



Inter-Agency Task Team  
to Address HIV  
in Humanitarian Emergencies

Interagency Task Team HIV in Humanitarian Emergencies  
**PMTCT IN HUMANITARIAN SETTINGS**

**Part II: Implementation Guide**





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## Interagency Task Team HIV in Humanitarian Emergencies **PMTCT IN HUMANITARIAN SETTINGS**

### **Part II: Implementation Guide**



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## CONTENTS

<b>ACRONYMS</b> .....	<b>vi</b>
<b>INTRODUCTION</b> .....	<b>1</b>
<b>SECTION 1: PREPAREDNESS AND CONTINGENCY PLANNING IN PMTCT PROGRAMMES</b> .....	<b>4</b>
1.1 Purpose of contingency planning .....	4
1.2 Developing and using contingency plans .....	4
1.3 Key preparedness actions .....	7
Issue 1. Disruption of regular drug supply .....	7
Issue 2. Population displacement .....	7
Issue 3. Disrupted treatment access .....	8
Issue 4. Patient tracing and information provision .....	8
Issue 5. Staff reduction .....	9
Issue 6. Access .....	9
<b>SECTION 2: KEY ACTIONS FOR PMTCT INCLUSION IN HUMANITARIAN SETTINGS</b> .....	<b>11</b>
2.1 Provide leadership .....	11
2.2 Involve HIV actors and humanitarian actors in implementation .....	13
2.3 Ensure funding for PMTCT in humanitarian response .....	13
2.4 Ensure arv and commodities supply .....	14
<b>SECTION 3: CRITERIA FOR PMTCT INCLUSION AND PRIORITY SETTING</b> .....	<b>15</b>
3.1 Criteria for inclusion of PMTCT in humanitarian response .....	15
3.2 Priority setting for PMTCT response in humanitarian settings .....	15
<b>SECTION 4: ENSURING CONTINUOUS ACCESS TO ARVS FOR PMTCT AT OUTSET OF EMERGENCY</b> .....	<b>17</b>
4.1 Adapt service delivery .....	17
4.2 Inform patients where to access ARVs .....	19
4.3 Set up ARV dispensing during acute emergency .....	21
<b>SECTION 5: INTEGRATING EXPANDED PMTCT RESPONSE INCLUDING INITIATION OF ART FOR PMTCT</b> .....	<b>22</b>
5.1 Set up of service delivery .....	24
5.2 Initiating expanded PMTCT response including ART for PMTCT .....	24
5.3 Challenges .....	25
5.4 PMTCT integration in humanitarian settings with weak health systems .....	25
5.5 Integration of services .....	27
<b>SECTION 6: MONITORING OF PATIENT COHORTS IN HUMANITARIAN SETTINGS</b> .....	<b>29</b>
<b>SECTION 7: RESOURCES</b> .....	<b>30</b>
<b>SECTION 8: REFERENCES</b> .....	<b>32</b>

## Acronyms

ANC	Antenatal care	MSF	Médecins sans Frontières
ART	Antiretroviral treatment	NGO	Nongovernmental organization
ARV	Antiretroviral (drug)	NVP	Nevirapine
AZT	Zidovudine	PEPFAR	US President's Emergency Plan for AIDS Relief
CHW	Community health worker	PLHIV	People Living with HIV
ECHO	European Commission Humanitarian Office	PMTCT	Prevention of mother-to-child transmission
FBO	Faith-based organization	WHO	World Health Organization
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria	UN	United Nations
HIV	Human immunodeficiency virus	UNAIDS	Joint United Nations Programme on HIV/AIDS
HTC	HIV testing and counselling	UNHCR	United Nations High Commissioner for Refugees
IASC	Inter-Agency Standing Committee	UNICEF	United Nations Children's Fund
ICAP	International Center for AIDS Care and Treatment Program	UNOCHA	United Nations Office for the Coordination of Humanitarian Affairs
IDP	Internally displaced person		
MNCH	Maternal, newborn and child health		

# INTRODUCTION

## Purpose of the guide

This guide is a compilation of recommendations to help improve the implementation of prevention of mother-to-child transmission (PMTCT) services in humanitarian settings. This guide focuses on PMTCT health service delivery and specifically on continuation or where possible initiation of ART during the PMTCT risk period or for life. The social and economic barriers preventing women from accessing PMTCT services and adhering to care and treatment in these settings and strategies to overcome these barriers are not addressed.

The recommendations focus on antiretroviral-based PMTCT interventions. They do not cover all aspects of PMTCT programming but are intended to complement other guidelines and resources including *the 2014 Guidelines for the Delivery of Antiretroviral Therapy to Migrants and Crisis-Affected Populations in Sub-Saharan Africa*, *the 2013 WHO Consolidated Guidelines on the Use of Antiretroviral Drugs for Treating and Preventing HIV Infection* and *the 2009 IASC Guidelines on addressing HIV in humanitarian settings*.<sup>1,2</sup> See *Section 8 for additional resources*.

This guide is based on a review of lessons learned from PMTCT programmes in humanitarian settings. *PMTCT in Humanitarian Settings – Part I: Lessons Learned and Recommendations*, a synthesis of the review, is available as a complementary resource providing more evidence for policy development and advocacy as well as practice examples.

## Audience

This guide is for HIV programme managers, programme officers and PMTCT programme implementers involved in the development of emergency preparedness, contingency planning and PMTCT service delivery in risk-prone, emergency-affected and fragile settings.



## Importance of PMTCT in humanitarian settings

Humanitarian crises be they natural disasters, armed conflicts or civil disturbances create many challenges for PMTCT programmes. Often leading to displacement of populations these crises can severely hamper health service delivery including in stable countries.<sup>3,4,5</sup> Patients may be unable to access their health facility. PMTCT services may become disrupted. Reasons include: problems with the antiretroviral drug (ARV) supply chain, health workers having left and/or the facility destroyed by natural disaster or looting.

Patients who are already on antiretroviral treatment (ART) for PMTCT are at risk of treatment interruption. Pregnant and breastfeeding women recently diagnosed with HIV are also at risk of not being able to enrol in a PMTCT programme. Experience from past humanitarian crises shows that treatment interruptions can be considerable when no preparedness measures and contingency plans are in place.<sup>6,7,8</sup> Treatment interruptions risk antiretroviral resistance and compromise the efficacy of ART for the individual as well as for PMTCT.<sup>9,10</sup> Prevention of interruption is key. Continuous access to HIV testing and counselling (HTC), initiation of ART for PMTCT, paediatric ARVs and cotrimoxazole prophylaxis are critical.





### What do we understand by humanitarian crisis contexts?

Humanitarian crisis contexts comprise various scenarios. They include predictable or unpredictable sudden onset or slow onset natural disasters, armed conflict or civil disturbance. These may result in complex emergencies affecting a large geographical area or remain localised and can be recurrent in chronically fragile and post-conflict settings. The contexts may differ depending on the crisis but they all pose a critical threat to the health, safety and security of a large group of people. Often they lead to displacement of populations and severely affect health services delivery.

### Potential negative impact of humanitarian crisis on PMTCT programmes

- Disruption of access to functional PMTCT services.
- Limited access to broader sexual and reproductive health services, in particular family planning.
- Treatment interruption, which contributes to loss of efficacy of treatment and risk of antiretroviral resistance.
- No access to ART for PMTCT, which may contribute to increases in new paediatric HIV infections.

