prevention in sexual and reproductive health settings; IPF; 2001; [http://www.ippf.org/NR/rdonlyres/CDB3B150-D4F2-4681-8A83-A7AEF26E7E31/0/Counselling\\_STIHIV.pdf](http://www.ippf.org/NR/rdonlyres/CDB3B150-D4F2-4681-8A83-A7AEF26E7E31/0/Counselling_STIHIV.pdf)

## HIV testing services

HIV testing can be undertaken in any existing laboratory service established in emergency settings.



### Reference:

- Guidelines on HIV Testing; March 2007; NACO; [http://www.nacoonline.org/Quick\\_Links/Publication/Blood\\_Safety\\_\\_Lab\\_Services/Operational\\_\\_Technical\\_guidelines\\_and\\_policies/Guidelines\\_for\\_HIV\\_test/](http://www.nacoonline.org/Quick_Links/Publication/Blood_Safety__Lab_Services/Operational__Technical_guidelines_and_policies/Guidelines_for_HIV_test/)

## Blood safety

While blood transfusions could be a life-saving measure during emergencies, it could also result in transmission of HIV, Hepatitis B & C and certain other STI.



The essential items required for collection, testing and transfusion of blood can be found from the following link: (Guidelines for HIV / AIDS Interventions in Emergency Settings; [www.unfpa.org/publications/detail.cfm?ID=165](http://www.unfpa.org/publications/detail.cfm?ID=165))

Mobilising safe blood is one of the challenges in an emergency. However, if efforts are made towards ensuring availability of safe donors, the risk of transmission of infected blood is drastically reduced.

To ensure safe blood:

- Encourage close relatives of the recipient to donate blood...this ensures not only the availability of the required blood group, but also lessens the risk of infected blood.

- Encourage voluntary blood donation and discourage professional donors. Voluntary blood donors are more likely to be safe from infections.
- Test the donated blood for infections before transfusion, if possible. HIV rapid tests; HBs Ag and tests for syphilis are fairly simple and can be done quickly.
- Ensure that syringe used is disposable (and not re-used).

Disposal of blood and blood products: Adopt universal precautions (refer Annexure on Universal Precaution) for safe disposal.



## Awareness and education programmes

Refer to tool 6 - pg. 50 - Planning programmes for specific vulnerable groups

## Condom related services

Condom-related services include awareness on usage of condoms and supply/distribution of condoms to prevent transmission of STIs and HIV. If awareness levels are low, awareness programmes need to be initiated. (Refer to tool 6 - pg. 50 - Planning programmes for specific vulnerable groups)

If awareness levels are high supply of products and services needs to be ensured – both through public and private channels. (Refer to tool 6 - pg. 50 - Planning programmes for specific vulnerable groups)

**The focus should be on promoting familiar products and not new ones. e.g., if female condoms are unheard of in the community, then promoting female condoms should not be a priority,** condom supply needs to be gauged so that adequate quantities can be ensured (Refer Box 7)



### Box 7 Assessment of requirement of condoms

(Ref: <http://www.rhrc.org/pdf/rhrkit.pdf>; Inter Agency Reproductive Health Kits for Crisis Situations, 4th Edition, 2006)

#### Male condoms:

Assume that 20 percent of the population in the camp are potentially sexually active men. (10,000 persons x 20 percent = 2,000 males) and 20 percent of this group will use condoms (2,000 x 20 percent users = 400 users) and that each user will need 12 condoms each month for the three months (400 x 12 x 3 months = 14,400 male condoms).

#### Female condoms:

Assuming that around 25 percent of the population in the camp are potentially sexually active women. (10,000 persons x 25 percent = 2,500 women) and that 1 percent will use female condoms (2,500 x 1 percent users = 25 users) and that each user would need 6 condoms each month (25 x 6 x 3 months = 450 female condoms).

#### Male condoms

Male Condoms	14,400
20 percent wastage	2,880
Total	17,280 (120 gross)
Safe Sex Leaflets	400

#### Female condoms


Female Condoms	450
20 percent wastage	90
Total	540 (3.8 gross)
Female Condom use Leaflets	25

For details on condom usage education: (Refer to Annexure 13 p. 94)



## Stigma & discrimination

### Reference:

 Reducing stigma and discrimination related to HIV and AIDS – Training for Health care workers; ENGENDERHEALTH; [http://www.engenderhealth.org/files/pubs/hiv-aids-stis/reducing\\_stigma\\_trainer\\_English.pdf](http://www.engenderhealth.org/files/pubs/hiv-aids-stis/reducing_stigma_trainer_English.pdf)

### References on stigma and discrimination:

1. Research study on stigma and discrimination: [http://data.unaids.org/Publications/IRC-pub01/JC316-Uganda-India\\_en.pdf](http://data.unaids.org/Publications/IRC-pub01/JC316-Uganda-India_en.pdf)
2. Stigma experienced by women: <http://www.fhi.org/NR/rdonlyres/ed3e6f12uuesonsukflop7quewh7meoh37gqhybvwtzz25dn675a4pu56nf5enzo7mb73xekndnme/stigmadisriminationwomennepal2004noenhv.pdf>
3. Examples of slogans against HIV related stigma and discrimination
  - Stigma is a nightmare - it affects the rights of PLHIV, societal coping mechanism and caring for the sick
  - Help prevent, reduce or eliminate stigma and discrimination - wherever they occur and in all their forms.
  - AIDS attacks the body - Prejudice attacks the spirit - One is caused by virus the other by ignorance - BOTH CAN KILL!!!
  - AIDS will not affect our friendship

Above slogans adapted from - <http://www.authorstream.com/Presentation/Miguel-35859-20020927-wac-presentation-en-World-AIDS-Day-1-December-primary-vehicle-awareness-Campaign-themes-so-far-Stigma-disc-as-Entertainment-ppt-powerpoint>.

For more samples of posters against stigma and discrimination visit the following link <http://www.avert.org/postershst.htm>

### Suggested medium for campaigning against stigma and discrimination

- Speeches – are particularly efficient in schools, places of worship, organisations and workplaces. Speeches/talks are often optimally around 30 minutes long and one should leave sufficient time for questions.
- Workshops - a workshop can be a few hours long and is a good way to inform people and solicit diverse viewpoints. Workshops give people a chance to discuss issues in greater detail. This would be a very effective medium to fight against stigma in a community.
- Plays and songs - can be a very effective way of getting a message across to people who do not want to sit in meetings or workshops. Involve cultural groups in developing education programmes.
- Consultative meetings/community meetings - consultative meetings are meetings of interested people from the community or from a specific target group, where people come together to discuss an issue.
- Door-to-door – this is a labour intensive method, but great for intensive targeting of communities where man power is not an issue.

- Pamphlets - pamphlets are a good way of spreading information about HIV/AIDS as well as information about the campaign. Pamphlets should be kept short and simple.

- Mass Media – Television, Radio and Newspaper allow for the dissemination of information. It provides a platform for public debate, and can serve as a mechanism for holding policymakers to account.

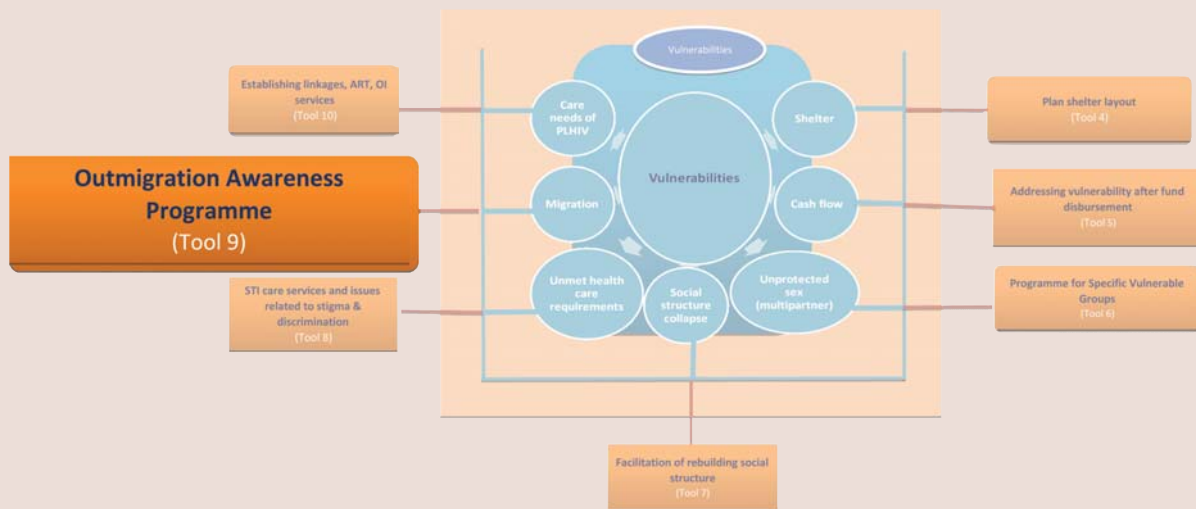


- Posters/pamphlets/graffiti - use posters and pamphlets to raise pertinent issues or give people information.
- Marches, events and cultural shows - marches, cultural events and parties can mobilise community support. Use "Breaking the silence" events where people living with AIDS come to talk about their experiences or plays and songs that show the reality of HIV/AIDS and highlight the need to fight against stigma and discrimination.
- Loudhailers, information tables - loudhailers can be used to talk in taxi ranks or in other public spaces. Information tables can be set up at busy places.
- Local / Community Radio – Local radio stations are often an effective means of campaigning. Stations may be willing to join the campaign and publicise it.



## Tool

9



## Improving awareness and services to migrants, post-disaster

### What the tool is about:

During a disaster, people are invariably brought in from other areas to help in the reconstruction, and also there are migrants who go to far away destinations in search of livelihood as a result of displacement due to a disaster. This tool addresses the issue of these 'migrants' having increased vulnerabilities to HIV, due to migration.

### Who can use the tool

- District administrations coordinating disaster response programmes at the field level.
- Donor agencies mobilising resources to address vulnerability.
- Technical support agencies that should ensure that the vulnerabilities due to migration are included in capacity building programmes and planning of interventions.
- Programme managers of disaster programmes — to help district administration to use the tool.

### When it is to be used:

This tool is to be used while planning the relief and rehabilitation implementation programme.



### Box 9: Migration and HIV

Migrant or mobile populations are people who move from one place to another temporarily, seasonally or permanently. Movement could be for a variety of reasons; it may be voluntary or involuntary. Migrants are at an increased risk of contracting HIV due to instability of social, economic and political factors in both origin and destination locales. UNAIDS reports around 86 million people to be international labour migrants and 175 million people who live permanently, or for extended periods of time, in foreign areas/countries.<sup>2</sup>

UNAIDS reports that factors of migration that lead to an increase of HIV risk include:

- Separation from spouse, families and social and cultural norms;
- Language barriers,
- Substandard living conditions;
- Instability;
- Exploitative working conditions, including sexual violence.<sup>3</sup>

Because migration increases one's personal stress, migrant workers may more easily engage in unsafe sexual behaviours to cope. Female migrants are particularly vulnerable because many are employed in relatively unskilled work – i.e. manufacturing, domestic help, entertainment, etc. – which limits access to services like health and legal aid. Some women may be pressured to exchange sexual favours to maintain a job and/or increase pay.

A survey conducted by International Organisation for Migration in Africa found migrants had lower levels of knowledge about HIV/AIDS than non-migrants. The study also revealed an extremely low level of condom use in sexual relationships among migrants and found migrant populations to be more difficult to reach for follow-up medical appointments.<sup>4</sup> Similar studies in India in select states (Rajasthan, Gujarat, Madhya Pradesh, Jharkhand) has revealed that migrants are at risk due to a combination of low awareness levels, access to commercial sex, sexual exploitation, low condom use and poor health seeking behaviour (Study conducted by Catalyst Management Services in conjunction with Gramin Vikas Trust, Care India)

<sup>1</sup> HIV and International Labour Migration: Policy Brief. ILO, IOM, UNAIDS. [document on the Internet]. UNAIDS, June 2008. [cited 2008 Nov. 17]. Available from [http://data.unaids.org/pub/Manual/2008\\_20080716\\_jc1513\\_policy\\_brief\\_labour\\_migration\\_en.pdf](http://data.unaids.org/pub/Manual/2008_20080716_jc1513_policy_brief_labour_migration_en.pdf)

<sup>2</sup> Migrants and mobile workers. [document on the Internet]. UNAIDS. [cited 2008 Nov. 17] Available from <http://www.unaids.org/en/PolicyAndPractice/KeyPopulations/MigrantsMobileWorkers/default.asp>

<sup>3</sup> HIV and International Labour Migration: Policy Brief. ILO, IOM, UNAIDS.

