



Integrating HIV in the Cluster Response



Inter-Agency Task Team
to Address HIV in
Humanitarian Emergencies



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Programme



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Introduction

The magnitude and frequency of humanitarian emergencies are increasing, including complex crises, food insecurity, climate change events, and protracted conflicts. In the wake of the increasing occurrence and impact of such events, improving the health and lives of people in humanitarian context needs to be central to the efforts to reach the Sustainable Development Goal target of ending acquired immunodeficiency syndrome (AIDS) as a public health threat by 2030. Every year hundreds of millions of people around the world are affected by humanitarian emergencies including a significant proportion of people living with HIV (PLHIV).

The risks and vulnerabilities to HIV transmission in emergencies are complex, vary by context and depend on many different and dynamic factors, including: breakdown of social cohesion; lack of income, shortages of food, shelter and hygiene items; the extent of rape and other forms of sexual violence; displacement and mobility, increased stigma and discrimination, disruption of services including school, communication systems and health care. Limited access to HIV treatment, prevention methods such as condoms, pre-exposure prophylaxis (PrEP), post-exposure prophylaxis (PEP) and prevention of mother-to-child transmission (PMTCT) services as well as Treatment as Prevention (TasP) are also pivotal. Emergency-related coping mechanisms such as selling sex may become one of the few options to secure livelihoods. Conversely, there are other factors that may affect and modify the HIV risk - and may even reduce the risk of HIV transmission in humanitarian contexts. These include the interplay between the baseline HIV prevalence, the degree of isolation of the affected communities, the extent of mobility limitations, the degree of interaction between displaced and host communities and the effectiveness of the humanitarian response.

At the onset of an emergency, the vulnerability of PLHIV can be further exacerbated: PLHIV and their households may have limited access to essential services, medicines and other commodities. Health care services may be disrupted, preventing PLHIV from accessing antiretroviral therapy (ART), as well as testing, care and treatment services for opportunistic infections, including TB. Existing HIV-related stigma and discrimination may be further exacerbated, making people living with, at risk or affected by HIV disproportionately more vulnerable. Also food and nutrition security may be further compromised. Understanding the baseline HIV prevalence and epidemiology including information on higher risk/burden groups⁴ in a specific context should inform an effective response.

HIV-related action

The focus of HIV related action in humanitarian settings is two-fold: Prevent the transmission of HIV and reduce morbidity and mortality due to HIV. To achieve this the humanitarian community should ensure that activities undertaken to support affected populations aim to reduce the vulnerability and risk of HIV and to minimise harms to people already living with HIV. Through the integration of HIV into the overall emergency response, lives can be saved, and further transmission of HIV can be reduced or avoided. The ability to address the needs of people living with, affected by and at increased risk of HIV in a timely manner is directly linked to the inclusion of these needs in the preparedness and contingency plans of both the HIV programme and the general national disaster preparedness plans or other national contingency plans.

Cluster Responses

The cluster approach aims to ensure that responses to emergencies are more predictable, more accountable and effectively coordinated, thus avoiding duplicative efforts. This guidance will cover the four clusters that are most relevant for the HIV and AIDS response. However, HIV is designated as a core cross-cutting area in humanitarian action, meaning that no single cluster or sector is expected to provide all the necessary HIV services and address all related risks and vulnerabilities. Instead, a multi-sectoral approach involving all relevant clusters or sectors should be followed. Intersectoral coordination among sectors/clusters is pivotal to ensuring coherence in achieving common objectives, agreeing on joint approaches, avoiding duplication and ensuring areas of greatest need are prioritized.

This guidance will focus on clusters immediately relevant to HIV, namely:

- Health
- Protection
- Nutrition
- Food security

1. Resolution A/RES/70/1: Transforming our world: the 2030 Agenda for Sustainable Development; New York; September 2015.

2. UNAIDS, UNHCR and WFP (2019). Information Note: HIV in Humanitarian Emergencies

3. Spiegel PB. HIV/AIDS among conflict-affected and displaced populations: dispelling myths and taking action. *Disasters*. 2004 Sep;28(3):322-39.