## The Guide

The guide for humanitarian settings is divided into seven main sections.

- SECTION 1:** PREPAREDNESS AND CONTINGENCY PLANNING IN PMTCT PROGRAMMES
- SECTION 2:** KEYS ACTIONS TO ENSURE PMTCT INCLUSION
- SECTION 3:** CRITERIA FOR PMTCT INCLUSION AND PRIORITY SETTING
- SECTION 4:** ENSURING CONTINUOUS ACCESS TO ARVS AT OUTSET OF EMERGENCIES
- SECTION 5:** INTEGRATING EXPANDED PMTCT RESPONSE INCLUDING INITIATION OF ART FOR PMTCT
- SECTION 6:** MONITORING OF PATIENT COHORTS
- SECTION 7:** RESOURCE DOCUMENTS

## PMTCT protocols

The PMTCT protocols refer to those recommended in the 2013 World Health Organization (WHO) guidelines outlined below. They comprise: 1) lifelong ART for *all* pregnant and breastfeeding women living with HIV (option B+) or 2) lifelong ART for *eligible* pregnant and breastfeeding women living with HIV and for non-eligible women stopping ART after cessation of breastfeeding (Option B). Option A is no longer recommended.<sup>1</sup>

### OPTIONS FOR ART FOR PMTCT, 2013 WHO CONSOLIDATED ARV GUIDELINES<sup>11</sup>

NATIONAL PMTCT PROGRAMME OPTION	PREGNANT AND BREASTFEEDING WOMEN WITH HIV		HIV-EXPOSED INFANT	
	Eligible for treatment	Not eligible for treatment	Breastfeeding	Replacement feeding
Use lifelong ART for all pregnant and breastfeeding women ("Option B+")	Regardless of WHO clinical stage or CD4 cell count		6 weeks of infant prophylaxis with once-daily NVP	4–6 weeks of infant prophylaxis with once-daily NVP  (or twice-daily AZT)
	Initiate ART and maintain on treatment after delivery and cessation of breastfeeding			
Use lifelong ART only for pregnant and breastfeeding women eligible for treatment ("Option B")	Initiate ART and maintain after delivery and cessation of breastfeeding	Initiate ART and stop after delivery and cessation of breastfeeding		

<sup>1</sup> The WHO 2013 Consolidated ARV guidelines recommend countries currently implementing Option A based on the 2010 guidelines transition with appropriate planning to Option B or B+ and B+ in high prevalence settings.

# SECTION 1

## PREPAREDNESS AND CONTINGENCY PLANNING IN PMTCT PROGRAMMES

### 1.1 Purpose of contingency planning

Experience shows HIV service disruption and ARV treatment interruptions can be considerable in humanitarian crises when no preparedness measures and contingency plans are in place. Incorporating risk analysis, preparedness and contingency planning for alternative modes of service delivery can help mitigate the impact of crisis on PMTCT/HIV treatment programmes and prevent individual treatment interruptions.

### 1.2 Developing and using contingency plans

Plan to undertake contingency planning at all levels involving relevant stakeholders before a disaster occurs.

- ▶ **Undertake contingency planning for emergency preparedness preferably at all levels:** 1) national programme; 2) supporting agency or nongovernmental organization (NGO); 3) health facility; 4) community; and 5) individual patient.
- ▶ **Involve all relevant stakeholders**, including organizations of people living with HIV (PLHIV) to allow optimal planning for a coordinated response. The level of programme planning determines who is involved and includes: national health authorities, HIV development actors, donors, humanitarian actors, health workers involved in PMTCT delivery, representatives of organizations/support groups of PLHIV, national NGOs and faith-based organizations (FBOs) working in HIV. Contingency planning at the health facility and patient level is the minimum required when contingency planning at the national level is not possible.
- ▶ **Ensure contingency plans for HIV and PMTCT are incorporated in two ways:**
  1. When national/regional disaster preparedness and response planning mechanisms are in place: HIV in general and PMTCT/ART in particular should be incorporated.
  2. National HIV plans should include contingency planning for emergencies.

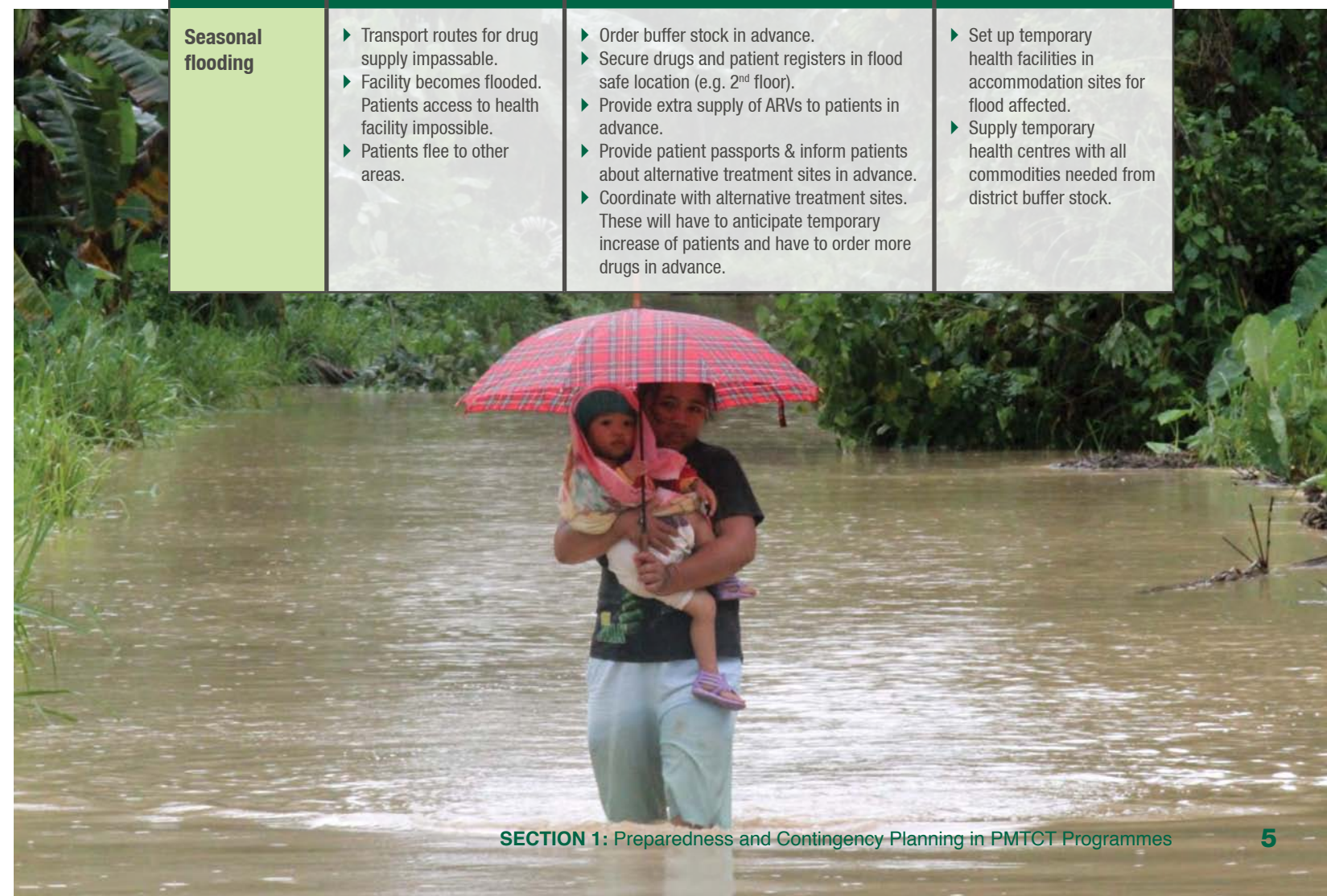
Dedicated working groups can develop specific sub-sections of these plans.