<sup>4</sup> HIV/AIDS, Women and Migration in Southern Africa. UN-INSTRAW. [document on the Internet]. ReliefWeb, 2008 July 31. [cited 2008 Nov. 17]. Available from <http://www.reliefweb.int/rw/RWB.NSF/db900SID/EGUA-7H3SMJ?OpenDocument>


### **Actions for improving awareness levels and HIV related services to migrants**

#### **Action 1: Planning Intervention:**

1. Focused Response: Level of vulnerability to HIV is high among migrant groups like those involved in daily labour, reconstruction workers (construction-related work), migrant sex workers etc. While planning programmes for these groups,



the 'targeted intervention' (TI) model of response can be planned. (see pg...35...):  
[http://www.nacoonline.org/Quick\\_Links/Publication/NGO\\_\\_Targeted\\_Interventions/](http://www.nacoonline.org/Quick_Links/Publication/NGO__Targeted_Interventions/)

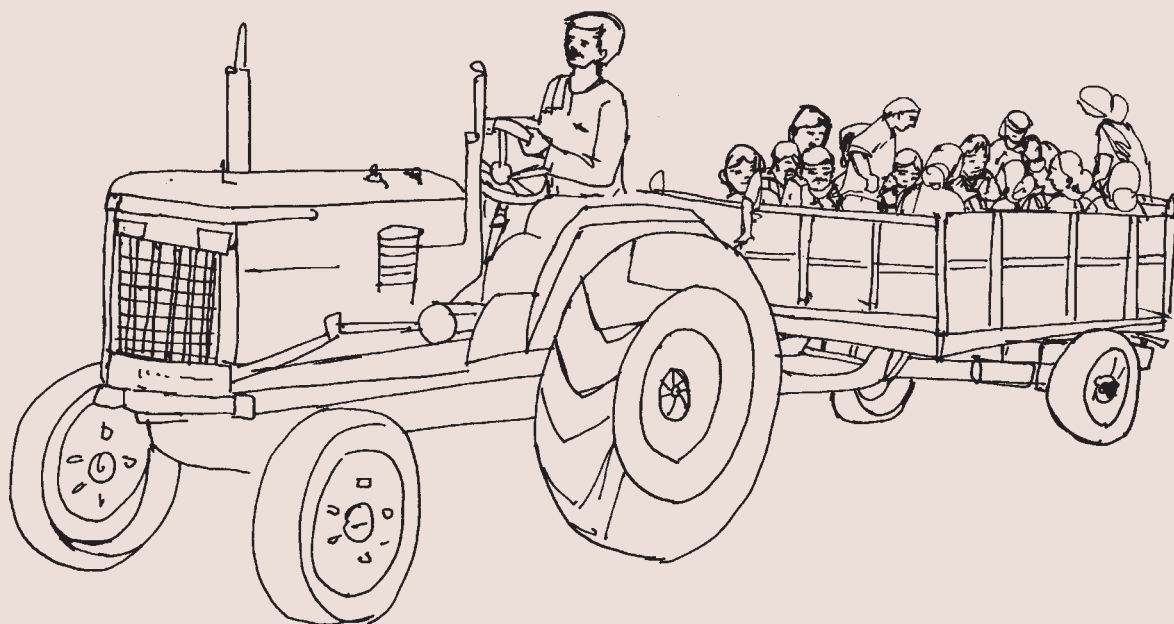
 Focus on Adolescent Children: Children in the context of migration are highly vulnerable to sexual exploitation along with other kinds of exploitation. Therefore a child-focused programme to contain this increased vulnerability to HIV should be initiated.

References on prevention strategies on child trafficking:

1. Reference guide on protecting the rights of child victims of trafficking in Europe: [http://www.unicef.org/ceecis/UNICEF\\_Child\\_Trafficking34-43.pdf](http://www.unicef.org/ceecis/UNICEF_Child_Trafficking34-43.pdf)
2. Some examples from India: [http://www.unicef-irc.org/research/resource\\_pages/worldcongress3/expertconsultation/kamath\\_ppt.pdf](http://www.unicef-irc.org/research/resource_pages/worldcongress3/expertconsultation/kamath_ppt.pdf)
3. A handbook on planning projects to prevent child trafficking: [http://www.terredeshommes.org/pdf/publication/handbook\\_june8.pdf](http://www.terredeshommes.org/pdf/publication/handbook_june8.pdf)
4. South Asia in Action: Preventing and Responding to Child Trafficking: <http://www.unicef.or.jp/osirase/back2008/pdf/South%20Asia%20in%20Action.pdf>

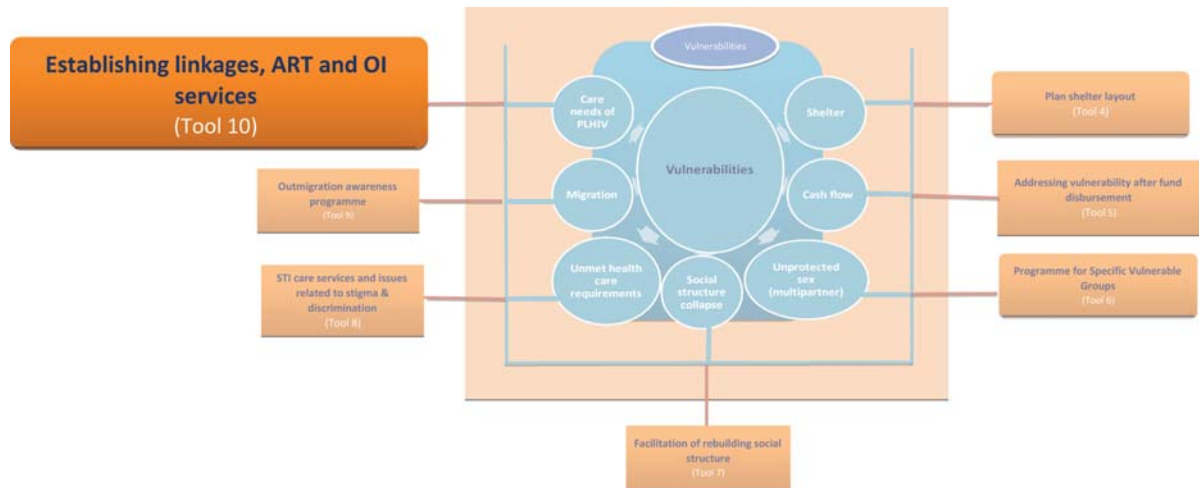
## **Action 2: Reaching out to the migrant destination**

Once the main migrant destinations following a disaster are established, district administrations should get in touch with the district administration of the destination place and provide information on migration and the need to plan different services including HIV-related services.



## Tool

10



## Enabling care services for persons living with HIV

### What the tool is about?

This tool provides inputs on facilitating access to care and support of Persons Living with HIV (PLHIV), especially continuing access to services like Anti Retroviral Therapy (ART)<sup>47</sup>, management of Opportunistic Infection<sup>48</sup>, Nutritional support etc. after a disaster, while planning the relief and rehabilitation programme.

### Who can use this tool:

- Government health authorities — so as to incorporate PLHIV related services in the overall health service plan.
- AIDS control authorities locally at the district/ state level.
- NGOs working on PLHIV related issues.

<sup>47</sup> Antiretroviral therapy (ART) is a treatment regimen for people with HIV which has been proven to reduce morbidity and mortality among PLHIVs, through taking a combination of drugs.

<sup>48</sup> Opportunistic infection (OI) is a disease caused by a microbial agent in the presence of a compromised host immune system. In relation to HIV and AIDS, an OI is another disease, illness or infection that adds to the complications of HIV and AIDS



## Box 10: Vulnerabilities of PLHIVs in a disaster


In a humanitarian disaster PLHIVs could be among the most vulnerable:

1. Discontinuation of ART – PLHIVs previously on ART are in danger of having to discontinue treatment as ART related facilities including drugs may not be available.
2. Non-initiation – PLHIVs who are not on ART would have to delay medication due to lack of facilities including trained medical & paramedical personnel; drugs; CD4 testing<sup>49</sup> etc.
3. Increased incidence of Opportunistic Infections – Emergency situations are usually challenging when it comes to water, food and environmental hygiene. Also, food scarcity/shortage, both in terms of caloric needs as well as macro and micronutrients, can occur for varying periods of time. Poor hygiene coupled with malnutrition can have adverse impacts on the health of PLHIVs making them more vulnerable to OIs.
4. OI treatment – Lack of, or limited access to, OI treatment and institutional care leads to increased morbidity and mortality among PLHIVs.
5. Early detection - HIV Test kits/testing facility not being available could affect early detection among those infected but unaware of their status.
6. Prevention of new infections - Non-availability of PPTCT drugs and services could lead to new infections among children.


### Step 1: Antiretroviral Therapy (ART)

The number of PLHIVs in the displaced/affected communities, including those on ART, need to be estimated. (refer tool 3 pg. 42 – Detailed Assessment)

Referral centres for critical treatment needs, like ART, are to be immediately established through linkages with nearby existing ART centres.


 For treatment protocols refer to 'Clinical Guidelines for antiretroviral therapy management for displaced populations - Southern Africa'; [www.aidsandemergencies.org/cms/documents/UNHCR\\_HIV\\_SAClinic\\_Eng\\_D.pdf](http://www.aidsandemergencies.org/cms/documents/UNHCR_HIV_SAClinic_Eng_D.pdf)

### Step 2: Management of Opportunistic Infections (OIs)<sup>50</sup>

 Most of the common OIs are treatable in resource-limited clinical settings and personnel in emergencies need to be oriented to management of common OIs.

Reference to Clinical management of OIs can be found at [www.cdc.gov/mmwr/preview/mmwrhtml/rr5315a1.htm](http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5315a1.htm)

### Step 3: Nutrition

 PLHIV are able to live healthier lives if adequate and appropriate medication is combined with proper nutrition. It is important that they can assess their daily nutritional requirements and management of malnutrition is planned to address nutritional requirements.

<sup>49</sup> The CD4 count tells the doctor how strong the immune system is and how far HIV disease has advanced (the stage of the disease), and helps predict the risk of complications and debilitating infections. CD 4 count test is compulsory before starting the ART treatment

<sup>50</sup> Opportunistic infection (OI) is a disease caused by a microbial agent in the presence of a compromised host immune system. In relation to HIV and AIDS, an OI is another disease, illness or infection that adds to the complications of HIV and AIDS

Refer to Annexure 6 (p.87) for details on Nutrition and HIV.

The objective of initiatives should be to integrate health needs of the PLHIV into health service delivery systems established /adopted during emergencies. Separate health facilities for PLHIV is not advisable.



### Key care and support programmes and strategies for PLHIV (Examples from India)

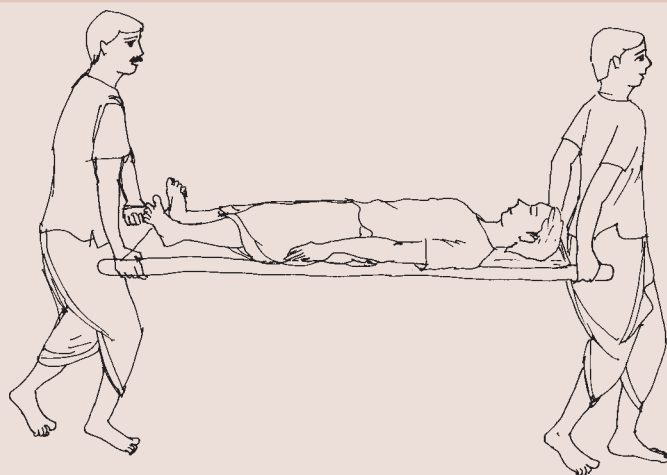
Programmes	Brief Description/Links	Where to Access Support
Integrated Counselling and Testing Centre (ICTC)	An integrated counselling and testing centre is a place where a person is counselled and tested for HIV, of his own free will or as advised by a medical provider. The main functions of an ICTC include: Early detection of HIV, basic information on HIV and promoting risk reduction through behaviour change especially among those infected. Referral linkages with other care and treatment services for HIV.	ICTCs have been established in several districts in the country and more details are available from the District Hospitals.
Anti Retroviral Therapy (ART) centres	Antiretroviral therapy (ART) is a treatment regimen for people with HIV which has been proven to reduce morbidity and mortality among PLHIV, through a combination of drugs. Although ART has many side effects and does not provide a cure for HIV or AIDS, the treatment is safe and prolongs the life of HIV infected persons. <sup>51</sup> National AIDS Control Organization (NACO) implements the ART programme in India (More details on ART programmes in the Annexure)	ART centres have been established in several of the high prevalent districts in the country. For details on the list of centres in India visit the following link: <a href="http://www.nacoonline.org/Living_with_HIVAIDS/Download_ART/">http://www.nacoonline.org/Living_with_HIVAIDS/Download_ART/</a>
Prevention of Parent to Child Transmission (PPTCT)	Parent-to-child transmission is when an HIV positive woman passes the virus to her baby — which can occur during pregnancy, labour or delivery. Prevention of parent-to-child transmission (PPTCT) is the prevention of such transmission. <sup>52</sup>	NACO implements PPTCT programmes in India through the SACS. PPTCT centres are established across the country especially in the high prevalent districts.