4. UNAIDS considers gay men and other men who have sex with men, sex workers, transgender people, people who inject drugs and prisoners and other incarcerated people as the five main key population groups that are particularly vulnerable to HIV and frequently lack adequate access to services

Key considerations that affect the HIV response in humanitarian situations

- With increasing access to effective diagnosis, treatment and care, including for opportunistic infections, HIV infection has become a manageable chronic health condition, enabling people living with HIV to lead long and healthy lives
- PLHIV who take HIV medicine as prescribed and acquire and maintain an undetectable viral load, have effectively no risk of transmitting HIV to their HIV-negative sexual partners.
- Many more people affected by humanitarian emergencies are already on ART: the continuum of care has become central in the HIV response including in early phases of humanitarian response.
- Increased HIV vulnerability is often associated with legal and social factors, which increases exposure to risk situations and creates barriers to accessing effective, quality and affordable HIV prevention, testing and treatment services: these factors can emerge or be exacerbated in humanitarian situations
- National HIV responses are becoming more and more differentiated and targeted based on the national and subnational HIV epidemiology requiring consideration when designing a comprehensive HIV response
- There is greater integration of displaced populations into national HIV responses including Global Fund grants
- There is greater flexibility with Global Fund grants in the context of emergencies with possibilities for using grant savings, reprogramming or emergency grant applications to meet additional needs.
- There is a high HIV incidence among key populations in both concentrated and generalized epidemics: services for key populations need to be considered in all contexts including humanitarian settings
- More than half of those newly infected with HIV today are between 15 and 24 years old: HIV services need to be tailored for adolescents and young people.
- There is an increased emphasis on integration of HIV into reproductive health, viral hepatitis, and TB services.

Key actions for a Minimum Initial Response will be listed in each of the cluster briefs. These actions need to be carried out as soon as possible in the emergency phase to ensure the continuum of care, reduce the risk of transmission of HIV and to prepare for expanding to comprehensive services. Interventions that are part of the Comprehensive Response should begin as soon as the minimum response is in place and the situation allows for an expansion of programming

KEY MESSAGES:

- ⇒ Emergencies compound the impact of HIV by disrupting services that prevent new infections and ensure continuation of treatment and care for this already infected
- ⇒ Emergencies may increase vulnerabilities to HIV, with women and children disproportionately affected.
- ⇒ In Humanitarian settings, there is an increased risk of PLHIV to Opportunistic infections, including TB.
- ⇒ Malnutrition, food insecurity, poverty and protection concerns also exacerbate risks and vulnerabilities, particularly for young girls and women.
- ⇒ Continuing to treat and prevent new infections during humanitarian emergencies is both critical and possible.

NOTE: During emergencies, humanitarian workers are also at risk of HIV infection, and appropriate programming is required to address their HIV prevention, care and treatment needs.

Health

Safeguarding health standards is in keeping with the mission and vision of the Global Health Cluster, which seeks to “improve the health outcomes of affected populations through timely, predictable, appropriate and effective coordinated health actions.” It also supports the Sustainable Development Goal target 3.8 “Achieve universal coverage including financial risk protection, access to quality essential health care services, and access to safe, effective, quality and affordable essential medicines and vaccines for all”.

Failure to meet the health needs of populations affected by humanitarian emergencies, including those related to HIV, endangers lives and wellbeing, deprives them of the ability to exercise their rights and will hinder progress towards universal access and other SDG targets in affected countries.

Minimum HIV-related action should be ensured at the onset of an emergency regardless of HIV epidemiology or prevalence aiming to prevent new HIV infection and reduce morbidity and mortality due to HIV and other STIs.