Analyse risks, identify preparedness measures and alternative service delivery methods

1. **Risk analysis is the first step in contingency planning.** Knowing the risks to PMTCT service disruption can help to analyse how an emergency could affect programmes. This will help to design and prepare programmes to reduce the risk of service disruption. The information is generally available at programme/country level. Regional risk analysis should be incorporated where relevant, for example, in preparation for a potential refugee influx from neighbouring countries.
2. **The second step is to identify additional preparedness measures for anticipated periods of increased risk** (e.g. increased insecurity or prior to flooding season) to minimise the risk of service disruption and individual treatment interruption. Actions include: pre-positioning ARV buffer stocks in health facilities at risk and providing extra ARV supplies to patients.
3. **The third step is to develop a plan with pre-identified alternative service delivery methods and supply mechanisms adapted to the emergency situation.** See example for a contingency planning matrix below.

**MATRIX FOR CONTINGENCY PLANNING: EXAMPLE OF SEASONAL FLOODING. THIS IS FOR GUIDANCE ONLY AND IS NOT A COMPREHENSIVE TABLE.**

RISK	IMPACT OF RISK	PREPAREDNESS	ALTERNATIVE SERVICE DELIVERY METHODS
Seasonal flooding	<ul style="list-style-type: none"> <li>▶ Transport routes for drug supply impassable.</li> <li>▶ Facility becomes flooded. Patients access to health facility impossible.</li> <li>▶ Patients flee to other areas.</li> </ul>	<ul style="list-style-type: none"> <li>▶ Order buffer stock in advance.</li> <li>▶ Secure drugs and patient registers in flood safe location (e.g. 2<sup>nd</sup> floor).</li> <li>▶ Provide extra supply of ARVs to patients in advance.</li> <li>▶ Provide patient passports &amp; inform patients about alternative treatment sites in advance.</li> <li>▶ Coordinate with alternative treatment sites. These will have to anticipate temporary increase of patients and have to order more drugs in advance.</li> </ul>	<ul style="list-style-type: none"> <li>▶ Set up temporary health facilities in accommodation sites for flood affected.</li> <li>▶ Supply temporary health centres with all commodities needed from district buffer stock.</li> </ul>



Compile contingency plan, disseminate document and assign roles and responsibilities

Monitor risks, trigger actions, revise and adapt contingency plan as needed

- ▶ Once the contingency plan is developed, regularly monitoring risks and updating the plan accordingly is important to keeping it current.
- ▶ Put a person or team in charge, to regularly monitor risks to decide when to activate which level of the plan. This is very important because an existing contingency plan may be overlooked after long periods of low risk. The person or team responsible for monitoring the risks should include someone responsible for HIV programming. People working on HIV need to know how to use this information for better programming.
- ▶ Hold meetings with all relevant stakeholders involved in contingency planning (preferably on a regular basis) for plan sensitization and coordination.

#### EXAMPLE OF ALERT LEVELS AND ACTIONS OF EMERGENCY PREPAREDNESS PLAN

ALERT LEVEL	ACTION
Stable situation /no anticipated risk	Normal activity
Localised risk of disrupted access in part of catchment area	<p><b>To patients who come from areas with potential barriers to access:</b></p> <ul style="list-style-type: none"> <li>▶ Provide extra supply of ARVs at least until one month after expected date of delivery (for three months in case of Option B in breast feeding period) plus nevirapine syrup for the infant.</li> <li>▶ Inform and educate patient about treatment protocol and alternative treatment sites including written protocol with explanation in local language.</li> </ul>
Risk of disrupted access in total catchment area	<p><b>To all patients:</b></p> <ul style="list-style-type: none"> <li>▶ Provide extra supply of ARVs and information package as for level 2.</li> <li>▶ Redistribute tasks to prepare for partial evacuation of staff.</li> </ul>
Acute emergency	<p><b>To all patients:</b></p> <ul style="list-style-type: none"> <li>▶ In case facility stays open dispense extra ARVs and information package as for level 2.</li> </ul>

### 1.3 Key preparedness actions



ISSUE	ACTION	DETAILS	COMPLETED
<b>ISSUE 1:</b> The potential disruption of the regular drug supply system and/or increase in quantities needed because of population displacement.	<b>Pre-position buffer stocks</b>	Place larger national order of ARVs and other commodities well in advance of predictable emergencies to allow for extra supply of patient held ARVs and facility buffer stocks. This can be done without increasing the yearly drug budget.	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A
		Prior to predictable emergencies pre-position greater quantities of commodities in areas/facilities at risk of being cut off from regular supply.	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A
		When buffer stocks cannot be organized through the national supply systems implementing partners can procure their own buffer stocks when feasible. (The quantity of buffer stocks depends on the assessment of disruption to the supply system and the potential influx of additional new patients).	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A
		Ensure that buffer stock expiry dates are three months minimum and manage stocks adequately to avoid expiration.	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A
		Secure buffer stocks against risk of flooding (e.g. by high-level storage) or looting (distribute smaller amounts to different storage places).	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A
<b>ISSUE 2:</b> Insecurity may lead to population displacement or stop patients from getting safely to the health facility.	<b>Patient held extra supply of ARVs</b>	Provide patients with an emergency bag of 2–3 months extra supply of ARVs.	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A
		For pregnant women on PMTCT treatment, provide ARVs for at least up to one month after the expected delivery date plus nevirapine syrup for the infant; where feasible provide ARVs for the mother for more than 1 month after delivery.	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A

continued ►

ISSUE	ACTION	DETAILS	COMPLETED
<b>ISSUE 3:</b> Risk of disrupted access to treatment.	<b>Patient education and patient passports</b>	Explain the importance of carrying extra ARVs in case they have to flee from their home.	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A
		Explain how to administer the nevirapine syrup to the infant and provide written explanation in local language/ with pictorials for illiterate patients.	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A
		Provide patient passports* for PMTCT, ART and HIV–exposed infants containing information about current treatment and essential history.  <i>*Experience has shown that patients often forget them in an emergency. However, it is good practice to provide them routinely to all enrolled patients letting them know why it is important to always carry them.</i>	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A
		Stress the importance of adherence to ART/PMTCT even in the event of crisis.	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A
		If provision of patient passports is not feasible at national level prior to a period of risk, provide temporary patient passports at facility level.	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A
		Share health workers' contact numbers and names and locations of alternative ARV sites.	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A
		Use mentor mothers or other peer counsellors in this process.	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A
<b>ISSUE 4:</b> Patient tracing and information provision due to displacement and disruption of services.	<b>Establish patient tracing including through communication networks</b>	Establish, regularly update and share list of relevant contacts: <ul style="list-style-type: none"> <li>▶ Patient phone numbers for tracing.</li> <li>▶ Other treatment sites in the area to prepare exchange of information about accessibility and referral of patients in times of crisis.</li> <li>▶ Relevant national and international health actors for organizing supplies and/or alternative service delivery methods.</li> <li>▶ Networks and support groups of PLHIV, community leaders for information on location of the displaced, accessibility, security constraints etc. to organize alternative service delivery methods.</li> </ul>	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A