<sup>51</sup> Antiretroviral Medication Policy for Refugees. [document on the Internet] The UN Refugee Agency, January 2007. [cited 2008 Nov. 13]. Available from [http://data.unaids.org/pub/Report/2007/20070326\\_unhcr\\_art\\_en.pdf](http://data.unaids.org/pub/Report/2007/20070326_unhcr_art_en.pdf).

<sup>52</sup> Preventing Mother to Child Transmission. [document on the Internet.] Avert, 2008. [cited 2008 Nov. 19]. Available from <http://www.avert.org/motherchild.htm>



Programmes	Brief Description/Links	Where to Access Support
Community Care Centre (CCC)	CCCs are short stay homes for PLHIV for treatment of opportunistic infections, psycho social support through counselling, management of stigma, referral linkages with key programmes like ART.	NACO is setting up CCCs across the country in all high prevalent districts (A&B districts) Details on CCCs are available with State AIDS Control Societies.
HIV-TB Co-infection	Tuberculosis (TB) is a disease which predominantly attacks the lungs and is a common opportunistic infection and cause of death for a person living with HIV. In developing countries, PLHIV frequently receive the diagnosis of HIV after diagnosis for TB. Key treatment for TB through the Directly Observed Therapy (DOT) is available through the Revised National TB Control Programme (RNTCP)	Efforts are being made by NACO and TB Division for better coordination so that the treatment can be quickly made available to HIV patients as TB is the number one killer disease of PLHIV. For more details visit the link: <a href="http://www.nacoonline.org/Quick_Links/FAQs/#HIV-TB%20Co-infection">http://www.nacoonline.org/Quick_Links/FAQs/#HIV-TB%20Co-infection</a>
PLHIV – Human Rights	India's National AIDS Control Organisation (NACO) states, "There can be no valid or effective response to HIV and AIDS without respect for the human rights, fundamental freedom and the dignity of human beings." NACO lists the right to informed consent, confidentiality and the right against discrimination as the three most important rights for PLHIV. <sup>53</sup> Although India's National AIDS Prevention and Control Policy directs much HIV and AIDS action, the policy does not have the status of law and is not binding or enforceable in court	Although India's National AIDS Prevention and Control Policy directs much HIV and AIDS action, the policy does not have the status of law and is not binding or enforceable in court For more details visit the following link: <a href="http://www.nacoonline.org/Quick_Links/Know_Your_Rights/">http://www.nacoonline.org/Quick_Links/Know_Your_Rights/</a>



<sup>53</sup> Know Your Rights. HIV Monitoring: Treatment for AIDS. [document on the Internet]. National AIDS Control Organisation, 2007. [cited 2008 Nov. 17] Available from [http://www.nacoonline.org/Quick\\_Links/Know\\_Your\\_Rights/](http://www.nacoonline.org/Quick_Links/Know_Your_Rights/)



# Cross-cutting areas

## Sustainability post-disaster

Sustainability is the ability or capacity of the community/ group/ individuals to continue to derive benefits of programs independently and effectively, as a tool of development of its members and the village, even after withdrawal of the external support.

Disaster response programmes normally run on a project mode and the funding would dry up after a period of time. It is therefore important to see how sustainability can be ensured. The following table discusses how these services can be sustained.

Scenarios	Strategies for sustainability
<b>HIV response in disaster prone areas</b>	While establishing prevention and care services – STI, condom, IEC, targeted intervention programme, Anti Retroviral Treatment services, Integrated Counselling and Testing Centre, Prevention of Parent to Child Transmission – linked up with existing public health programmes. If new programmes are to be initiated focus on building capacity of the local health care provider to provide these services and ensure continuity through linkages with existing public health programmes.
<b>Planning awareness campaigns among the general population, particularly the youth</b>	Work with the community, local NGOs, government programmes focused on youth groups, existing grass root level programme staff (Eg. literacy mission in India) and other local volunteer network. This will ensure these trained resources are available beyond the project period. Awareness programme for students in the school can be implemented through the existing life skill education programme implemented by the education department (as is the case in India).
<b>Planning programmes for key population groups and groups with high-risk behaviour</b>	The targeted intervention programme model that provides prevention services to the key population groups is currently moving towards community mobilisation and community participation approach. The focus of these programmes is to build capacity of the community members so that the service initiated can be made available beyond the project period. While designing the programme for the key population groups in the context of disaster, similar models should be initiated which will ensure sustainability of access to key services.
<b>Strengthening STI/HIV treatment and care services in the existing health system during disasters</b>	The guide discusses strategies and approaches of linking and strengthening the existing services available within the public health system or the National Programme on HIV. This, if implemented, should ensure the availability of the service beyond the project period.



## Scenarios

## Strategies for sustainability

### Establishing care and support services

Key services required by the PLHIV like ART services, linkages with hospice, treatment facility for opportunistic infection etc to be made available by accessing the existing facility in the public health system and national programme on HIV. This will ensure availability of these services beyond the project period.

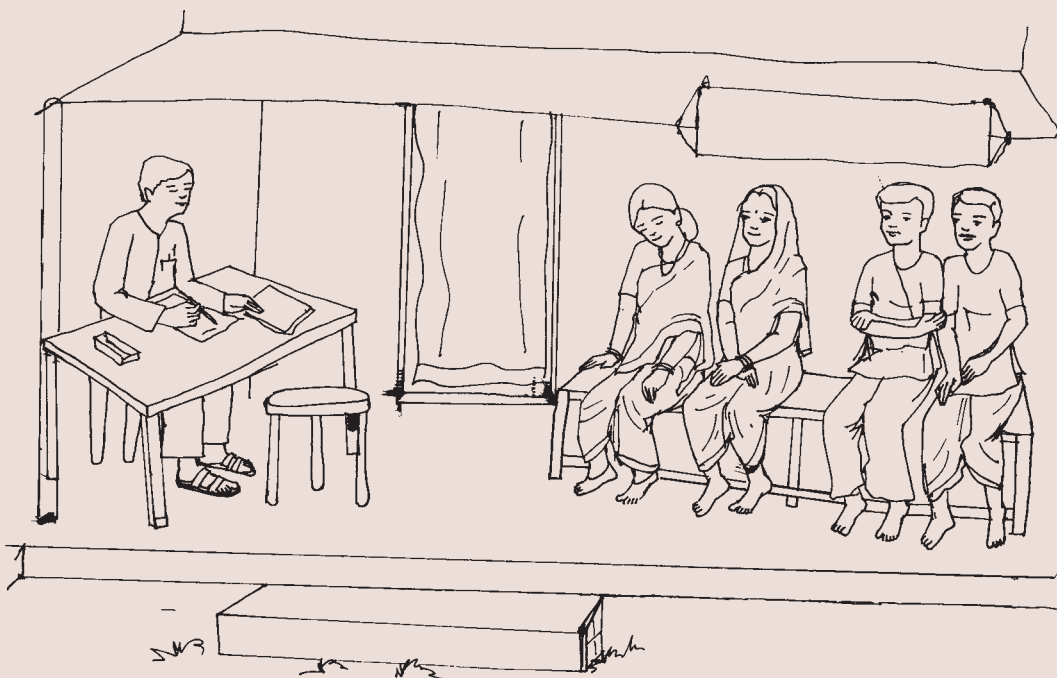
## Monitoring and evaluation

System for monitoring the programmes should not be something external to the disaster response programmes. All the HIV related services could be either monitored as part of the disaster response programme monitoring system or linked to monitoring systems of the national programme on HIV. Progress and status of various programmes can be made known to all the different stakeholders through a sharing platform that should be established at the district level in which key programme officers involved in the disaster response programme as well as other linked programmes should participate.

While finalizing the monitoring indicators for the disaster programme, HIV relevant indicators can be picked up to be part of the overall monitoring system. Following is a list of HIV related indicators (see indicators on next page).

### Key indicators for monitoring sexual health related programmes in the context of disaster response

The success of implementing initiatives of sexual health related programming in the context of disaster response can be evaluated using the following indicators. They include resource, service, knowledge and behavioural indicators at the level of inputs, outputs and outcome.



## Box 11: Key elements of monitoring

**Inputs:** Resources invested into a programme – Eg. Human resources, machines, money, methods

**Outputs:** Immediate result of activities achieved. Outputs are deliverables within a project. The project holder is responsible for delivering the outputs. – Eg. Number of workshops conducted, number of IEC materials distributed, Number of medical camps conducted, number of shelters erected etc

**Outcome:** Changes observed among the target community as a result of delivering the outputs and providing key services and information through the project. Eg. Changes in behaviour or skills – increased knowledge in the community on HIV, increased use of condom, decreased cases of violence and trafficking etc.

**Impact:** Long term changes that occur at the community level as a result of a programme. Eg. As a result of conducting the prevention programme in a district, the HIV prevalence in the district comes down.

### Indicators for monitoring sexual health related programmes in disaster response

	Indicator	Means of Verification
<b>Inputs</b>	Health-related products purchased and available (condoms, ART/PEP supplies, needles/syringes)	Expenditure reports for disaster relief
	Nutritional Food purchased	Expenditure reports for disaster relief
	People/organisations involved in relief process	Disaster relief rosters
	Clinics established (Counselling/ Testing, STI/HIV/AIDS screening)	Disaster relief records
<b>Outputs</b>	Rapid assessment completed and report available	Report
	Detailed assessment completed and report available	Report
	Number of blood units screened for HIV in a quality-assured manner	National Blood Transfusion Service or National Blood Programme Manager in the Ministry of Health
	Number receiving HIV Counselling and Testing	Patient records, behavioural surveillance or HIV surveillance system
	Number of needle prick incidents and number of instances PEP given	HIV surveillance system & hospital records
	Number of adults and children with advanced HIV infection receiving ART treatment	ART registers & HIV surveillance system
	Pregnant mothers receiving Nevirapine for PPTCT measures	Programme monitoring records & HIV surveillance system
	Babies receiving Nevirapine for PPTCT measures	Programme monitoring records & HIV surveillance system
	Number receiving STI treatment	HIV surveillance system
	Number receiving both HIV and TB treatment	Patient records (ART or TB) & TB estimates



**Indicator**

Number of HRGs receiving condoms  
 Number of general population knowing safe practices for sexual health  
 Number of injecting drug users reporting the use of sterile injecting equipment  
 Number of people trained through outreach programmes  
 Number condoms distributed  
 Number needles/syringes distributed  
 Number printed materials distributed  
 Number of Interventions set up for migrant workers  
 Money spent  
 Evaluation of indicators conducted

**Means of Verification**

Behavioural surveillance  
 Behavioural surveillance  
  
 Behavioural surveillance  
  
 Training records  
  
 Expenditure reports for disaster relief  
 Expenditure reports for disaster relief  
 Expenditure reports for disaster relief  
  
 Expenditure reports for disaster relief  
 Expenditure reports for disaster relief  
 Post-evaluation results

**Out-comes**

Mortality due to HIV/AIDS decreasing  
 Incidence of HIV/AIDS in the general population decreasing  
 Incidence of HIV/AIDS among key population groups (i.e. WSWs, IDUs, MSMs, mobile populations)  
 Reducing incidence of other STI  
 Reducing incidence of babies born with HIV  
 Reducing prevalence of children under 5 years old with HIV/AIDS  
 Incidence of GBV reducing  
 Reduction in incidence of stigma and discrimination against PLHIV

HIV surveillance system  
 HIV surveillance system  
  
 HIV surveillance system  
  
 Behavioural surveillance system  
 HIV surveillance system  
  
 HIV surveillance system  
 Police records  
 Stigma Index

### Links:

- NACO Core Indicators for Monitoring and Evaluation  
<http://www.nacoonline.org/upload/Publication/M&E%20Surveillance,%20Research/Core%20Indicators%20for%20Monitoring%20&%20Evaluation.pdf>
- Revised UNGASS Indicators for 2008 Reporting.