Comprehensive HIV services should be established as soon as feasible and should be in line with the national HIV strategy including access to HIV counselling and rapid diagnostic testing, use of additional HIV diagnostic tests (such as PCR DNA), provision of ART in people newly diagnosed with HIV, access to sexual and reproductive health services, prevention of mother to child transmission and comprehensive services for key populations, including mental health and psychosocial support, amongst others. The Interagency Field Manual on Reproductive Health in Humanitarian Settings provides guidance on the Minimal Initial Service Package and transitioning to comprehensive services.⁵



5. Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings: <https://iawgfieldmanual.com/manual>



KEY ACTIONS FOR A MINIMUM INITIAL RESPONSE:



Ensure that HIV is integrated into the Health cluster response and that intersectoral coordination is in place

- ▶ Ensure that HIV is systematically incorporated into humanitarian assessments and the humanitarian need overview (HNO), regardless the HIV prevalence
- ▶ Inclusion of HIV considerations in cluster guidance and training packages
- ▶ Integrate HIV into humanitarian response plans to ensure adequate resources are planned and budgeted, including human resources
- ▶ Include relevant HIV related activities as in the Minimal Initial Services Package (MISP) into the initial package of essential healthcare services



Prevent HIV transmission in health care facilities

- ▶ Ensure standard precautions are followed within healthcare settings, including adequate medical waste management
- ▶ Guarantee blood safety in health facilities through selection of appropriate donors and screening of all blood products for HIV, Hepatitis B and C, and syphilis as a minimum with blood grouping and compatibility testing
- ▶ Coordinate with the national blood transfusion service (where it exists)
- ▶ Develop or adapt criteria for blood transfusion to minimise unnecessary transfusions



Maintain treatment and care for PLHIV including for opportunistic infections

- ▶ Support the provision of antiretrovirals (ARVs) to continue treatment for people who were enrolled in an anti-retroviral therapy (ART) programme prior to the emergency, including women who were enrolled in PMTCT
- ▶ Ensure procurement systems are in place to respond to urgent ARV supply needs: check that the pre-requisites for continuation of ART are in place (supply of drugs and trained clinicians as a minimum)
- ▶ Let community members know that continuation of treatment for people with chronic diseases, such as HIV and TB, is available. Use pre-existing community-based organisations of PLHIV to trace PLHIV and refer for continued treatment and care
- ▶ Include PLHIV in long lasting insecticide treated nets distribution (if not a blanket distribution) in areas where there is moderate to high malaria transmission
- ▶ Support the provision of co-trimoxazole prophylaxis for opportunistic infections for patients found to have HIV or already diagnosed with HIV
- ▶ For people with advanced HIV disease provide screening, treatment and prophylaxis for major opportunistic infections (such as TB and bacterial infections, and cryptococcal meningitis), rapid initiation of ART with intensified treatment adherence support



Ensure access to condoms and manage sexually transmitted infections (STIs)

- ▶ Procure and provide good quality male condoms, and where applicable (e.g., already used by the population) ensure provision of female condoms
- ▶ Consult community leaders and stakeholders in decisions about how to make condoms available in a socially and culturally acceptable way
- ▶ Distribute condoms with appropriate education HIV/STI material, with a focus on most vulnerable, and most-at-risk groups; make condoms and education material available in places where they can be easily accessed in privacy e.g. latrines in health facilities, bars etc
- ▶ Ensure the availability in health facilities of syndromic diagnosis and treatment of STIs



Provide PEP after occupational and non-occupational exposure to HIV

- ▶ Ensure that post-exposure prophylaxis (PEP) is part of the package of services offered to rape survivors (within 72 hours of exposure), and for occupational exposure to blood or other bodily fluids , as appropriate
- ▶ Provide other relevant post-rape care according to timing of presentation; in relation to HIV, survivors presenting after 72 hours can be referred for voluntary HIV counselling and testing services with subsequent follow-up



Prevent mother to child transmission

- ▶ Ensure clean and safe deliveries
- ▶ Accelerate access to ARV for HIV-positive pregnant and lactating women
- ▶ Provide appropriate treatment, care and support for infants, and work with nutrition cluster for including infant feeding counselling to mothers according to the national protocols and in line with WHO/UNICEF guidelines