continued ►

ISSUE	ACTION	DETAILS	COMPLETED
<b>ISSUE 5:</b> Staff reduction because of a crisis may hinder continued service provision.	<b>Organize multi-skilled staff (including task shifting and task sharing)</b>	Ensure that a maximum number of health workers in each facility are trained in PMTCT instead of only one or two prescribers.	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A
		Integrate CHWs, mentor mothers, peer counsellors from the community in the PMTCT team and train them in adherence and infant feeding counselling and ARV dispensing.	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A
		Specify in the contingency plan which tasks will be delegated to whom in case of staff reduction in an emergency situation. Where community-based ARV groups exist prepare leaders who are ready to get involved in community ARV dispensing during emergencies.	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A
<b>ISSUE 6:</b> Access.		Decentralize PMTCT services (HTC including ARV dispensing) to the primary health care level if possible.	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A
		Consider introducing advanced decentralization with community-based ARV dispensing through expert patients.	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A





## Preparedness Actions

### Patient held extra supply of ARVs

- ▶ Provide patients with an emergency bag of 2-3 months extra supply of ARVs.
- ▶ For pregnant women on PMTCT treatment provide ARVs for at least up to one month after the expected date of delivery plus nevirapine syrup for the infant where/if feasible.

### Patient education & patient passports

- ▶ Explain the importance of carrying extra ARVs in case they have to flee from their home.
- ▶ Explain how to administer the nevirapine syrup to the infant and provide written explanation in local language / with pictorials for illiterate patients.
- ▶ Provide patient passports for PMTCT, ART and HIV-exposed infants.
- ▶ Stress the importance of adherence to ART/PMTCT even in the event of crisis.
- ▶ If provision of patient passports is not feasible at national level prior to a period of risk provide temporary patient passports at facility level.
- ▶ Share health workers' contact numbers and names and locations of alternative ARV sites.
- ▶ Mentor mothers or other peer counsellors can play an active role in this process.

### Pre-positioning buffer stocks

- ▶ Place larger national order of ARVs and other commodities well in advance of predictable emergencies to allow for extra supply of patient held ARVs and facility buffer stocks. This can be done without increasing the yearly drug budget.
- ▶ Prior to predictable emergencies pre-position greater quantities of commodities in areas/facilities at risk of being cut off from regular supply.
- ▶ When buffer stocks cannot be organized through the national supply systems implementing partners can procure own buffer stocks when feasible.
- ▶ The quantity of buffer stocks depends on the assessment of disruption to the supply system and the potential influx of additional new patients.
- ▶ Ensure that buffer stock expiry dates are three months minimum and manage stocks adequately to avoid expiration.
- ▶ Secure buffer stocks against risk of flooding (e.g. by high-level storage) or looting (distribute smaller amounts to different storage places).

### Communication networks

Establish, regularly update and share list of relevant contacts:

- ▶ Patient phone numbers for tracing.
- ▶ Other treatment sites in the area to prepare exchange of information about accessibility and referral of patients in times of crisis.
- ▶ Relevant national and international health actors for organizing supplies and/or alternative service delivery methods.
- ▶ Networks and support groups of people living with HIV, community leaders for information on location of the displaced, accessibility, security constraints etc. to organize alternative service delivery methods.

### Multi-skilled staff (including task shifting)

- ▶ Ensure that a maximum number of health workers in each facility are trained in PMTCT instead of only one or two prescribers.
- ▶ Integrate CHWs, mentor mothers, peer counsellors from the community in the PMTCT team and train them in adherence and infant feeding counselling and ARV dispensing.
- ▶ Specify in the contingency plan which tasks will be delegated to whom in case of staff reduction in an emergency situation. Where community-based ARV groups exist prepare leaders who are ready to get involved in community ARV dispensing during emergencies.

### Decentralization

- ▶ Decentralize PMTCT services (HTC including ARV dispensing) to the primary health care level if possible.
- ▶ Consider introducing advanced decentralization with community-based ARV dispensing through expert patients.

## SECTION 2

### KEY ACTIONS FOR PMTCT INCLUSION IN HUMANITARIAN SETTINGS

#### 2.1 Providing leadership

Leadership is needed to ensure HIV in general and PMTCT and ART in particular are integrated into the emergency response from the start. Advocacy with government, donors, national, international humanitarian and development HIV actors is needed at the international, country/emergency levels together with action on the ground to support timely, effective and well-coordinated integration of PMTCT and ART during a humanitarian crisis.

#### Key advocacy messages for PMTCT inclusion in humanitarian settings

- ▶ Restoring immediate access to ARVs and (re)-establishing access to ART for PMTCT is life-saving because uninterrupted ART for PMTCT:
  - ▶ prevents children becoming HIV positive;
  - ▶ prevents HIV positive mothers' health deteriorating because of treatment interruption;
  - ▶ prevents long-term treatment failure because of antiretroviral drug resistance as a result of treatment interruption; and
  - ▶ reduces risk of transmission of HIV to sexual partner of mother.
- ▶ Including PMTCT actions in humanitarian settings is feasible as long as ARVs and commodities and the necessary funding are made available.



KEY ACTIONS TO ENSURE PMTCT IS ADDRESSED IN HUMANITARIAN RESPONSE		
ACTION	DETAILS	COMPLETED
<b>Advocate</b>	with government, donors, national and international humanitarian actors and development HIV actors at international, national/emergency level for the inclusion of PMTCT in the humanitarian response. Estimation of the magnitude of need may be helpful.	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A
<b>Incorporate HIV in national disaster contingency plans.</b>		<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A
<b>Integrate PMTCT/ART together with other HIV priorities in humanitarian assessments.</b>	See UNHCR/UNAIDS: <i>HIV-related Needs in Internally Displaced Persons and Other Conflict-affected Populations: A Rapid Situation Assessment Tool</i> . < <a href="http://www.unhcr.org/477cd4762.pdf">www.unhcr.org/477cd4762.pdf</a> >	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A
<b>Put PMTCT with other HIV priorities on health cluster/health coordination meeting agendas.</b>		<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A
<b>Consider creation of HIV sub-cluster (under health).</b>	depending on the nature of the epidemic in the affected population and appoint an <b>HIV focal person</b> to lead coordination of HIV response.	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A
<b>Coordinate PMTCT/ART response.</b>	Map functional HIV prevention, care, treatment & support services.	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A
	Map other health service providers that could include PMTC ART actions.	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A
	Share information of HIV assessment and mapping with health cluster/HIV sub-cluster.	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A
	Mobilise humanitarian/HIV development NGOs to support implementation.	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A
	Organize regular meetings to coordinate who is doing what, where, when to ensure good coverage for all programme components.	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A
	Prioritise access to ARVs for those on ART for PMTCT before crisis.	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A
	Restore/establish access to expanded PMTCT services with initiation of ART for PMTCT as soon as situation allows.	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A
	Share relevant information, e.g. where to order ARVs and other commodities, tools e.g. for data collection, guidance for implementation etc. with health services providers inexperienced with PMTCT programmes.	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A
	If relevant, support organization of rapid ARV supply ( <i>see Section 3.1</i> ).	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A
If relevant, support mobilisation of funding for rapid response ( <i>see Section 3.4</i> ).	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A	

## 2.2 Involving HIV actors and humanitarian actors in implementation

A strong government-led HIV programme together with established HIV development actors can provide a timely and effective response to disrupted access to HIV treatment/PMTCT in humanitarian settings. In complex emergencies and large-scale natural disasters disruption of HIV services and treatment interruption can be particularly devastating where health systems and HIV treatment and PMTCT programmes were weak before the crisis.