# JAMES HOSPITAL COLACHEL TSUNAMI MEMORIAL

TABLET WAS LAID BY  
SUNIL PALIWAL I.A.S.,  
JUDGE OF KANYAKUMARI DISTRICT  
IN THE PRESENCE OF  
RAKASHI GOVINDASAMY I.A.S.,  
JUDGE COLLECTOR OF KANYAKUMARI DISTRICT  
AND  
RAJASEKARAN I.P.S.,  
JUDGE, KANYAKUMARI DISTRICT

THE NUMEROUS LIVES  
SAVED DURING TSUNAMI  
IN REMEMBRANCE OF  
THE DOCTORS AND NURSES  
WHO WERE KILLED BY  
THE TSUNAMI KILLER WAVE  
ON 26 DECEMBER 2005



WHEN TSUNAMI KILLER WAVES DEVED  
AND THE SURROUNDING COAST  
ON THAT BLACK SUNDAY OF 26<sup>TH</sup>  
THE SELFLESS BRAVE, AND TIMELY  
OF  
THE DOCTORS, NURSES AND NURSES  
JAMES HOSPITAL,  
SAVED COUNTLESS DYING VICTIMS  
THAT DECEMBER 26, 2005. THE  
TSUNAMI  
JAMES HOSPITAL WAS THE ONLY  
AFFECTED HOSPITAL IN THE DISTRICT



# Part III

## Annexures



## **Brief notes and references on programmes, available guidelines and resources:**

### **Annexure 1**

### **Summary of the Study Findings**

#### **Understanding the vulnerability of coastal communities to HIV and AIDS in Tsunami hit areas of India (Swasti with the support of Oxfam, America)**

The Tsunami disaster of 2004 led to massive damage to lives, shelter and livelihoods, particularly in the East Coast of India. Oxfam has been working with its partners in the humanitarian response to the tsunami in India. Given the understanding of the relationship between the humanitarian crises and HIV and AIDS, and the gaps in field level information on these issues, Oxfam commissioned Swasti Health Resource Centre<sup>1</sup>, to undertake a study to understand the vulnerability of coastal communities to HIV and AIDS and the effects of the tsunami on the vulnerability. The study is meant to contribute to OXFAM's programme for mainstreaming HIV and AIDS.

The study worked with the hypothesis that the humanitarian crisis as a result of the tsunami, and the subsequent relief and rehabilitation measures, influenced the behaviour and practices of the affected populations, increasing their vulnerability<sup>2</sup> to acquiring HIV and AIDS. The hypothesis was tested in 30 locations across five Tsunami affected states of India, representing different profiles (in terms of level of damages; type of locations such as intermediate shelters, permanent shelters; and geographically – state-wise) and sub-populations (gender, marital status, occupation). This extensive field study was conducted over a period of six months, using the principles of action research. The study used a mix of qualitative and quantitative techniques. Apart from the large field survey, the study also used extensive literature review and secondary stakeholder consultations in each state to understand and assess vulnerability. This is the final report of the study.

#### **Key Findings**

The results of the study revealed high levels of vulnerability of coastal communities of the study locations to contracting HIV and AIDS. Except for one location out of 30 covered in the study, (location – Chauldari, Andaman), communities were found to be vulnerable to HIV and AIDS in all other locations. Of the four main modes of transmission of HIV, the sexual route was found to be the major mode heightening vulnerability to HIV and AIDS. High prevalence of unprotected non-regular partner sex, combined with untreated STI, was the main risk factor. More than a third of all respondents<sup>3</sup> across all study locations said they had sex with non-regular partners. On STI, about 21 percent reported having symptoms of STI during the time of study and 15 percent reported recurrence of the symptoms in the last three years. Condom use in sex with partners outside marriage or with non-regular partners was reported only in about 10 percent of the cases. The awareness on condoms was high; but more as a family planning mechanism rather than one preventing spread of infection.

On other routes of transmission of STI and HIV, communities and a few key informants reported that there could be potential vulnerability due to exposure to blood without precautionary measures during rescue and recovery operations post-Tsunami and through cases of HIV-infected mothers giving birth (reported in two of the locations studied). HIV

transmission through sharing of infected needles was not reported in any of the locations.

About 17 percent (range 2%<sup>4</sup> to 46%<sup>5</sup>) of the population was found to be vulnerable to HIV and AIDS, of which about a third were found to be 'directly'<sup>6</sup> vulnerable. The vulnerability to HIV and AIDS was found to be heightened after the tsunami disaster in two-thirds of research locations (20 out of 30). A number of factors that existed pre-tsunami, in combination with emergent factors post-tsunami, increased vulnerability manifold in these locations. Of the factors that emerged post-tsunami, the physical proximity (created through intermediate shelters and proximity between habitations and intermediate shelters) of displaced populations (social groups, localities, gender, marital status) was found to be the primary factor that contributed to a chain of events that led to increased vulnerability to HIV and AIDS. Other factors included breakdown of social institutions and controls and access to abandoned, empty spaces and structures; behavioural factors such as alcohol consumption leading to family disruptions and affecting condom use; poor health seeking behaviour for STI treatment and; lack of knowledge and misconceptions related to STI and HIV.

Of various sub-groups within the community, married men and women were found to be the groups with the highest vulnerability (97%). Unmarried women were the least vulnerable among all the groups, with over 50 percent of the group found to be vulnerable — which is significant. Stricter social controls, marriage at an early age, relationship with men that led to marriage were causes for lower vulnerability.

Among these groups, the highest increase in vulnerability, due to the tsunami, was found in unmarried women. The new vulnerabilities, post-tsunami, were on account of girls being alone at home in intermediary shelters while their parents went out to work, the presence of hideout areas and greater mobility. The next highest increase in vulnerability was among married women. Physical proximity and intermediate separation from spouse was the trigger to vulnerability. Most unmarried men reported stricter social controls over sexual relationships with unmarried women and, no fear of pregnancy in a sexual relationship with married women as the main reasons for married women being the preferred sexual partner. Increased access to commercial sex, increased cash flow received as compensation combined with leisure time increased vulnerability of unmarried men.

In terms of profile of locations, the vulnerability seems to have increased in locations where there has been a high level of displacement<sup>7</sup>, combined with physical proximity of communities<sup>8</sup> (in 11 of the locations). Even in locations with less damage (such as at Kesavanpalayam and Pushpavanam in Tamil Nadu) but with proximity to intermediate shelters, vulnerability was found to be heightened (in 9 of the locations). A number of case studies were generated during the course of the study to provide deeper understanding of these risk and influencing factors.

Strong traditional panchayat<sup>9</sup> and their social control systems seem to have contributed to lesser vulnerability in a few locations, particularly for unmarried females. Disincentives (such as fines, social isolation, forced marriages, etc. for sex outside marriage and sexual abuses were observed.

The results of the study show that there have been very limited and ad-hoc responses to either understand or reduce HIV vulnerability in post-disaster situations. Interviews with secondary stakeholders (NGOs and the government) in all the states revealed that efforts were mainly limited to awareness campaigns and distribution of condoms in a few places, mainly through a campaign mode. Except for a few places where Integrated Counselling and Testing Centres (ICTCs) were involved, NGOs working on relief and rehabilitation were the main implementers of these programmes. In most locations, Village Health Nurses



(VHNs) were reported to be the main service provider for information and treatment related to STI.

To conclude, the results of the study clearly point out the existence of vulnerability in most coastal communities in the study area, irrespective of geographical or other segmentation even before the tsunami. The study proves that there is a high likelihood of vulnerability to HIV and AIDS in the post-disaster situation, given the environmental, social and cultural context. There has been a limited or complete absence of a response related to addressing HIV and AIDS vulnerability in the post-tsunami scenario.

### **Implications for future**

Although this study has been conducted in coastal communities and with specific reference to the tsunami and its consequences, the findings of the study provide lessons for any humanitarian response effort since the key factors which heighten vulnerability are to a large extent common across most humanitarian emergency situations – people affected living in intermediate shelters, cultural norms and control being temporarily suspended or watered down, and grief and coping. This study therefore has implications for both HIV and AIDS and humanitarian aid sectors. Few pointers are provided here:

1. For humanitarian aid agencies: There is a need to incorporate behavioural elements, particularly sexual health behaviour in humanitarian aid efforts. Psycho-social programmes need to address sexual health behaviour in a culturally appropriate way. As far as is practical, the designs of intermediate shelters and allocation of shelters need to incorporate issues related to privacy and restoring the original social order (which was in the original location). Cash relief needs to be carefully planned so that large infusion of cash does not increase high risk behaviour. The time gap between the relief and rehabilitation phases is crucial and one in which sexual health products and services, along with knowledge, should be a priority. Health service provisions in humanitarian aid efforts should incorporate sexual health services, including gender and friendly services, within the ambit of medical services.
2. For HIV and AIDS prevention and care: There is a need to include coastal communities under HIV and AIDS programmes, given their low awareness, existence of non-regular partner sex and low condom use. There is also a need for focused prevention efforts to reach the general population of these communities, so that the underlying vulnerability is addressed. Condom availability and accessibility in the area needs to be ensured through strategies that make condoms visible and available on demand. Local sensitivities need to be kept in mind while designing HIV and AIDS prevention strategies in the context of humanitarian emergencies. It is extremely important to build capacities of institutions working on relief and rehab on sexual health issues and HIV and AIDS to effectively implement such programmes.

It is suggested that the findings of the study, issues raised and the implications be widely shared with both HIV and AIDS and the humanitarian aid sector, both at policy and programme levels, so that the learnings are incorporated into future interventions. Developing guidelines and tool kits and focussed capacity building of NGOs and other key stakeholders to mainstream HIV and AIDS issues would be necessary to address vulnerability in an effective manner. The learning from these efforts would not only help in improving current programmes but also feed into effective programmes for disaster preparedness and future humanitarian responses.

## Annexure 2

# Key government programmes for HIV prevention and care in the South Asian countries

### India

Despite many programmes and initiatives directed toward the prevention of HIV, India has the second largest population of HIV-affected individuals in the world, with 2.5 million living with HIV and a prevalence rate of 0.36 percent. Increases in HIV have transitioned from urban to rural in recent years, with youth especially at risk. Injection drug users (IUDs) are the major cause of spread of HIV in India's north eastern states.<sup>54</sup>

The National AIDS Control Organisation-III aims to reverse the HIV and AIDS epidemic over the next five years through coverage of high-risk groups with targeted intentions (TIs), scaled up interventions, prevention, care and support, and treatment efforts at the district, state and national levels.<sup>55</sup> Strategic efforts plan to reduce new infections by 60 percent in high prevalence states and by 40 percent in vulnerable states.<sup>56</sup>

For details on the India programme log on to: [www.nacoonline.org](http://www.nacoonline.org)

### Bangladesh

The National AIDS Committee (NAC), National AIDS/STD Programme (NASP), and development partners are conjointly working to combat the threat of HIV/AIDS. The Bangladesh National Strategic Plan for HIV/AIDS 2004-2010 acknowledges the need for continued and increased efforts to "ensure desired human and socio-economic development."<sup>57</sup>

Bangladesh has committed to the UNGASS Declaration and Millennium Development Goals, prioritising five programme objectives:

- Provide support and services for priority groups;
- Prevent vulnerability to HIV infection in Bangladesh society;
- Promote safe practices in the health care system;
- Provide care and support services for people living with HIV/AIDS;
- Minimise the impact of the HIV/AIDS epidemic.

Strategies for the objectives have been developed and are being implemented; however, more effort needs to be directed toward fulfilling the objectives.<sup>58</sup>

### Bhutan

UNAIDS estimates around 500 PLHIV in Bhutan at the end of 2005. Due to increased border migration and behaviour risk factors, an increase in the percentage of PLHIV are expected in upcoming years.<sup>59</sup>

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<sup>54</sup> NACP-III. National AIDS Control Organisation. [document on the Internet]. Ministry of Health and Family Welfare Government of India, 2007. [cited 2008 Nov. 13] Available from [http://www.nacoonline.org/National\\_AIDS\\_Control\\_Program/](http://www.nacoonline.org/National_AIDS_Control_Program/)

<sup>55</sup> Ibid.

<sup>56</sup> Ibid.

<sup>57</sup> National Strategic Plan for HIV/AIDS 2004-2010. Bangladesh. National AIDS/STD Programme (NASP) Directorate General of Health Services Ministry of Health & Family Welfare.

<sup>58</sup> Ibid.

<sup>59</sup> HIV/AIDS in Bhutan. The World Bank. [document on the Internet]. August 2006. [cited 2008 Nov. 13] Available from <http://siteresources.worldbank.org/INTSAREGTOPHIVAIDS/Resources/HIV-AIDS-brief-August06-BTA.pdf>



Commercial sex work is on the rise along with growing numbers of migrant labourers, truckers and transport workers. These at-risk populations and other factors increase the vulnerability of people in Bhutan, including:

- More than 35 percent of the population living below the poverty line;
- Risk of substance abuse;
- Trafficking of women and girls into prostitution;
- Male resistance to condom use, stigma of sex, and less rigid sexual norms;
- Misconceptions among youth about sex – with 63 percent of population under age 25.<sup>60</sup>

The Government of Bhutan National HIV/AIDS and STI Control Programme's (NAP) HIV efforts requires scaling up, including increasing preventative services, targeting youth, addressing stigma, and gathering more accurate data on HIV prevalence in the nation.<sup>61</sup>

### **Maldives**

Maldives began addressing HIV and AIDS four years before any cases were reported, minimising the country's HIV threat. The National AIDS Council's main activities include prevention efforts, blood-product screening, and care of the Country's approximately 200 PLHIV. Condoms are widely accessible and the government requires a mandatory HIV screening of citizens when they return from international travel of more than a year.<sup>62</sup>

Risk factors of HIV include:

- Mobility of the population and tourism;
- High divorce rates;
- Drug use among youth;
- Dispersed population, spread over 200 islands.<sup>63</sup>

### **Nepal**

Despite conflict persisting during Nepal's five-year USD 95 million National Operational Plan, the country has had many successes in development of HIV programmes. The five initial goals included:

- Prevention of STI and HIV among the vulnerable groups;
- Prevention of new infections among young people;
- Ensuring availability and accessibility of care and support services for all people infected and affected by HIV/AIDS;
- Expansion of monitoring and evaluation frame through evidence based effective surveillance and research; and
- Establishment of an effective and efficient management and implementation mechanism for an expanded response.