Provide minimum package of health care and support to key populations

- ▶ Where injecting drug use (IDU) is known to occur provide harm reduction activities in line with national policies (needle syringe programming, peer support using already trained and identified peer counsellors/educators); oral substitution therapy (OST) for those already on OST in line with national guidance and mental health and psychosocial support)
- ▶ Ensure access to condoms, lubricant, syndromic management of STIs, continuation of ART for male, female and transgender sex workers, gay men and other men who have sex with men and persons who inject drugs
- ▶ Continue Pre-exposure prophylaxis (PreP) for those already on PreP
- ▶ Promote non-discriminatory access to primary health care and sexual and reproductive health services for key populations
- ▶ Where they already exist support peer networks to continue outreach and linkages to services for key populations
- ▶ Disseminate information about referral mechanisms for human rights violations against key populations including sexual and other violence
- ▶ Ensure linkages with Mental health and psychosocial support



Ensure that people living with, affected by or/and at risk of HIV have access to appropriate mental health and psychosocial support (MHPSS) to protect and promote psychosocial well-being, prevent or treat mental disorders

- ▶ Integrate MHPSS approach in all programmes and ensure that interventions foster the dignity and resilience of this vulnerable population
- ▶ Ensure that mental health care is functionally linked to and preferably integrated into HIV services, avoiding establishment of parallel mental health services

PROTECTION

The realisation of human rights is essential to addressing HIV as it impacts marginalized groups most severely. Furthermore, the spread of HIV exacerbates inequality and impedes the realization of a range of human rights. As such, the cluster response should ensure protection of the basic human rights of those most vulnerable to HIV and those most likely to suffer from stigma and discrimination due to their HIV status. In addition, it is crucial to ensure that strategies and programmes do not increase stigma, and are based on a human-rights based approach.

The Global Protection Cluster's vision is of "a world in which boys, girls, women and men affected or threatened by humanitarian crises are fully protected in accordance with their rights." International laws guarantees clear and objective protection rights and standards for children, PLHIV and key populations at higher risk of exposure to HIV.

These rights and obligations of States are clearly outlined in the following:

- International Covenant on Civil and Political Rights
- International Covenant on Social, Economic and Cultural Rights
- Convention on the Elimination of All Forms of Discrimination against Women
- Convention on the Rights of the Child
- Related regional human rights instruments
- Norms of customary international law

These are supported by the Declaration of Commitment on HIV/AIDS adopted by the United Nations General Assembly in 2001.

In keeping with the mission of the Global Protection Cluster (GPC) "to facilitate a more predictable, accountable and effective response to protection concerns in complex emergencies and disaster situations" it is vital to understand the context and anticipate the consequences of humanitarian actions that may affect the safety, dignity and rights of the affected population.

These include, but they are not limited to:

- Identify what are the protection threats, risks and vulnerabilities across the whole population, and specifically for PLHIV
- Assess if there is enough capacity amongst service providers, social workers, law enforcement officials, and community level workers to interact or work with PLHIV and with key populations in a respectful and non-discriminatory way
- Understand if there are obstacles preventing PLHIV from accessing assistance and protection and/or participation in consultation and decision-making processes
- Assess if there are punitive policies or laws that pose a protection risk e.g. mandatory reporting of HIV status, mandatory testing for HIV, denial of access to care and treatment for PLHIV.
- Contribute to the development of appropriate strategies to address these issues; ensure gender sensitive programming and promote gender equality; ensure that the needs, contributions and capacities of women and girls as well as men and boys are addressed;

UNHCR's Note on HIV and AIDS and the Protection of Refugees, IDPs and Other Persons of Concern⁶ outlines the fundamental rights relating to HIV and the potential rights violations that can be encountered, such as denial of the right to seek asylum, denial of right to return in safety and dignity and restrictions on freedom of movement for PLHIV and their families. In addition, UNHCR's statement on HIV Testing and Counselling examines the role of HIV testing and counselling in health facilities in increasing access to HIV prevention, treatment, care and support services for refugees, asylum-seekers, internally displaced persons (IDPs) and stateless persons. It also identifies specific issues regarding HIV testing amongst these populations and gives recommendations asserting that all HIV testing services should always adhere to the "Five Cs": informed Consent, Confidentiality, Counselling, Correct test results, and Connection or linkage to prevention, care and treatment

Below summarises key actions for ensuring the minimum initial protection response. In order to ensure a comprehensive protection response, it is necessary to mainstream a human-right-based approach into all responses and build local capacity of affected populations to claim their rights.