KEY ACTIONS	
ACTION	COMPLETED
<b>Mobilise HIV actors present in country to engage in implementation of PMTCT in humanitarian response by quickly redirecting their activities.</b>	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A
<b>In complex emergencies or large-scale natural disasters humanitarian actors need to make a timely shift to direct implementation support to assure essential service delivery.</b>	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A

## 2.3 Ensuring funding for PMTCT in humanitarian response

Funding constraints are often a barrier to including PMTCT when responding to an acute crisis.

KEY ACTIONS TO ENSURE PMTCT IS ADDRESSED IN HUMANITARIAN RESPONSE		
ACTION	DETAILS	COMPLETED
<b>Integrate emergency preparedness (systems preparedness, contingency planning) in HIV development grants in line with their provisions e.g. to PEPFAR and GFATM.</b>	The Global Fund (GFATM) Operations Policy Manual ( <i>see Resources</i> ) refers to humanitarian emergencies as a reason for reprogramming. Reprogramming is possible at any time when requested by the principal recipient or country coordinating mechanism. The HIV community can advocate for it. If the principal recipient is incapacitated or a totally new approach is required, the GFATM can provide partner assistance to implement the reprogramming.	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A
<b>In case of acute country supply shortages during emergencies approach PEPFAR or other partners to access their emergency procurement fund. The option of GFATM, UNICEF and ECHO can also be explored.</b>	The GFATM has developed a new emergency response funding mechanism for countries where reprogramming is not an option, no other funding source is accessible and they are experiencing UN or WHO level 2 or 3 classified emergency.	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A
<b>Re-programme on-going HIV/PMTCT grants to finance emergency response activities. The GFATM and PEPFAR explicitly foresee this possibility.</b>		<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A
<b>Include PMTCT actions in humanitarian funding proposals until longer-term development funding can be accessed for protracted crisis/recovery/chronic fragile settings.</b>	ECHO for example, considers funding PMTCT under certain conditions. Continuation of therapy for already enrolled women would be considered a priority. ECHO is less favourable to funding the establishment of a comprehensive PMTCT programme but can provide funding for medicines. ECHO can provide finances in the short-term until longer-term financing is found. ( <i>see Resources</i> )	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A

KEY ACTIONS TO ENSURE PMTCT IS ADDRESSED IN HUMANITARIAN RESPONSE		
ACTION	DETAILS	COMPLETED
Humanitarian and development NGOs can use accessible private funds to integrate PMTCT/ART actions in their emergency response.		<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A
Additional funding and support for the HIV response (i.e. as was done in the Central African Republic with the Global Fund, UNHCR and IFRC).		<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A

## 2.4 Ensure ARV and commodities supply

PMTCT inclusion necessitates a stable supply of ARVs and other commodities. Existing and new ARV dispensing facilities in all settings, including IDP camps, refugee camps or in chronically fragile settings need drug supplies.

KEY ACTIONS TO ADDRESS ARV SUPPLY ISSUES		
ACTION	DETAILS	COMPLETED
Pre-position buffer stocks.	in health facilities or regional medical stores prior to predictable emergencies (See Section 1.3 on preparedness).	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A
Provide transport support.	(UN agencies, implementing NGOs) when the order and supply chain mechanism is disrupted.	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A
Assess need and redistribute drugs.	among facilities/districts in case of localised shortage.	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A
Access ARVs for temporary health facilities from the national system.	This is often possible in countries with pre-existing PMTCT systems.	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A
Use HIV implementing NGOs/agencies buffer stocks.	These are procured with their own means as back-up to prevent stock-outs and to facilitate immediate ARV dispensing in new emergency programmes.	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A
Procure ARVs and commodities.	<ul style="list-style-type: none"> <li>▶ When national drug stocks are destroyed approach HIV donors, e.g. PEPFAR, GFATM to help with emergency procurement and shipment using reprogrammed funds or emergency procurement funds.</li> <li>▶ When national supplies cannot be accessed for the emergency-affected population because of limited national funding, request it in emergency proposals.</li> </ul>	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A

# SECTION 3

## CRITERIA FOR PMTCT INCLUSION AND PRIORITY SETTING

### 3.1 Criteria for inclusion of PMTCT in humanitarian response

Including ARV-based PMTCT actions in the humanitarian health sector response will depend upon the HIV prevalence and risk exposure of the affected population. The evaluation needs to take into account that HIV prevalence in a displaced population may differ from that of the host community. PMTCT needs to be included in contexts with a generalised HIV epidemic. See table below.



HIV EPIDEMIC	PMTCT INCLUSION IN HUMANITARIAN RESPONSE
Generalised HIV epidemic <sup>2</sup>	▶ Include PMTCT
Low-level or concentrated HIV epidemics	<ul style="list-style-type: none"> <li>▶ No general inclusion of PMTCT</li> <li>▶ Where feasible, test and refer HIV positive pregnant women to available PMTCT services in the region</li> </ul>