Nepal also committed to the Millennium Development Goals, UNGASS, Universal Access and "three ones" principle.<sup>64</sup>

Prevention programmes have reached a significant portion of WSWs, IDUs, MSMs and migrant populations; however, service delivery remains inadequate with only a small percentage receiving HIV testing and counselling. Care and support services were either established or expanded to reach wider populations – including VCT centres, ART sites,

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<sup>60</sup> Ibid, p. 2

<sup>61</sup> Ibid, p. 3

<sup>62</sup> Maldives. HIV/AIDS South Asia. [document on the Internet]. The World Bank, 2008. [updated 2006 April; cited 2008 Nov. 13] Available from <http://web.worldbank.org/WBSITE/EXTERNAL/COUNTRIES/SOUTHASIAEXT/EXTSAREGTOPHEANUT/EXTSAREGTOPHIVAIDS/0,,contentMDK:20288503~menuPK:568875~pagePK:34004173~piPK:34003707~theSitePK:496967,00.html>

<sup>63</sup> Ibid.

<sup>64</sup> National HIV and AIDS Strategy 2006-2011. Nepal. Draft. p. 7-8



and PPTCT centres. However, various challenges were faced in full implementation of the plan.<sup>65</sup>

## **Pakistan**

UNAIDS reports about 96,000 PLHIV at the end of 2007 in a total population of around 150 million. Underreporting is prevalent however, due to social stigma, limited voluntary counselling and testing services, and lack of knowledge of HIV among the population overall.<sup>66</sup>

IDU PLHIV are growing in major cities due to high-risk behaviour and limited knowledge of the spread of HIV. Other risk factors that contribute to the risk of HIV in Pakistan:

- Unsafe practices of female and male sex workers and transgender populations;
- Increase in migrants and refugees;
- Inadequate blood screening and high proportion of professional donors;
- Unsafe medical practices;
- Low levels of education.<sup>67</sup>

The Government National AIDS Prevention and Control Programme (NACP) focused on diagnosis at the onset of efforts, but currently focus programming at the community level. Main efforts include prevention, safe blood transfusions, surveillance, training of health staff, research studies and programme management. However, more needs to be done with outreach to high-risk groups, access to treatment and care, monitoring and evaluation, advocacy and work with policy makers. The government recently finalised action plans for the next phase of programming covering the period from 2009-2013.<sup>68</sup>

## **Sri Lanka**

With a HIV prevalence of less than 0.1 percent, Sri Lanka witnesses most of its HIV with most at-risk populations (MARPs). Underreporting is common due to several factors especially because of stigma and discrimination.<sup>69</sup>

Vulnerabilities to HIV in Sri Lanka include:

- Low condom use;
- High number of commercial sex workers;
- Mobility;
- IDUs;
- Low levels of knowledge and high levels of stigma.<sup>70</sup>

The efforts of the Government National STD and AIDS Control Programme (NSACP) to reduce HIV includes mass media strategies, care and treatment to PLHIV, surveillance systems, monitoring and evaluation efforts in the form of a Management Information System, improvement of quality of equipment/clinics, blood safety screening, and scaling up of ART services.<sup>71</sup>

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<sup>65</sup> NCASC (2005) Status of the 2005 National Response to the UNGASS Declaration of commitment on HIV/AIDS, Nepal Country Report.

<sup>66</sup> Pakistan. HIV/AIDS South Asia. [document on the Internet]. The World Bank. [updated 2008 July 29; cited 2008 Nov 13]. Available from <http://web.worldbank.org/WBSITE/EXTERNAL/COUNTRIES/SOUTHASIAEXT/EXTSAREGTOPHEANUT/EXTSAREGTOPHIVAIDS/0,,contentMDK:20287584~menuPK:568879~pagePK:34004173~piPK:34003707~theSitePK:496967,00.html>

<sup>67</sup> Ibid.

<sup>68</sup> Ibid.

<sup>69</sup> Sri Lanka. HIV/AIDS South Asia. [document on the Internet]. The World Bank. [updated 2008 July 29; cited 2008 Nov 13]. Available from <http://web.worldbank.org/WBSITE/EXTERNAL/COUNTRIES/SOUTHASIAEXT/EXTSAREGTOPHEANUT/EXTSAREGTOPHIVAIDS/0,,contentMDK:20287586~menuPK:568884~pagePK:34004173~piPK:34003707~theSitePK:496967,00.html>

<sup>70</sup> Ibid.

<sup>71</sup> Ibid.



## Annexure 3

### Post Exposure Prophylaxis (PEP)

Post-exposure prophylaxis (PEP) is a short-term anti-retroviral treatment (ART) to reduce the likelihood of HIV infection after potential exposure, either occupationally or through sexual intercourse.

The risk of HIV transmission from exposure to needle sticks, contact with blood/body fluids and by other means exist in all clinical settings and certain non-clinical settings. The availability of PEP can reduce the occurrence of HIV infection among personnel involved in providing health care to affected populations.

In emergency settings where tensions are high, accidental exposure may occur to health professionals, volunteers or patients. Emergency relief programming should provide access to PEP treatments, specifically in the settings of health centres, blood banks and ART clinics.

#### **Links to PEP guidelines from:**

- NACO India: [http://www.nacoonline.org/National\\_AIDS\\_Control\\_Program/PEP\\_full/](http://www.nacoonline.org/National_AIDS_Control_Program/PEP_full/)
- NACO PowerPoint Training: [http://www.go2itech.org/ppt/p06-db/db-51052/SP\\_12\\_PEP.ppt](http://www.go2itech.org/ppt/p06-db/db-51052/SP_12_PEP.ppt)
- WHO: [www.who.int/hiv/topics/prophylaxis/en/](http://www.who.int/hiv/topics/prophylaxis/en/)
- CDC: <http://medind.nic.in/maa/t08/i3/maat08i3p250.pdf>

## Annexure 4

### Universal Precautions

Universal precautions are a set of procedures used in medical settings to minimise the risk of transmission of blood-borne pathogens, including HIV, to and from patients and health workers. The primary principle in universal precautions is to assume that all blood products and body fluids are potentially infectious.<sup>72</sup>

Universal precautions should be implemented in all healthcare settings, especially in emergency settings when individuals are highly vulnerable. Following universal precaution guidelines strictly will help in eliminating the risk of infections contracted from the medical setting itself.

#### Universal Precaution links:

- NACO PowerPoint Training: [http://www.go2itech.org/ppt/p06-db/db-51052/SP\\_5\\_%20BiomedWaste.ppt](http://www.go2itech.org/ppt/p06-db/db-51052/SP_5_%20BiomedWaste.ppt)
- Indian Academy of Paediatrics: <http://www.iapindia.org/guidelines/hiv5.cfm>
- IASC guidelines: <http://202.54.104.236/intranet/eha/iascguidelines/action-sheet7-8.html>
- CDC & Universal Precautions for Prevention of Transmission of HIV and Other Blood borne Infections: [http://www.cdc.gov/ncidod/dhqp/bp\\_universal\\_precautions.html](http://www.cdc.gov/ncidod/dhqp/bp_universal_precautions.html)

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<sup>72</sup> Action sheet 7.8 Universal Precautions. Guidelines for HIV/AIDS interventions in emergency settings. [document on the Internet]. IASC Guidelines. [cited 2008 Nov. 13]. Available from <http://202.54.104.236/intranet/eha/iascguidelines/action-sheet7-8.html>



## Annexure 5

### Anti Retroviral Therapy (ART)

Antiretroviral therapy (ART) is a treatment regimen for people with HIV which has been proven to reduce morbidity and mortality among PLHIV, through taking a combination of drugs. Although ART has many side effects and does not provide a complete cure to HIV or AIDS, the treatment is safe and prolongs the life of HIV infected persons.<sup>73</sup>

Disaster and Emergency settings often lead to disruption of essential services and there is every chance that a PLHIV's regular access to ART medication would be affected. Since maintenance of ART medication is necessary for PLHIV to maintain health and immunity levels, emergency response efforts must include evaluation of PLHIVs' access to ART. Emergency personnel may need to make linkages for individuals to ART clinics or provide access to medicines through outside procurement.

#### Links:

- ART in India: [http://www.nacoonline.org/Quick\\_Links/FAQs/#Antiretroviral%20Therapy](http://www.nacoonline.org/Quick_Links/FAQs/#Antiretroviral%20Therapy)
- NACO training: <http://www.go2itech.org/itech?page=co-05-10>
- Scaling up ART in Resource-Limited Settings: <http://www.who.int/hiv/topics/arv/en/>
- About ART: <http://www.avert.org/treatment.htm>
- Types of ART treatments: <http://hivinsite.ucsf.edu/>

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<sup>73</sup> Antiretroviral Medication Policy for Refugees. [document on the Internet] The UN Refugee Agency, January 2007. [cited 2008 Nov. 13]. Available from [http://data.unaids.org/pub/Report/2007/20070326\\_unhcr\\_art\\_en.pdf](http://data.unaids.org/pub/Report/2007/20070326_unhcr_art_en.pdf).

## Annexure 6

### Malnutrition and HIV

People living with HIV require proper nutritional intake to maintain health as HIV weakens the immune system and changes the metabolism. Adults living with HIV have 10"30 percent higher energy requirements than an adult without HIV, and children living with HIV have 50"100 percent higher than average requirements.<sup>74</sup>

Emergency situations may limit access to food supply. Food distribution and programming must ensure outreach to and coverage of PLHIV. Food distribution to PLHIV should be combined with outreach and distribution of educational materials, so PLHIV are informed on what nutritional requirements are necessary to maintain good health.

#### Malnutrition and HIV links:

- India & Malnutrition: <http://www.gainhealth.org/system/files/FS-india.pdf>
- Management of Severe Malnutrition: <http://whqlibdoc.who.int/hq/1999/a57361.pdf>
- Guide for Nutrition Support for PLHIVs (provides nutritional charts, dietary costing tools)  
<http://www.foodaid.org/pdffdocs/HIVAIDSNutrition.pdf>
- UNAIDS: [http://data.unaids.org/pub/Manual/2008/jc1515a\\_policybrief\\_nutrition\\_en.pdf](http://data.unaids.org/pub/Manual/2008/jc1515a_policybrief_nutrition_en.pdf)
- Fanta Project: [http://www.fantaproject.org/downloads/pdfs/NHANM\\_Session8.ppt](http://www.fantaproject.org/downloads/pdfs/NHANM_Session8.ppt)

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<sup>74</sup> HIV, Food Security and Nutrition: Policy Brief. WFP, WHO and UNAIDS. [document on the Internet]. UNAIDS, May 2008. [cited 2008 Nov. 17] Available from [http://data.unaids.org/pub/Manual/2008/jc1515a\\_policybrief\\_nutrition\\_en.pdf](http://data.unaids.org/pub/Manual/2008/jc1515a_policybrief_nutrition_en.pdf)



## Annexure 7

### Understanding key issues of Orphaned and Vulnerable Children (OVC)

Orphans and vulnerable children (OVC) are a population at-risk as they are without parents, caretakers or supervision. Core OVC groups include orphans, street children, children affected by conflict, those with disabilities or chronic illnesses, children in hazardous forms of child labour, and children affected by HIV and AIDS – including AIDS orphans, HIV positive children, those with HIV positive parents and caretakers of those with HIV.<sup>75</sup> OVC are at higher risk of abuse, exploitation, gender-based violence, and recruitment into fighting forces and domestic labour.<sup>76</sup>

As approximately 30 million AIDS-affected children and seven million disaster-affected children exist globally, emergency situations place OVC even more at risk.<sup>77</sup> In emergency programming, OVC require attention in realms of health and nutrition, education, psychosocial support, economic support, a proper living environment, policy and law (anti-trafficking), and access to basic human rights. For implementers, it is crucial to account for children living with HIV and AIDS as well as adults.

#### Links

- OVC Toolkit: <http://www.ovcsupport.net/sw505.asp>
- World Bank and OVC: <http://info.worldbank.org/etools/docs/library/164047/pdf/ovc.pps>
- Family Health International on OVC: <http://www.fhi.org/en/hivaids/pub/fact/carorphans.htm>
- UNICEF: [http://www.unicef.org/protection/index\\_orphans.html](http://www.unicef.org/protection/index_orphans.html)
- HIV in Humanitarian Situations and OVC: [http://www.aidsandemergencies.org/cms/index.php?option=com\\_content&task=view&id=33&Itemid=82](http://www.aidsandemergencies.org/cms/index.php?option=com_content&task=view&id=33&Itemid=82)

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<sup>75</sup> Ibid.