6. Note on HIV/AIDS and the Protection of Refugees, IDPs and other Persons of Concern: <https://www.unhcr.org/uk/444e20892.pdf>



KEY ACTIONS FOR ENSURING A MINIMUM INITIAL RESPONSE:



Integrate HIV into analysis and need assessments and monitor allegations of HIV-related human rights violations

- ▶ Conduct contextual analysis and localised assessments of risks
- ▶ Focusing on community level trends and patterns, actively monitor threats and allegations of HIV-related human rights violations such as violence against people living with HIV, denial of access to health, education, food and other support, segregation and violation of the right to privacy
- ▶ Monitor access, discrimination, and whether any services are being diverted for key vulnerable populations including male, female and transgender sex workers, gay men and other men who have sex with men, transgender and injecting drug users and their partners and families
- ▶ Coordinate and establish mechanisms to identify and refer PLHIV in a safe and ethical manner , in close collaboration with other clusters
- ▶ Ensure that protection cluster members and partners are aware of recurring protection challenges and that appropriate and relevant changes are made to the delivery of humanitarian assistance with regard to the violations
- ▶ Determine the capacity gaps at all levels—State, civil society and others—in protecting vulnerable populations, including people living with HIV



Ensure that HIV is integrated into the Protection Cluster response and considered as a factor that can lead to discrimination and other rights violations

- ▶ Ensure that HIV is systematically incorporated and mainstreamed into the protection component of humanitarian needs assessments, monitoring and response planning
- ▶ Inclusion of HIV in cluster guidance and training packages



Ensure that HIV is mainstreamed in the response of other clusters

- ▶ Engage and coordinate with other clusters to make sure that each cluster response meets minimum standards for protection of people living with and affected by HIV, using a human-rights-based approach
- ▶ Ensure that protection principles of equality and non-discrimination, accountability and the rule of law, participation and inclusion, and universality and indivisibility of rights, are incorporated into all programmes



Protect child-headed households, unaccompanied and separated children

- ▶ Register, support and oversee child-headed households, unaccompanied and separated children, including those living with HIV
- ▶ Take measures to undertake tracing and reunification of families
- ▶ Target child-headed households with support for basic needs including food support and other forms of assistance such as cash transfers



Protect people living with, affected by and at high risk of HIV against human rights violations

- ▶ Ensure that PLHIV and their families have access to appropriate services from trained and non-discriminatory service providers who use appropriate protocols, including confidential data collection and storage
- ▶ Work with health cluster to ensure that all HIV service provision, including testing takes place under the conditions of privacy, confidentiality and informed consent
- ▶ Advocate against mandatory HIV testing and discriminatory actions on the basis of HIV status such as denial of freedom of movement
- ▶ Respond to the protection threats by taking appropriate, community guided action including training and support for relevant community stakeholders to raise awareness on HIV, combat stigma and discrimination and promote human rights, including gender equality and universal access to prevention, treatment, care and support
- ▶ Learn from and build on community-level successes in responding to threats and, where appropriate, disseminate the strategies that the community (or a relevant segment of the community) has developed to protect itself
- ▶ Involve PLHIV in the design and implementation of programmes as well as decision making processes
- ▶ Address the specific economic, social, health and psychosocial needs of older persons and person with disabilities affected by HIV and AIDS
- ▶ Promote the right to access HIV and AIDS information, livelihood opportunities, social schemes, education and healthcare



Establish mechanisms to prevent and respond to Sexual and Gender-Based Violence (SGBV) disorders

- ▶ Initiate SGBV prevention and response programming from the start of an emergency, whether or not cases have been reported
- ▶ Coordinate with the health cluster to ensure that specific HIV prevention and response interventions are developed for survivors of rape, intimate partner violence and other forms of sexual violence
- ▶ Establish a clear and acceptable referral and reporting system that respects confidentiality and the rights of GBV survivors and ensure that these rights are known to the community
- ▶ Provide survivors of GBV appropriate care and support
- ▶ Work with other sectors to minimise GBV related risks such as ensuring lockable shelters, latrines and washrooms, adequate lighting in communal facilities and thoroughfares and other risk mitigation measures