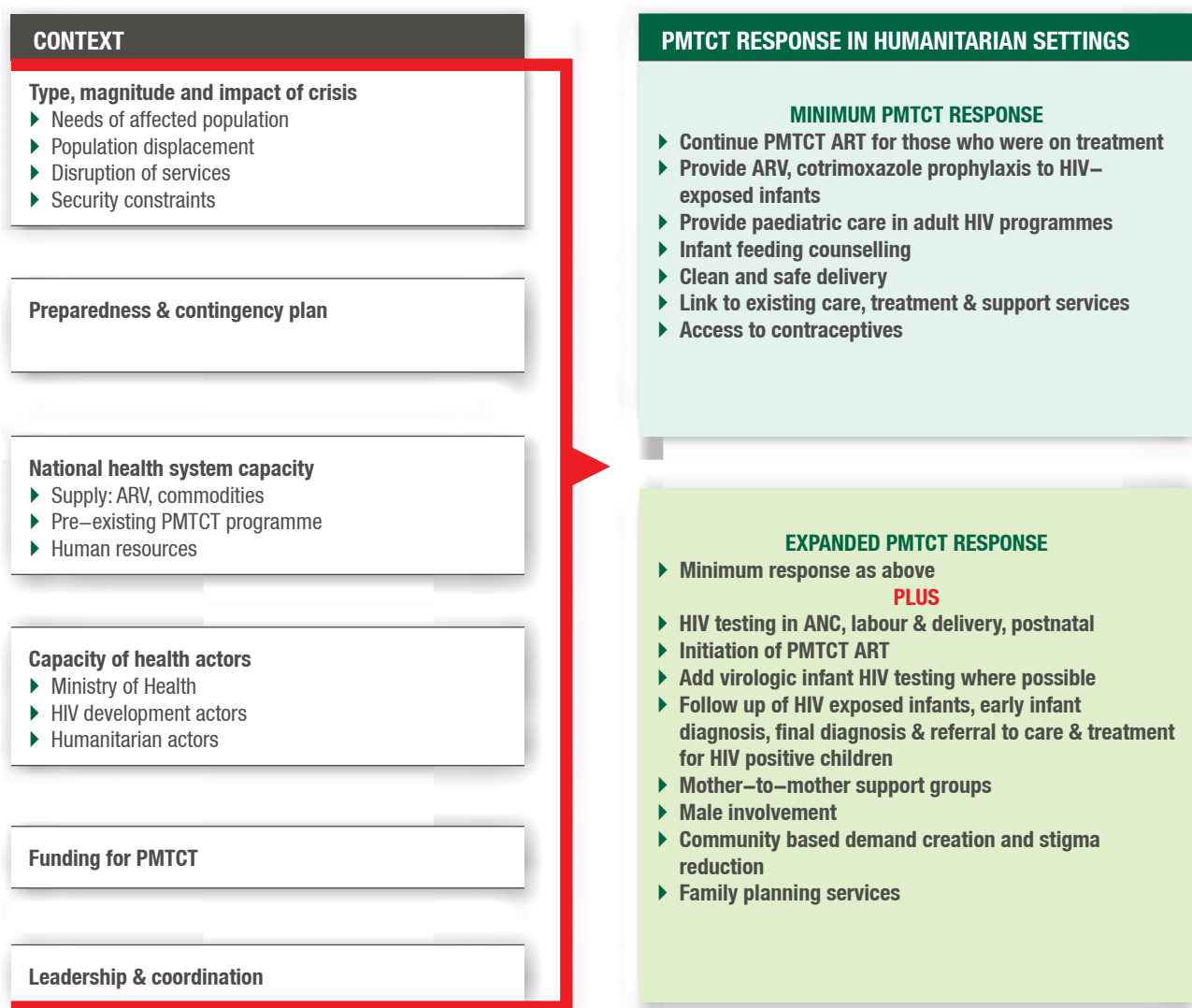
### 3.2 Priority setting for PMTCT response in humanitarian settings

- ▶ Analyse the situation to decide which components of PMTCT services can be offered when. See Figure 1 below. Temporary priority setting for the minimum PMTCT response may be required.
- ▶ **Provide access to the minimum PMTCT response package** in all settings from the outset. As soon as possible (re)-establish or set up access, if not available, before the crisis and where feasible an **expanded PMTCT response package**. See Figure 1 below.
- ▶ Initiating ART for PMTCT can be feasible from the outset of an emergency depending on the context.

<sup>2</sup> **Generalised HIV Epidemic:** The HIV prevalence is >1% among pregnant women attending antenatal care  
**Concentrated HIV Epidemic:** The HIV prevalence is <1% in the general population, but >5% in at least one subpopulation.  
**Low-level HIV epidemic:** Where the HIV prevalence is not > 5% in in any subpopulation and HIV prevalence in the general population < 1%. UNAIDS. UNAIDS Terminology Guidelines. 2011 October. [www.unaids.org/en/media/unaids/contentassets/documents/unaidspublication/2011/JC2118\\_terminology-guidelines\\_en.pdf](http://www.unaids.org/en/media/unaids/contentassets/documents/unaidspublication/2011/JC2118_terminology-guidelines_en.pdf)



**FIGURE 1: CONTEXT FACTORS AND PRIORITY SETTING FOR PMTCT SERVICE DELIVERY IN HUMANITARIAN SETTINGS**



## SECTION 4

### ENSURING CONTINUOUS ACCESS TO ARVs FOR PMTCT AT OUTSET OF EMERGENCY

#### 4.1 Adapt service delivery

ARV dispensing can be organized in a number of ways. Do an initial assessment to identify the most appropriate solution. Several service delivery methods may need to be combined to achieve the best coverage, for example, in a situation with large population displacement and access problems because of insecurity.

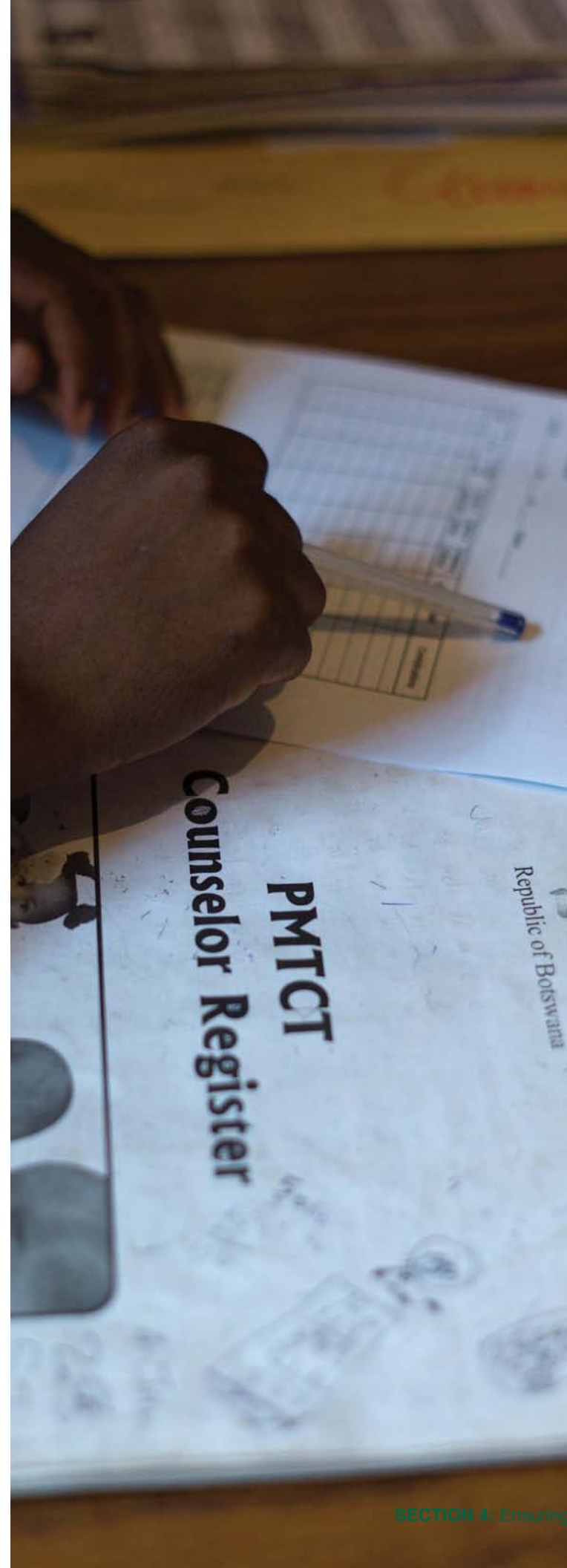
ACTION	DETAILS	COMPLETED
(Re)-open PMTCT/ARV providing services as soon as possible.	When health facilities have been partially damaged, consultation rooms can be used, but ensure confidentiality.	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A
	When national PMTCT services have broken down because of conflict or natural disasters development or humanitarian NGOs can help to restart them.	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A
	When insecurity poses a challenge for health workers to access the facility security management can keep health services running even in times of conflict, e.g. transporting staff with humanitarian agency vehicle, assign staff to reduce their exposure to risk in the context of ethnic violence.	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A
	In conflict situations ensure population of all parties are granted non-discriminatory access.	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A
Integrate ARV dispensing in camp health facilities/camp services.	Integrate ARV dispensing in temporary primary health care facilities in refugee or IDP camps to achieve good coverage.	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A
	Integrate ARV dispensing with other services, for example, with nutrition if it can be organized so patients cannot be identified as HIV positive.	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A
Referral/self-referral to pre-existing accessible ARV providing health services.	Refer IDPs or refugees to pre-existing health facilities of the host region or host country when the facilities have capacity to receive additional patients, are not far and security is not a problem.	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A