<sup>76</sup> Orphans and vulnerable children and HIV. HIV in Humanitarian Situations. [document on the Internet]. 2008. [cited 2008 Nov. 25] Available from [http://www.aidsandemergencies.org/cms/index.php?option=com\\_content&task=view&id=33&Itemid=82](http://www.aidsandemergencies.org/cms/index.php?option=com_content&task=view&id=33&Itemid=82)

<sup>77</sup> Ibid.



## Annexure 8

# Understanding TB-HIV co-infection and related issues

Tuberculosis (TB) is a disease which predominantly attacks the lungs and is a common opportunistic infection and cause of death for a person living with HIV. In developing countries, PLHIV frequently receive the diagnosis of HIV after diagnosis of TB.

Inactive PLHIV may start showing symptoms due to a weakened immune system.<sup>78</sup>

Symptoms of TB include persistent cough, weight loss and loss of appetite, fever, night sweats and coughing up blood.<sup>79</sup> TB progresses faster in PLHIV, is more likely to be fatal if left undiagnosed or untreated in a PLHIV and is the only AIDS-related opportunistic infection that also puts non-PLHIV at risk.<sup>80</sup>

Health systems in emergency situations must be aware of concurrent TB and HIV diagnoses. Emergency situations may favour the spread of TB because of close quarters and a high amount of human contact. Therefore, emergency relief and rehabilitation programmes need to be attuned to the risks of TB and HIV for prevention and care services.

### Links:

- NACO on co infection: [http://www.nacoonline.org/Quick\\_Links/FAQs/#HIV-TB%20Co-infection](http://www.nacoonline.org/Quick_Links/FAQs/#HIV-TB%20Co-infection)
- NACO Training Modules for HIV/TB Coordination:
- <http://www.nacoonline.org/upload/Final%20Publications/Training%20module%20for%20medical%20officers%20on%20TBHIV.pdf>
- <http://www.nacoonline.org/upload/Basic%20Services/Training%20Module%20on%20TBHIV%20for%20Counsellors.pdf>
- Q & A on TB: <http://www.who.int/tb/challenges/hiv/faq/en/index.html>
- TB/HIV Fact Sheet: <http://www.cdc.gov/hiv/resources/factsheets/hivtb.htm>

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<sup>78</sup> Tuberculosis. [document on the Internet]. Avert, 2008 Sept. [cited 2008 Nov. 17] Available from <http://www.avert.org/tuberculosis.htm>

<sup>79</sup> Frequently asked questions about TB and HIV. [document on the Internet]. World Health Organisation, 2008. [cited 2008 Nov. 17] Available from <http://www.who.int/tb/challenges/hiv/faq/en/index.html>

<sup>80</sup> Ibid.



## Annexure 9

### What is Opportunistic Infection?

An opportunistic infection (OI) is a disease caused by a microbial agent in the presence of a compromised host immune system. In relation to HIV and AIDS, an OI is another disease, illness or infection that adds to the complications of HIV and AIDS. An OI deteriorates and weakens the immune system to a point where a PLHIV cannot fight off the infection. OIs account for a high number of deaths among PLHIV.<sup>81</sup>

Common OIs of PLHIV include tuberculosis, yeast infection, pneumonia, parasitic disease, fungal disease, other STIs and diarrhoea. ART can help the immune system to lower the risk of OIs.

In emergency situations, simple precautions can be taken to minimise risk of OIs for PLHIV. Promotion of eating properly cooked food, drinking boiled/bottled water, hand-washing after toilet use, avoiding situations with a high risk of infection, receiving appropriate and timely immunisations, and availability of ART<sup>82</sup> all contribute to lessening the risk of OIs. Medical services must provide education and medical attention to PLHIV to lessen the overall occurrence of OIs in emergency settings.

#### Links:

- NACO OI facts:
- [http://www.nacoonline.org/Quick\\_Links/FAQs/](http://www.nacoonline.org/Quick_Links/FAQs/)
- <http://www.nacoonline.org/upload/Publication/Treatment%20Care%20and%20support/uidelines%20for%20Prevention%20and%20Management%20of%20common%20opportunistic%20infections.pdf>
- NACO OI PowerPoint Facilitator's Guide: <http://www.go2itech.org/itech?page=db-02-00&id=51048&bkto=db-00-00&bktopost=>
- UNAIDS HIV-related OI: [http://data.unaids.org/Publications/IRC-pub05/opportu\\_en.pdf](http://data.unaids.org/Publications/IRC-pub05/opportu_en.pdf)

<sup>81</sup> FAQs. National AIDS Control Organisation. [document on the Internet] Ministry of Health & Family Welfare Government of India. [cited 2008 Nov. 17] Available from [http://www.nacoonline.org/Quick\\_Links/FAQs/](http://www.nacoonline.org/Quick_Links/FAQs/)

<sup>82</sup> Guidelines for Prevention and Management of Common Opportunistic Infections/Malignancies among HIV-Infected Adult and Adolescent. NACO. [document on the Internet]. Ministry of Health and Family Welfare, Government of India, May 2007. [cited 2008 Nov. 17]. Available from <http://www.nacoonline.org/upload/Publication/Treatment%20Care%20and%20support/Guidelines%20for%20Prevention%20and%20Management%20of%20common%20opportunistic%20infections.pdf>

## Annexure 10

### What are the guidelines on breastfeeding?

One of the biggest challenges of public health personnel is to prevent transmission of HIV from mother to child through breast feeding. Breast milk contains HIV virus (in an infected mother) in enough quantity to infect the child and at the same time lack of breastfeeding during the first year of life leads to increased risk of malnutrition and disease. Besides in developing countries, not breastfeeding during the first two months of life is associated with a six-fold increase in mortality.<sup>83</sup> For an HIV positive mother, formula substitutes should be used when available, affordable and clean water is present for the mixture. For resource limited countries, like India, breastfeeding is recommended for HIV positive mothers. The benefits of breast milk outweigh the effects that can occur when feeding the child formula mixed with unsafe water, which can cause life-threatening diarrhoea.<sup>84</sup>

In emergency settings, breastfeeding is most likely the best option for HIV positive mothers. Programme designers and implementers must be educated on breastfeeding techniques so they can best advise women on their options and properly refer them to a physician.

#### Links:

- NACO India stance on breastfeeding:
- [http://www.nacoonline.org/Quick\\_Links/FAQs/#Prevention%20of%20Parent%20to%20Child%20Transmission%20\(PPTCT\)](http://www.nacoonline.org/Quick_Links/FAQs/#Prevention%20of%20Parent%20to%20Child%20Transmission%20(PPTCT))
- WHO guidelines
- [http://www.who.int/child\\_adolescent\\_health/documents/who\\_cdr\\_93\\_3/en/index.html](http://www.who.int/child_adolescent_health/documents/who_cdr_93_3/en/index.html)
- [http://www.who.int/child\\_adolescent\\_health/documents/infant\\_feeding/en/index.html](http://www.who.int/child_adolescent_health/documents/infant_feeding/en/index.html)
- [http://www.who.int/child\\_adolescent\\_health/documents/9789241594745/en/index.html](http://www.who.int/child_adolescent_health/documents/9789241594745/en/index.html)
- Complementary feeding
- <http://whqlibdoc.who.int/paho/2004/a85622.pdf>

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<sup>83</sup> HIV and Infant Feeding: Framework for Priority Action. [document on the Internet]. WHO, 2003. [cited 2008 Nov. 19]. Available from [http://data.unaids.org/publications/External-Documents-Restored/who\\_infantfeeding\\_framework\\_en.pdf](http://data.unaids.org/publications/External-Documents-Restored/who_infantfeeding_framework_en.pdf)

<sup>84</sup> Ibid.



## Annexure 11

# What is Prevention of Parent to Child Transmission (PPTCT) and Guidelines for safe delivery

Parent-to-child transmission is when an HIV positive woman passes the virus to her baby, which can occur during pregnancy, labour or delivery. Prevention of parent-to-child transmission (PPTCT) is the prevention of such transmission.<sup>85</sup>

A single dose of Nevirapine given to the mother at the onset of labour has proven effective – reducing the rate by half – of preventing transmission of HIV from mother to child. Often used in resource limited settings, a single dose of Nevirapine is also given to the newborn baby immediately after birth for prevention.<sup>86</sup> As this method only involves one pill, women commonly develop resistance to the drug, eliminating future benefits of the drug.

Healthcare systems in emergency settings must have a supply of Nevirapine, and understand its usage in PPTCT efforts.

### Links:

- NACO guidelines on PPTCT: [http://www.nacoonline.org/National\\_AIDS\\_Control\\_Program/Services\\_for\\_Prevention/PPTCT/](http://www.nacoonline.org/National_AIDS_Control_Program/Services_for_Prevention/PPTCT/)
- NACO PowerPoint training: [http://www.go2itech.org/ppt/p06-db/db-51052/SP\\_7\\_%20PPTCT.ppt](http://www.go2itech.org/ppt/p06-db/db-51052/SP_7_%20PPTCT.ppt)
- WHO guidelines: <http://www.who.int/entity/hiv/pub/guidelines/pmtctguidelines3.pdf>
- Avert guidelines: <http://www.avert.org/motherchild.htm>
- ICW guidelines: <http://www.icw.org/node/118>

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<sup>85</sup> Preventing Mother to Child Transmission. [document on the Internet.] Avert, 2008. [cited 2008 Nov. 19]. Available from <http://www.avert.org/motherchild.htm>

<sup>86</sup> Ibid.

## Annexure 12

### What is BCC?

Behaviour change communication (BCC) is a process of working with individuals to change high-risk behaviour, promote positive behaviour and educate communities to support long-term change. Prevention of HIV is related to behaviour change in individuals who have the capacity to adopt safer sexual practices. To be effective, BCC should be accompanied by services like HIV and STI treatment, condom provision, creation of enabling environment, etc.<sup>87</sup>

To effectively carry out a BCC effort in an emergency setting, repeated contact with the targeted population, understanding the means of behaviour change, and utilising available community supports are necessary. Tailoring messages to the specific needs of a population is vital to be able to change behaviour, attitudes and practices.<sup>88</sup>

#### Links:

- India framework for BCC/IEC: [http://dsacs.delhigovt.nic.in/naco\\_pdf/iec\\_strategy.pdf](http://dsacs.delhigovt.nic.in/naco_pdf/iec_strategy.pdf)
- BCC in emergencies UNICEF toolkit: [http://www.unicef.org/influenzaresources/index\\_668.html](http://www.unicef.org/influenzaresources/index_668.html)
- Communication principles: [http://keenhosting.net/unicef/communication\\_emergencies/pdf/Behaviour\\_Change\\_Principles.pdf](http://keenhosting.net/unicef/communication_emergencies/pdf/Behaviour_Change_Principles.pdf)

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<sup>87</sup> BCC. [organisational document]. Swasti. [cited 2008 Nov. 18] [www.swasti.org](http://www.swasti.org)

<sup>88</sup> UNESCO. Educational Responses to HIV and AIDS for Refugees and Internally Displaced Persons: Discussion Paper for Decision-Makers. [cited 11 Nov. 2008] Available from <http://unesdoc.unesco.org/images/0014/001493/149356e.pdf>



## Annexure 13

### Understanding the Condom programme, including female condoms

Both female and male condoms decrease the risk of HIV, STI and pregnancy when engaging in sexual intercourse – whether vaginal, oral or anal. Other than abstinence, condoms are one of the most important methods to decrease the risk of HIV and STI.

Condoms can be distributed to populations affected by emergencies, for STI and HIV prevention. Without proper knowledge of usage, the condoms cannot be effective. Rural populations, in particular, may never have had sexual education prior to humanitarian aid efforts. In emergencies therefore, education must accompany resource distribution. Materials in various languages, such as the UNAIDS Awareness Card which contains facts, prevention instructions, and a pocket for a condom, can be effective in HIV/AIDS awareness raising. The Awareness Cards are available at the UNAIDS Office on AIDS, Security and Humanitarian Response: [unaids@unaids.org](mailto:unaids@unaids.org).<sup>89</sup>

#### Links:

- Information on sexual health: [http://www.nacoonline.org/Quick\\_Links/Youth/Information\\_on\\_Safe\\_Sex/](http://www.nacoonline.org/Quick_Links/Youth/Information_on_Safe_Sex/)
- NACO on condom promotion: [http://www.nacoonline.org/Quick\\_Links/FAQs/#Condom%20Promotion](http://www.nacoonline.org/Quick_Links/FAQs/#Condom%20Promotion)
- Inter-Agency Reproductive Health Kits for Crisis Situations provide methods to calculate condom needs for a given population: <http://www.rhrc.org/pdf/rhrkit.pdf>
- Guidelines for condom promotion: <http://www.ifrc.org/Docs/pubs/health/archi/condompromotion.pdf>

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<sup>89</sup> Guidelines for HIV/AIDS Interventions in Emergency Settings. IASC. [document on the Internet]. [cited 2008 Nov. 18] Available from [http://www.unfpa.org/upload/lib\\_pub\\_file/249\\_filename\\_guidelines-hiv-emer.pdf](http://www.unfpa.org/upload/lib_pub_file/249_filename_guidelines-hiv-emer.pdf)



## Annexure 14

### Understanding the STI programme including SCM

A sexually transmitted infection (STI) is a reproductive tract infection of the genital region that is acquired through sexual contact with an infected partner. Common STIs include gonorrhoea, Chlamydia, syphilis, genital herpes, genital warts, and HIV. Some STIs can be cured using antibiotics or other agents, while others are incurable. Some STIs have defining symptoms, such as genital ulcer or discharge; while other STIs have no visible symptoms at the onset. Health problems may also arise from an STI, including pelvic inflammatory disease, infertility, difficulty with pregnancy, miscarriage and congenital infection.<sup>90</sup>

Complete treatment of an STI includes visiting a physician, taking required medicines, going to follow-up appointments, treating sexual partner(s), and avoiding sexual intercourse during treatment. Syndromic case management (SCM) eliminates the lengthy treatment process and treats by giving medicine with the identification of obvious symptoms through one appointment/medical visit. In emergency settings when resources and time are limited and many individuals may need treatment, emergency personnel and medical services should be knowledgeable about STI treatment, including SCM procedures. Management of STI is critical to prevent increase in HIV transmission.