Ensure mechanisms in place to prevent and respond to sexual exploitation and abuse (SEA)

- ▶ All humanitarian agencies and contractors are aware of and sign a code of conduct
- ▶ Ensure the affected population is aware of their entitlements and how to report attempts of exploitation and abuse
- ▶ Ensure service providers are aware of mandatory reporting requirements for SEA



Ensure that people living with, affected by or/and at risk of HIV have access to appropriate mental health and psychosocial support (MHPSS) to protect and promote psychosocial well-being, prevent or treat mental disorders

- ▶ Integrate MHPSS approach in all programmes and ensure that interventions foster the dignity and resilience of this vulnerable population
- ▶ Ensure that mental health care is functionally linked to and preferably integrated into HIV services, avoiding establishment of parallel mental health services

NUTRITION

It is increasingly recognised that HIV and malnutrition are closely interlinked, forming a vicious cycle. Energy and nutrient requirements are high for people living with HIV who are not on ART and virally suppressed, as well as those with opportunistic infections, such as TB⁸. Opportunistic illnesses frequently faced by people living with HIV, such as those affecting the gastro-intestinal tract, can reduce appetite and food intake or decrease nutrient absorption, which increase the risk of becoming malnourished. Side effects of ART such as nausea or vomiting can also affect appetite and food intake.

Several studies show⁹ that infants born to mothers living with HIV have poorer growth and higher morbidity and mortality than children who are born to mothers who are not infected with HIV. Furthermore, abnormalities in growth are common in children infected with HIV and children living with HIV/AIDS are at increased risk of malnutrition¹⁰.

Malnutrition also has an immensely negative effect on the well-being of PLHIV who have special dietary and nutritional needs. It may weaken the immune system even further, which increases susceptibility to infections, lowers quality of life and may increase progression of HIV to AIDS and mortality risk, particularly if viral suppression is not achieved and maintained. Malnourished PLHIV on antiretroviral therapy are more likely to die than PLHIV with adequate nutritional status¹¹. Mortality risk is particularly high during the first few months of treatment and is inversely proportional to BMI. Children living with HIV with severe acute malnutrition under nutritional treatment are almost three times more likely to die than their HIV-negative counterparts¹².

Therefore ensuring adequate nutrition support is essential to reducing these risks and contributing to breaking this cycle. This is particularly important in humanitarian contexts where, PLHIV and their households are more likely to be vulnerable and often less able to cope with additional shocks.

The Global Nutrition Cluster plays a key role in supporting the needs of PLHIV. With its vision to “safeguard and improve the nutritional status of emergency affected populations” and ability to help ensuring a coordinated and timely response, its work can help reduce the nutrition insecurity faced during periods of crisis, particularly for those most impacted by HIV.

A comprehensive nutrition response would involve scaling up the below interventions by strengthening involvement of communities and by assisting the government, when possible, in developing a long-term strategy for ensuring availability and accessibility of integrated and comprehensive nutrition support into the health system.



7. Energy requirements 10% asymptomatic and 20-30% in symptomatic, For children 30-50% more?

8. Morbidity and Mortality among Infants Born to HIV-Infected Women in South Africa: Implications for Child Health in Resource-Limited Settings. Kartik K. Venkatesh et al

9. Growth of young HIV-infected and HIV-exposed children in western Kenya: A retrospective chart review. Megan S et al.

10. 2014 Guidance note, Nutritional Assessment Counselling and Support for adolescents and adult living with HIV. WFP, PEPFAR, USAID and UNAIDS.