ACTION	DETAILS	COMPLETED
Mobile outreach teams for ARV dispensing in IDP camps/mobile clinics.	<b>Sending mobile teams of health workers from ARV providing facilities to dispense ARV integrated in IDP camp health facilities on specific days can be a perfect solution to rapidly establish access to specialised care.</b>	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A
	<b>Where mobile clinics for primary health care or immunisation are organized, ARV dispensing should be systematically included.</b>	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A
Home dispensing by CHWs or health workers dispensing at pre-arranged meeting points.	<b>Home dispensing or dispensing ARVs at pre-arranged meeting points for individual patients or groups of patients can be appropriate in some contexts, for example, when insecurity makes access difficult. Well-established communications networks between patients and health facilities, good security management for service providers and commitment to organize outreach services are important for this to work.</b>	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A
Dispensing ARV through other patients.	<b>Dispensing ARVs through other people living with HIV is feasible when some can access their ARV clinic and are willing to carry ARVs to others in their community and/or support group. This needs to be done with sensitivity and confidentiality.</b>	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A
Integrate PMTCT with sexual, reproductive health/family planning/maternal, newborn and child health services.	<b>Integrate PMTCT with sexual, reproductive health/family planning/maternal, newborn and child health services as much as possible.</b>	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A
	<b>Ensure adults in inpatient care know where HIV paediatric care can be accessed.</b>	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A

**Context-specific challenges** to continuous access to ARVs in humanitarian settings may have to be addressed. See table below.

#### CHALLENGES TO CONTINUOUS ACCESS TO ARVs

CHALLENGE	SOLUTION
<b>Competing priorities</b>	▶ Prioritise ARV and cotrimoxazole dispensing and add clinical consultations at a later stage.
<b>Supply problems</b>	▶ See Section 3.1.
<b>Staffing</b>	▶ Restrict to ARV dispensing only. This does not require clinical HIV management skills. ▶ Orient health workers/pharmacy dispensers on refilling ARVs only. ▶ Try to mobilise ARV experienced staff among displaced population. ▶ Try to organize mobile outreach teams of health workers experienced in provision of ARVs.
<b>Patients not knowing their ARV regimen</b>	▶ Develop system to help identify ARVs by labels of containers, colour and form of pills.
<b>Fear of HIV related stigmatisation</b>	▶ Integrate HIV dispensing into general health care.
<b>Repatriation or resettlement of refugees/IDPs/migrants in areas with poor PMTCT/ART services coverage</b>	▶ Provide ARVs up until one month or more after delivery + nevirapine for infant. ▶ Provide three months extra supply of ARVs for breastfeeding women.
<b>Mobility of displaced population</b>	▶ Educate patient to tell of planned movements to receive extra supply of ARVs. ▶ Provide extra supply of ARVs in areas with potential for increased mobility.



## 4.2 Inform patients where to access ARVs

Letting patients who are on PMTCT/ART and have lost access to their health facilities during emergencies know in a timely way where to receive refills for their medication is critical.

### Letting people know where to access ARVs during a humanitarian crisis

#### ACTIONS:

- Information at camp registration point
- Community conversations targeting pregnant women
- Patient networks
- House-to-house and community information campaign
- Public messaging at mobile clinics, during immunisation campaigns, food distribution, nutrition programmes etc.
- Radio, TV messages
- Mobile phone tracing
- Physical tracing
- Phone hotline

#### Considerations for implementation:

- ▶ **Combined methods** seem to have the best coverage.
- ▶ **Relying on CHWs/peer educators/mentor mothers for tracing during the acute phase of crisis** when they are personally affected **may not be effective**. Alternative ways of passing on the information may have faster results.
- ▶ **Do not ask individuals to identify as HIV positive in front of others to avoid any potential stigmatization.**



### 4.3 Set up ARV dispensing during acute emergency

For efficiency, ARV dispensing for PMTCT and ART should be planned and organized jointly, and ideally integrated with dispensing of tuberculosis drugs.

#### 1. Rapid needs assessment

This should be integrated into general humanitarian/health assessments.<sup>3</sup>

The following minimum **basic information needs to be collected**:

- HIV prevalence, ANC HIV surveillance data of country/region/affected area or country/area of origin in case of refugees or IDPs
- Rough estimate of number of pregnant women on PMTCT among affected population. Was PMTCT/ART available prior to crisis? How many women were enrolled?
- Available and accessible health services with/without PMTCT services in the area
- National PMTCT/ART protocols
- Availability/accessibility of ARV stocks

#### 2. Organize supply

- If possible access available national in country stocks for ARVs, HIV tests, cotrimoxazole. This might involve support for transportation from central medical stores or redistributing commodities among facilities.
- If no national in country stocks are available or accessible, organize an emergency supply/procurement. *See Section 3.1.*

ACTION	DETAILS	COMPLETED
<b>Information at the camp registration point</b>	This is an excellent opportunity to reach all new arrivals in camp settings. It is easy to combine with other information about health services.	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A
<b>Community conversations targeting pregnant women.</b>	Of particular relevance for illiterate women; provides a space for questions and identification of women lost to follow-up.	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A
<b>Patient networks</b>	e.g. mother-to-mother support groups are a good way to spread information informally and discretely. Ask people who come for ARV refills to let it be known where ARVs can be accessed.	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A
<b>House-to-house information campaign</b>	Can be organized by CHWs/peer educators and is best combined with other health messages to avoid any potential stigmatization. Distribute leaflets with place and opening times of ARV dispensing site.	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A
<b>Public messaging</b>	Can be easily combined with other health promotion activities. Distribute leaflets with place and opening times of ARV dispensing site.	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A
<b>Radio/TV messages</b>	Have the advantage of reaching large groups but only work in areas where people can listen/watch. Find out which radio stations and TV channels have coverage in the area.	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A
<b>Mobile phone tracing</b>	Can be very time consuming for large patient cohorts but is suitable for small cohorts in areas with good mobile phone coverage. Mentor mothers could be involved.	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A
<b>Physical tracing</b>	Is only possible where there are no problems of access and patient cohorts are not too large.	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A
<b>Phone hotlines</b>	Can be useful to inform patients where to find alternative treatment sites in case of unforeseen problems of access to their usual health facility. Hotlines can be a useful complement to radio and TV messaging when large geographical areas and large patient cohorts are affected. Try to negotiate a toll free number with mobile phone providers.	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A



<sup>3</sup> For more guidance on HIV assessment see also UNHCR/UNAIDS. HIV-related needs in internally displaced persons and other conflict-affected populations: A Rapid Situation Assessment Tool - [www.unhcr.org/477cd4762.pdf](http://www.unhcr.org/477cd4762.pdf)

# SECTION 5

## INTEGRATING EXPANDED PMTCT RESPONSE INCLUDING INITIATION OF ART FOR PMTCT

- 1 Set up/organise access to ARV dispensing sites**
  - ▶ See Section 4.1.
  - ▶ There is a need to agree with HIV actors on whether unknown patients who present for ARV dispensing will be retested for HIV or not.<sup>4</sup> The decision may be determined by the number of patients in need, the availability of test kits and the feasibility to retest all or not.
  