#### More information on STIs:

- NACO PowerPoint training: [http://www.go2itech.org/ppt/p06-db/db-51052/SP\\_17\\_STIs\\_Skin.ppt](http://www.go2itech.org/ppt/p06-db/db-51052/SP_17_STIs_Skin.ppt)
- National Guidelines on Prevention, Management, Control of STIs: [http://www.go2itech.org/pdf/p06-db/db-51052/Annex\\_8\\_Guidelines\\_STI\\_1106.pdf](http://www.go2itech.org/pdf/p06-db/db-51052/Annex_8_Guidelines_STI_1106.pdf)
- WHO on STIs: [http://www.who.int/reproductive-health/publications/rtis\\_gep/rtis\\_gep.pdf](http://www.who.int/reproductive-health/publications/rtis_gep/rtis_gep.pdf)
- WHO on SCM: [https://www.who.int/reproductive-health/publications/trainingmodules\\_syndromic\\_mngt\\_stis/m2.pdf](https://www.who.int/reproductive-health/publications/trainingmodules_syndromic_mngt_stis/m2.pdf)

#### Blood Safety programme

Blood safety ensures all individuals have access to blood and blood products that are safe, available at reasonable cost, adequate to meet the needs of all patients, transfused only when necessary, and provided as part of a sustainable blood programme within an existing healthcare system.<sup>91</sup>

Blood transfusions save millions of lives; yet in countries where blood supply is limited, many still die. Medical services and relief organisations in both the relief and rehabilitation phases of emergencies need to ensure availability of adequate supplies of blood and blood products, accessibility to all patients requiring transfusion, safety of blood and blood products, and safe and appropriate clinical use of blood and blood products.<sup>92</sup> Training on


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<sup>90</sup> Sexually Transmitted and Other Reproductive Tract Infections: A guide to essential practice. [document on the Internet]. World Health Organisation, 2005. [cited 2008 Nov. 13] Available from [http://www.who.int/reproductive-health/publications/rtis\\_gep/rtis\\_gep.pdf](http://www.who.int/reproductive-health/publications/rtis_gep/rtis_gep.pdf)

<sup>91</sup> Blood Safety. [document on the Internet]. World Health Organisation, 2008. [cited 2008 Nov. 13]. Available from [http://www.who.int/topics/blood\\_safety/en/](http://www.who.int/topics/blood_safety/en/)

<sup>92</sup> Universal Access to Safe Blood Transfusion. [document on the Internet]. World Health Organisation, 2008. [cited 2008, Nov. 13]. Available from <http://www.who.int/bloodsafety/en/>.





blood safety may need to during emergency response along with other programmes for relief health care workers.

#### **Links**

- NACO & blood safety & lab services guidelines:
- [http://www.nacoonline.org/Quick\\_Links/Publication/Blood\\_Safety\\_\\_Lab\\_Services/](http://www.nacoonline.org/Quick_Links/Publication/Blood_Safety__Lab_Services/)
- <http://www.nacoonline.org/upload/Blood%20Saftey/Status%20note%20on%20Blood%20Safety.pdf>
- WHO blood safety information: [http://www.who.int/topics/blood\\_safety/en/](http://www.who.int/topics/blood_safety/en/)

## Annexure 15

### What are the issues related to trafficking during a disaster

Trafficking is the buying, selling or trading of individuals, often for sexual exploitation.

Besides initiatives like UNDP India Prevention of Trafficking, HIV and AIDS in Women and Girls (TAHA), India has four principal laws addressing trafficking, including the Immoral Trafficking (Prevention) Amendment (ITPA) Act, provisions on the Indian Penal Code, the Juvenile Justice Act and the Child Labour Act.<sup>93</sup>

Since conflict and natural disasters lead to rise in human trafficking, as seen following the 2004 tsunami with affected countries showing increases in rape, sexual abuse, kidnapping and trafficking,<sup>94</sup> emergency planning needs to include policies to prevent trafficking – such as increased police oversight and keeping displaced families and communities together.

#### Links:

- India Scheme to Prevent Trafficking: <http://wcd.nic.in/Comscheme.doc>
- UNDP report, “Human Trafficking and HIV” [http://www.undp.org/hiv/docs/alldocs/human\\_traffick\\_hiv\\_undp2007.pdf](http://www.undp.org/hiv/docs/alldocs/human_traffick_hiv_undp2007.pdf)
- UNDP-India TAHA reports: <http://data.undp.org.in/hiv/MigrationGoneWrong.pdf> <http://data.undp.org.in/hivreport/mediakit.pdf>

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<sup>93</sup> Trafficking in Persons Report. Office to Monitor and Combat Trafficking of Persons. [document on the Internet]. U.S. Department of State, 2004. [cited 2008 Nov. 18] Available from <http://www.state.gov/g/tip/rls/tiprpt/2004/33197.htm>

<sup>94</sup> Human Trafficking and HIV: Exploring the Vulnerabilities and Responses in South Asia, p. 13.



## Annexure 16

### Understanding legal aspects of HIV

India's National AIDS Control Organisation (NACO) states, "There can be no valid or effective response to HIV and AIDS without respect for the human rights, fundamental freedom and the dignity of human beings." NACO lists the right to informed consent, confidentiality and the right against discrimination as the three most important rights for PLHIV.<sup>95</sup>

In India, however, a part of the population with HIV and AIDS is not given the fundamental freedoms that individuals without HIV possess: Homosexuality is illegal; injection drug users are criminalised; due to stigma and discrimination, sex workers are ostracised, specifically if they are HIV positive.

Although India's National AIDS Prevention and Control Policy directs much HIV and AIDS action, the policy does not have the status of law and is not binding or enforceable in court. In emergency situations, policy makers, stakeholders and implementers need to keep "human rights, fundamental freedom and the dignity of human beings" at the forefront of planning and disaster response.

#### Links:

- NACO Know Your Rights: [http://www.nacoonline.org/Quick\\_Links/Know\\_Your\\_Rights/](http://www.nacoonline.org/Quick_Links/Know_Your_Rights/)
- WHO Legal Guide to HIV/AIDS: <http://siteresources.worldbank.org/INTHIVAIDS/Resources/375798-1103037153392/LegalAspectsOfHIVAIDS.pdf>
- Lawyers' Collective : <http://www.lawyerscollective.org/>

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<sup>95</sup> Know Your Rights. HIV Monitoring: Treatment for AIDS. [document on the Internet]. National AIDS Control Organisation, 2007. [cited 2008 Nov. 17] Available from [http://www.nacoonline.org/Quick\\_Links/Know\\_Your\\_Rights/](http://www.nacoonline.org/Quick_Links/Know_Your_Rights/)

## Annexure 17

# Understanding HIV and Migration

Emergencies may bring about increases in migration.

Factors of migration that lead to an increase of HIV risk include:

- Separation from spouse, families and social and cultural norms;
- Language barriers,
- Substandard living conditions;
- Instability;
- Exploitative working conditions, including sexual violence.<sup>96</sup>

Strategies to reduce HIV among the migrant population in emergency situations include keeping families and communities together, promoting educational campaigns in local language and by word-of-mouth, and increased condom availability in places of migration (roadside hotels/food stands/high-risk migration corridors). Implementing policies that limit migration – like local work initiatives – may further lessen HIV risk.

### Links:

- NACO Safe Zones for Migrants: <http://www.expressindia.com/news/fullstory.php?newsid=80614>
- UNAIDS and Migration: [http://data.unaids.org/pub/Manual/2008/20080716\\_jc1513\\_policy\\_brief\\_labour\\_migration\\_en.pdf](http://data.unaids.org/pub/Manual/2008/20080716_jc1513_policy_brief_labour_migration_en.pdf)  
<http://www.unaids.org/en/PolicyAndPractice/KeyPopulations/MigrantsMobileWorkers/default.asp>
- Relief Web & Migration: <http://www.reliefweb.int/rw/RWB.NSF/db900SID/EGUA-7H3SMJ?OpenDocument>

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<sup>96</sup> HIV and International Labour Migration: Policy Brief. ILO, IOM, UNAIDS.



## Annexure 17

### Life-Skills Based Education

In emergencies when educational systems may break down, temporary educational sessions can be held for youth of all ages depending on the demonstrated need. By using the NACO Life Skills Development Guide (link below), implementers are provided with approaches and strategies that have proven effective for life skill education among youth.

#### Links:

- NACO:
- Life Skills Development Guide: <http://www.nacoonline.org/upload/NACOinAction/Facilitators%20Guide.pdf>
- On Adolescence Education Programming [http://www.nacoonline.org/Quick\\_Links/Youth/School\\_Age\\_Education\\_Program\\_SAEF/](http://www.nacoonline.org/Quick_Links/Youth/School_Age_Education_Program_SAEF/)
- UNICEF: <http://www.unicef.org/lifeskills/index.html>
- Schools and Health: <http://www.schoolsandhealth.org/Pages/default.aspx>



## Annexure 18

### List of Organisations working on HIV issues in India

<b>Government Agencies/ Programmes</b>	<b>Web site</b>	<b>Description</b>
National AIDS Control Organisation (NACO) (India)	<a href="http://www.nacoonline.org">http://www.nacoonline.org</a>	A division of India's Ministry of Health and Family Welfare providing leadership to the HIV/AIDS control programme in India
North East Regional Office (NERO)		NACO sub-office established at Guwahati to provide technical support to the SACS of 8 North East States. Regional office has been established by NACO with the support of UNAIDS.
State AIDS Control Society (SACS)	<a href="http://www.nacoonline.org/Quick_Links/Connect/">http://www.nacoonline.org/Quick_Links/Connect/</a>	Implements the NACO programme at state level, with functional independence to upscale and innovate
District AIDS Prevention and Control Unit (DAPCU)		District level units of SACS to manage the NACP III programme at the grass root level. DAPCUs are being established in most of the districts in the country
<b>Donor Agencies/ Programmes</b>	<b>Web site</b>	<b>Description</b>
Action Aid International	<a href="http://www.actionaid.org/india">http://www.actionaid.org/india</a>	An international anti-poverty agency aiming to fight poverty worldwide, also works in HIV/AIDS
AusAID	<a href="http://www.ausaid.gov.au/">http://www.ausaid.gov.au/</a>	Australian Government agency responsible for managing Australia's overseas aid program
The Bill & Melinda Gates Foundation	<a href="http://www.gatesfoundation.org/Pages/home.aspx">http://www.gatesfoundation.org/Pages/home.aspx</a>	Dedicated to bringing innovations in health and learning to the global community
CARE India	<a href="http://www.careindia.org">http://www.careindia.org</a>	India-based organisation working with vulnerable families, especially women and girls – involved in HIV and disasters