11. Fergusson P, Tomkins A. HIV prevalence and mortality among children undergoing treatment for severe acute malnutrition in Sub-Saharan Africa: a systematic review and meta-analysis



KEY ACTIONS FOR ENSURING A MINIMUM INITIAL RESPONSE:



Ensure that HIV is integrated into the Nutrition cluster/sector response

- ▶ Identify the nutrition needs of the most vulnerable population, including of people living with and affected by HIV
- ▶ Include HIV in the Nutrition Cluster agenda, including into cluster guidance and training packages
- ▶ Integrate HIV into the nutrition strategy of the humanitarian response plan to ensure adequate resource are in place to address nutrition needs of people living with and affected by HIV, including funding and human resources
- ▶ Coordinate with other clusters, in particular with the Health cluster to establish referral mechanisms between health and nutrition services as well as the Food Security cluster for integration of HIV into food and nutrition assessments



Define the best approach for reaching individuals, households and communities living with, affected by and/or at high risk of HIV

- ▶ In coordination with the food security cluster, consult with PLHIV and HIV affected families as well as with community-based organizations and identify the best distribution modalities for nutrition assistance (in-kind or cash/voucher) that is non-stigmatizing, preserving privacy and confidentiality
- ▶ Provide nutrition support in accessible sites, and prioritize integration and linkages between the provision of nutrition support and HIV services



Promote and establish appropriate feeding practices for infants, children and pregnant and lactating women living with and affected by HIV, including those on ART

- ▶ In line with national guidance, ensure that breastfeeding support and counselling services are provided to all mothers living with HIV to support exclusive breastfeeding for the first 6 months and breastfeeding for at least 12 months, and up to 24 months or longer while receiving anti-retroviral therapy¹³
- ▶ Ensure strict targeting and use, procurement, management and provision of breastmilk substitutes, based on needs and risks assessments. All breastmilk substitutes must comply with Codex Alimentarius and the Code which protect artificially fed babies
- ▶ Monitor infants of both breastfeeding and non-breastfeeding mothers living with HIV for growth, weight gain and infections
- ▶ In line with the cluster approach, in settings where HIV infection is common (HIV prevalence more than 1 percent) refer children with severe acute malnutrition with medical complications for HIV testing
- ▶ Provide acutely malnourished infants, children and pregnant and lactating women living with HIV with therapeutic feeding or supplementary feeding programmes and provide in-patient therapeutic care for severe acutely malnourished HIV-positive children with complications
- ▶ Refer children and PLW infected or affected by HIV to nutrition preventing programmes (e.g., supplementary feeding programme), when in place



Promote and establish appropriate nutrition response for adults and adolescents living with HIV, including those on ART

- ▶ Monitor nutritional status of HIV-positive adolescents and adults and provide counselling to maintain a healthy nutrition status
- ▶ In settings where HIV infection is common (HIV prevalence more than 1 percent) refer adults with acute malnutrition for HIV testing
- ▶ Establish therapeutic and supplementary feeding programmes for HIV-positive adults with acute malnutrition

12. If anti-retroviral drugs are not available, cluster partners in consultation with National or subnational health authorities should choose the strategy that gives infants the greatest chance of HIV-free survival, taking into account that displaced or humanitarian affected population may have greater difficulty in safely using or accessing breast milk substitutes.

FOOD SECURITY

Food security exists when all people have physical and economic access to sufficient, safe and nutritious food that meets their dietary needs and food preferences for an active and healthy life. In a humanitarian crisis, food security responses should aim to meet short-term needs and reduce the risk for the affected population to adopt potentially damaging coping strategies.

The vision of the Food Security Cluster is that the specific food security needs of individuals and communities affected by or at risk of being affected by humanitarian crises (whether sudden onset or protracted) are met.

Adherence to HIV treatment can be severely affected by lack of food: ART clients are often unable to continue their treatment because certain side effects are more likely when they don't have access to adequate food. A person who does not take their medication consistently is less likely to benefit fully from treatment and will not achieve satisfactory viral suppression thus increasing likelihood of both disease progression and transmission. Compounding this persons living with progressive HIV-related illnesses are no longer well enough to produce or earn the resources necessary to buy their food.

In humanitarian settings, in situations of food insecurity, people may turn to risky options to feed themselves and their families. Women and girls may be sell or exchange sex for cash or food. Selling sex not only exposes vulnerable women and girls to HIV infection but also places them at risk of gender-based violence.

Food assistance (in-kind or through cash-based transfer) and livelihood support benefit vulnerable groups who are food insecure, including people living with and affected by HIV. Such support can improve household food security and prevent households from needing to adopt potentially harmful coping mechanisms, including selling sex. In addition, it can help PLHIV to maintain or regain wellbeing as well as to access services, and adhere to treatment.

A minimum initial food assistance response is part of a life-saving, short-term response to improve households' food security. At the same time, livelihood support enables affected households to strengthen their livelihoods and provides a safety net for recovery. For a comprehensive food security response consider measures to support, protect, promote and restore food security in the medium to longer term in order to achieve higher coverage, which include economic strengthening as well as livelihood interventions.





KEY ACTIONS FOR ENSURING A MINIMUM INITIAL RESPONSE:



Ensure that HIV is integrated into the food security cluster response

- ▶ Integrate HIV into food security and vulnerability assessments to assess the level of food insecurity and the specific constraints and strategies of people living with and affected by HIV which can affect their food security
- ▶ Ensure that HIV is incorporated into the Food Security Cluster agenda, including into cluster guidance and training packages
- ▶ Integrate HIV into the food security strategy of the humanitarian response plan to ensure adequate resource are in place to address food security needs of people living with and affected by HIV, including funding and human resources.
- ▶ Coordinate and engage with other clusters, including with the nutrition cluster



Define the best approach for reaching people living with and affected by HIV with food assistance (in-kind or through cash-based transfers) and livelihood support

- ▶ Work with established community-based organization and institutions already involved with HIV to define appropriate food assistance and livelihood activities
- ▶ Ensure that the provision of food assistance and livelihood activities does not increase stigmatization for PLHIV and their families (e.g., avoid separating distribution sites or labelling differently the CBT/food transfers for PLHIV and their families)
- ▶ Revise the targeting criteria to ensure that vulnerable PLHIV and affected households are benefiting from the food assistance and livelihood support
- ▶ In coordination with the nutrition cluster, consider the special nutritional needs of people living with and affected by HIV in planning rations or transfer size of any food or cash-based intervention
- ▶ When in kind assistance is provided, distribution sites should be chosen carefully, considering walking distance, terrain and the practicalities of transporting for vulnerable population, including PLHIV
- ▶ Allow for an alternative person if the principal recipient is sick or otherwise unable to receive rations/ participate in livelihood activities on behalf of the household
- ▶ Channel food assistance (as appropriate to the local context) through programmes such as, home-based services, antiretroviral treatment, or programmes that provide care and support to orphans and vulnerable children (OVC)
- ▶ Promoting alternative livelihood activities compatible with the constraints faced by people living with and affected by HIV and alleviating discrimination (e.g., introduction of less labour-intense income generating activities)



Distribute food aid to people, households and communities infected with and affected by HIV

- ▶ Provide PLHIV and their families with in-kind and/or cash-based interventions (cash or voucher) to ensure that immediate needs are met
- ▶ In settings where HIV infection is common (HIV prevalence more than 1 percent), design a general food ration that meets the need of PLHIV, example milling and fortifying foods, or including fortified or specialised nutritious foods in the food basket. In some situations, it may be appropriate to increase the overall size of any food ration





Main Source

- 2018 Inter-Agency Field Manual on Reproductive health in Humanitarian Settings (IAFM): <https://iawgfieldmanual.com/>
- SPHERE Handbook, 2018: <https://www.spherestandards.org/handbook-2018/>
- Guidelines for Integrating Gender-Based Violence Interventions in Humanitarian Action: Reducing risk, promoting resilience and aiding recovery (2015) https://gbvguidelines.org/wp/wp-content/uploads/2015/09/2015-IASC-Gender-based-Violence-Guidelines_lo-res.pdf
- UNHCR. Note on HIV/AIDS and the Protection of Refugees, IDPs and Other Persons of Concern: <http://www.unhcr.org/publ/PUBL/444e20892.pdf>
- WHO and UNICEF. HIV and infant feeding in emergencies: operational guidance (2018). <https://www.who.int/nutrition/publications/hiv aids/hiv-if-emergencies-guidance/en/>