UK Department for International Development (DFID)	<a href="http://www.dfid.gov.uk/">http://www.dfid.gov.uk/</a>	The part of the UK Government that manages Britain's aid to countries working to get rid of extreme poverty
Elizabeth Glaser Paediatric AIDS Foundation	<a href="http://www.pedaids.org/">http://www.pedaids.org/</a>	Seeks to prevent paediatric HIV infection and to eradicate paediatric AIDS through research, advocacy, and prevention and treatment programs
Global Fund to fight AIDS, Tuberculosis, and Malaria (GFATM)	<a href="http://www.theglobalfund.org/en/about/aids/">http://www.theglobalfund.org/en/about/aids/</a>	Created to finance a dramatic turn-around in the fight against AIDS, tuberculosis and malaria
India HIV/AIDS Alliance	<a href="http://www.aidsallianceindia.net/">http://www.aidsallianceindia.net/</a>	Expands and intensifies the global strategy of supporting community action to reduce the spread of HIV and mitigate the impact of AIDS
International AIDS Vaccine Initiative (IAVI)	<a href="http://www.iavi.org">http://www.iavi.org</a>	To ensure the development of safe, effective, accessible, preventive HIV vaccines for use in the world
International Labour Organisation (ILO)	<a href="http://www.ilo.org/hivaidsindia">http://www.ilo.org/hivaidsindia</a>	UN agency that brings together governments, employers and workers of its member states in common action to promote decent work throughout the world
PATH: a catalyst for global health	<a href="http://www.path.org/">http://www.path.org/</a>	An international, non-profit organisation creating sustainable, culturally relevant solutions, enabling communities worldwide to break longstanding cycles of poor health
Population Services International – India (PSI)	<a href="http://www.psi.org.in/">http://www.psi.org.in/</a>	Registered Indian society which harnesses the vitality of the private sector to address the health problems of low-income and vulnerable populations
United Nations Programme on HIV/AIDS – India (UNAIDS)	<a href="http://www.unaids.org.in">http://www.unaids.org.in</a>	Through joint UN Team on AIDS – works closely with NACO and other partners
United Nations Development Programme – India (UNDP)	<a href="http://www.undp.org.in">http://www.undp.org.in</a>	Supports government and vulnerable groups to stem the spread of HIV

United Nations Children's Fund (UNICEF) – India	<a href="http://www.unicef.org/india/">http://www.unicef.org/india/</a>	Committed to working with the Government of India to ensure that each child born develops to his/her full potential
United Nations Office of Drug Control & Crime in South Asia (UNODC)	<a href="http://www.unodc.org">www.unodc.org</a>	Works towards mainstreaming HIV/AIDS and drug abuse concerns in the ongoing programmes in India
United States Agency for International Development (USAID)	<a href="http://www.usaid.gov/">http://www.usaid.gov/</a>	An independent federal government agency that supports long-term and equitable economic growth and advances U.S. foreign policy objectives
William J. Clinton Foundation	<a href="http://www.clintonfoundation.org/">http://www.clintonfoundation.org/</a>	Focuses on worldwide issues that demand urgent action, solutions, and measurable results – i.e. global climate change, HIV/AIDS
World Bank India	<a href="http://www.worldbank.org.in">http://www.worldbank.org.in</a>	Provides financial and technical assistance, including to specific work in India with HIV/AIDS
World Health Organisation HIV/AIDS Programme – India	<a href="http://www.whoindia.org/">http://www.whoindia.org/</a>	A directing and coordinating authority on international health – collaborates with Government of India and stakeholders in health development and HIV/AIDS efforts
<b>Technical &amp; Management Support Systems</b>	<b>Web site</b>	<b>Description</b>
Karnataka Health Promotion Trust (KHPT)	<a href="http://www.khpt.org">http://www.khpt.org</a>	Supports activities in the areas of reproductive health and HIV/AIDS
National AIDS Research Institute	<a href="http://www.nari-icmr.res.in/">http://www.nari-icmr.res.in/</a>	An Indian institute devoted exclusively to HIV/AIDS research
Solidarity and Action Against the HIV Infection in India (SAATHI)	<a href="http://www.saathii.org/">http://www.saathii.org/</a>	Strengthens the capacity of organisations working against the HIV/AIDS epidemic in India
Swasti Health Resource Centre (India)	<a href="http://www.swasti.org">http://www.swasti.org</a>	A health resource centre seeking to improve health outcomes, working with communities and development partners through action research, consulting services and knowledge management
<b>Implementing Agencies</b>	<b>Web site</b>	<b>Description</b>
NGOs working with	<a href="http://www.nacoonline.org/">http://www.nacoonline.org/</a>	NGOs make a significant



NACO	Partnerships/Civil_Society/	contribution in HIV prevention and care services to highly vulnerable population groups, working through NACO
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<b>Community Care Centres in India</b>	<a href="http://www.nacoonline.org/upload/NACO_04LIST%20OF%20CCC%20for%20NACO%20website.xls">http://www.nacoonline.org/upload/NACO_04LIST%20OF%20CCC%20for%20NACO%20website.xls</a>	Play a critical role in providing treatment, care and support to people living with HIV/AIDS
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<b>Networks</b>	<b>Web site</b>	<b>Description</b>
Indian Network for People Living with HIV/AIDS (INP+)	<a href="http://www.inppplus.net/">http://www.inppplus.net/</a>	A national network for people living with HIV/AIDS
Positive Women Network (PWN+)	<a href="http://www.pwnplus.org/">http://www.pwnplus.org/</a>	An organisation formed by women living with HIV/AIDS to address the need for a support system and to improve the quality of life of women living with HIV, and their children, in India

<b>E-Forums</b>	<b>Web site</b>	<b>Description</b>
AIDS-India	<a href="http://oldforum.aidworkers.net/messages/141/10749.html?1054548583">http://oldforum.aidworkers.net/messages/141/10749.html?1054548583</a>	An electronic forum to foster communication and collaboration among those who are involved in AIDS related issues in India
AIDS-Asia	<a href="http://health.groups.yahoo.com/group/AIDS_ASIA/">http://health.groups.yahoo.com/group/AIDS_ASIA/</a>	An e-newsletter committed to the development of an Asian and Pacific perspective on the causes, consequences and mitigating the impact of HIV epidemic
SEA AIDS	<a href="http://www.healthdev.org/eforums/cms/individual.asp?sid=96&amp;sname=SEA-AIDS">http://www.healthdev.org/eforums/cms/individual.asp?sid=96&amp;sname=SEA-AIDS</a>	A regional electronic discussion forum focused on HIV/AIDS, TB and other health and development issues in Asia and the Pacific
Solution Exchange	<a href="http://www.solutionexchange-un.net.in/en/index.php">http://www.solutionexchange-un.net.in/en/index.php</a>	An initiative of the UN in India to help attain India's development objectives and Millennium Development Goals by connecting development professionals and enabling sharing, learning and collaboration

## Annexure 20

### Technical note related to key systems

Procurement and supply management for sexual health-related products

In a disaster, procuring HIV and AIDS and sexual health related products must be an efficient and effective process. In India, the National AIDS Control Organisation provides access to such resources through NACP-III. The World Bank also provides various guidelines and approaches to procurement that can be used globally.

In an emergency, various components need to be considered in procuring supplies.

- Who should receive care?
- Which are the treatments to be provided?
- What is the adequate time horizon of the estimation?
- What is the degree of accuracy required?

Therefore, before procurement, the following needs to be considered:

- Who does what (Who will order medicines for which locality, etc.)
- Types of supplies (medicines, testing supplies, IEC supplies, condoms, etc.)
- Drug selection (i.e. drugs for ART, PEP, antibiotics)
- Quantity
- Capacity to distribute (Licensed physicians to disseminate medicines, locations of distribution, other staff members to assist, etc.)
- Procurement method
- Pricing
- Economic impact on entire emergency.<sup>97</sup>

Procurement approaches

World Bank recommends four methods of procuring supplies:

- Directly from the manufacturer;
- Contracting an agent to procure from manufacturers;
- From a UN-related agency
- From a social marketing organisation for promotion, distribution as well as procurement.<sup>98</sup>

Option	Borrower's experience and capacity	Size and complexity of procurement	Strength of distribution network
Direct from manufacturer	Country should have a proven track record; if not, risk of failure is high	Better for larger procurements & when other commodities being procured in addition to condoms	Country should have well developed logistics management and distribution system
Through a procurement agent	Better if country does not have experience; important to ensure that agent is qualified	Also an option for larger, more complex procurements	If logistics weak, tender should require technical support
Through UNFPA	Better for countries that lack experience and capacity	Better for smaller amounts and when limited to condoms and contraceptives	If logistics weak, ensure that UNFPA also addresses this issue
Through a social marketing organization	An alternative if country willing to contract out	A good bet if country wants to combine procurement with promotion/distribution	If logistics and distribution weak, SM may be the best option

<sup>97</sup> Battling HIV/AIDS: A Decision Maker's Guide to the Procurement of Medicines and Related Supplies. [document on the Internet]. WHO, 2004. [cited 2008 Nov. 20]. Available from <http://siteresources.worldbank.org/INTPROCUREMENT/Resources/Technical-Guide-Procure-HIV-AIDS-Meds.pdf>

<sup>98</sup> Merrick T, Epp J. Condom Procurement Guide: Population and Reproductive Health Thematic Group Knowledge and Practice Guide Series. Health Nutrition and Population. [document on the Internet]. The World Bank, 2001. [cited 2008 Nov. 20]. Available from <http://siteresources.worldbank.org/INTHIVAIDS/Resources/375798-1103037153392/CondomProcurementGuide.pdf>



## **From Condom Procurement Guide, World Bank, 2001. \*(condom-specific guide)**

In an emergency, humanitarian organisations may have their own supplies and countries may have back-up supplies for preparedness efforts as well. Back-up supplies should be accounted for and wholly utilised before more supplies are procured.

### **Sustainability of supply**

Procurement should ensure that products are sustainable. At the onset, products should be new, have a long shelf life and be procured by humane and acceptable means.

### **Making linkages**

Promoting health education and community mobilisation during the procurement process can avoid duplication of efforts in HIV and AIDS prevention. With condoms, distributing information on condom usage (with pictorial guides) along with the condom itself can allow for a smooth transition from procurement to HIV and AIDS efforts.

### **Legal issues**

Some countries have national laws and policies on by whom and where drugs can be prescribed, dispensed and sold. Even in emergencies when situations are dire, HIV/AIDS Control Organisations must be consulted to determine proper methods to be undertaken. Such policy and legal issues affecting procurement include:

- Intellectual property (patent) legislation of medicines;
- Health rights and access to HIV-related treatment when there are limited supplies may rest upon eligibility criteria for selection
- Security issues – since ARTs are high in value, illegal buying/selling and stealing of medicines may arise.<sup>99</sup>

### **Links:**

- WHO:
  - <http://siteresources.worldbank.org/INTPROCUREMENT/Resources/Technical-Guide-Procure-HIV-AIDS-Meds.pdf>
  - <http://siteresources.worldbank.org/INTHIVAIDS/Resources/375798-1103037153392/CondomProcurementGuide.pdf>
- NACO procurement strategies:  
[http://www.nacoonline.org/upload/Publication/finance%20&%20Procurement/Procurement%20Manual%20for%20National%20AIDS%20Control%20Programme%20\(NACP-III\).pdf](http://www.nacoonline.org/upload/Publication/finance%20&%20Procurement/Procurement%20Manual%20for%20National%20AIDS%20Control%20Programme%20(NACP-III).pdf)

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<sup>99</sup> Battling HIV/AIDS: A Decision Maker's Guide. WHO, 2004.





Swasti is a health resource centre, that enhances health and well being through innovation, particularly for the marginalised. It aims to advance health by mobilising communities to better address healthcare priorities, and by improving the efficiencies and effectiveness of organisations in the health sector. Swasti combines sectoral knowledge with gender and equity perspectives and management skills.

Swasti is a registered not-for-profit society and a part of the Catalyst Group of institutions that has been working in the development sector for 15 years. In addition to Swasti, the group comprises of Catalyst Management Services, a consultancy, research and training organisation; and Vrutti, a livelihoods resource centre.

Swasti works with a range of organisations from grassroots community based organisations to NGOs, bi-lateral and multi-lateral donors, government departments and academic and corporate bodies.



Oxfam International is a confederation of 13 like-minded organizations working together and with partners and allies around the world to bring about lasting change. Oxfam works directly with communities and seeks to influence the powerful to ensure that poor people can improve their lives and livelihoods and have a say in decisions that affect them.



Disasters – natural or otherwise lead to an environment in which the risk of sexual health vulnerabilities, particularly transmission of HIV is increased. In December 2004 after the tsunami devastated coastal areas around the Indian Ocean, many humanitarian agencies, funding organisations, governments, NGOs and private individuals came forward to support relief and rehabilitation initiatives. In India, the coastal areas of Southern India and the Andaman and Nicobar islands were the most affected.

Mainstreaming sexual health, particularly HIV related issues, into disaster response has emerged as one of the strategic ways of averting new infections after a natural disaster. The existing guidelines and policies (e.g. SPHERE) have clearly laid out the processes to be followed under humanitarian emergencies; but none directly address the needs of communities with regard to sexually transmitted infections including HIV, in the form of guidelines or minimum standards that can be incorporated as part of relief and rehabilitation programmes

The purpose of this guide is to help in addressing sexual health related issues and in mainstreaming HIV prevention and AIDS care in humanitarian emergencies, especially natural disasters, by providing clear guidelines, recommendations and plans for action in disaster relief and rehabilitation. The design and the approaches in the guide are based on the study 'Vulnerability to HIV following a natural disaster' in the tsunami affected areas in India' done by Swasti with the financial support of Oxfam.



[www.swasti.org](http://www.swasti.org)  
[www.oxfam.org](http://www.oxfam.org)