- 2 Inform patients where to get ARVs and receive support where available**
  - ▶ Organize information campaign about where to access ARVs **only when ARV dispensing sites are ready.** See Section 4.2.
  
- 3 Dispense ARVs/cotrimoxazole and educate patients**
  - Provide at least a one-month supply of ARVs.
  - Provide full dose of nevirapine syrup for HIV-exposed infant according to PMTCT protocol.
  - If further population movement is possible, dispense extra supply of ARVs, if sufficient ARVs are in stock. For pregnant women, provide for at least one month until after expected delivery and nevirapine syrup for infant. Explain protocol and provide written explanation with pictorials.
  - Dispense cotrimoxazole to women and HIV-exposed infant according to protocol.
  - Record dispensing on patient passport if available/provide patient passport.
  - Educate patients about importance of carrying extra supply of ARVs and patient passport, alternative treatment sites, provide contact phone numbers.

<sup>4</sup> Reports about false positive HIV tests have led some HIV actors to decide to retest all unknown patients in an emergency situation.



- 4 Collect basic data at dispensing sites**
  - In temporary dispensing sites, collect basic data of PMTCT/ART patients: date, number of patients, quantity of ARVs and other drugs dispensed; register patient contact details.
  - In regular functional PMTCT sites, use standard registers for data collection.
  - Use patient passport as portable patient record.
  
- 5 Add PMTCT actions at labour and delivery**
  - Assess staff experience with PMTCT.
  - Assess availability of HIV test kits and ARV => order from national central medical store or procure and supply, if not available.
  - Inform/orient staff if not trained about safer delivery practices to reduce risk of transmission and PMTCT protocol including infant feeding guidance.
  - Administer ARVs to women and dispense ARVs for breastfeeding period according to national protocol.
  - Start nevirapine for HIV-exposed infant, counsel mother on infant feeding and refer to MNCH services, if available, for regular follow-up and early infant diagnosis at week six, or alternatively, periodic HIV antibody testing as recommended by WHO.<sup>5</sup>
  - If feasible and acceptable, propose HTC to women who deliver with unknown HIV status and initiate PMTCT/ART for HIV positive women.

<sup>5</sup> When no early infant diagnosis is available perform HIV antibody test of child at 9 months, 12 months, 18 months. See 2013 WHO Guidelines, Annex 5.

## 5.1 Set up of service delivery

The **setup of service delivery for initiation of PMTCT treatment** depends on the context. Carry out an **HIV needs assessment, if not done at an earlier stage, for planning.** See Section 4.3.

ACTION	DETAILS	COMPLETED
Patients are often able to access pre-existing PMTCT/ART health facilities.	where pre-existing PMTCT/ART services remain functional, have supplies as well as providers or where refugees arrive in a host country with functional PMTCT facilities.	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A
PMTCT initiation and follow-up of HIV-exposed infants can be offered in temporary health facilities and/or in mobile clinics.	where access to pre-existing facilities in the emergency affected area is not possible because of the crisis (security constraints, infrastructure damage, not enough capacity to accommodate additional patient load). Development partners or humanitarian actors often support these temporary facilities. This may be an interim solution until patients are able to access pre-existing facilities. In protracted refugee situations, the <b>camp health facility</b> set up may evolve into a long-term service delivery model.	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A
In a chronic fragile context or in a country recovering from long-term armed conflict PMTCT services may need to be set up as an integrated component of primary and secondary health care services.		<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A

## 5.2 Initiating expanded PMTCT response including ART

ACTION	DETAILS	COMPLETED
Regular supply of ARVs and other commodities (HIV test kits) needs to be organized and assured before enrolling pregnant women in PMTCT.	When PMTCT services are starting up, funding for drugs and commodities should be assured for at least one year while longer-term funding solutions are being identified. See Sections 3.1 and 3.4.	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A
Trained staff needs to be available.	Health workers without specific knowledge can dispense ARVs for women and infants who have been on PMTCT treatment before the crisis. Offering expanded PMTCT services with HTC, enrolment, adherence counselling and follow-up of HIV-exposed infants requires staff with PMTCT training. Where PMTCT services did not exist before the crisis, staff will need to be trained according to national protocols. Technical and general programme guidance for PMTCT is also applicable in humanitarian settings. Service delivery may need to be adapted depending on the context.	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A

## 5.3 Challenges

Challenges in assuring access to comprehensive PMTCT services can vary depending on the context. For context factors also see Section 3.2.

In contexts with minimal security constraints and pre-existing well-run PMTCT services, systems challenges will be easier to address. Using pre-existing staff and systems, activities can be redirected to new service delivery points. Setting up alternative treatment sites, mobile clinics and outreach services may need additional resources. HIV development actors, present in country before the crisis, can play a major role in supporting this process.

In a context with a weak pre-existing national HIV programme and weak health system, it is more difficult to (re)-establish access to the comprehensive PMTCT package. Integration of comprehensive PMTCT services with good outcomes usually requires humanitarian actors providing strong implementation support and greater investment. The HIV assessment will often reveal many gaps.

## 5.4 PMTCT integration in humanitarian settings with weak health systems

The main challenges include:

- Supply of ARVs and other commodities
- Insufficient number of staff and poor staff capacity
- Laboratory support
- Access to ART for patients needing treatment for their own health
- Chronic or recurrent instability leading to problems of access
- Competing priorities
- Funding
- Sustainability





ACTION	DETAILS	COMPLETED
<b>Key elements to overcome these challenges and make PMTCT happen in these difficult contexts are: contingency planning, simplification of protocols, task shifting and funding for implementing partners.</b>	Contingency planning is critical for the potential disruption of access to services ( <i>see Section 2</i> ) because of armed conflict, civil unrest, local outbreak of violence or disaster and as a back-up for weaknesses in national drug supply or blood sample transport system. <ul style="list-style-type: none"> <li>▶ Procuring a buffer stock of ARVs and other essential commodities for implementing partners who rely on the government supply system is recommended.</li> <li>▶ Where no reliable transport system for drugs or blood samples, e.g. dry blood spot samples for early infant diagnosis is in place, implementing partners should temporarily take over this task.</li> </ul>	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A
<b>Simplification of protocols is critical in these challenging settings.</b>	<ul style="list-style-type: none"> <li>▶ <b>Test and treat (Option B/B+)<sup>6</sup></b> PMTCT ARV protocol with one pill a day for pregnant and breastfeeding women as recommended by WHO in 2013 can simplify PMTCT programming including clinical and supply chain management. It can be started without access to a laboratory and reduces training needs. When there are many other competing priorities, simplification will help convince health workers to include PMTCT in basic health care programmes. WHO recommends where possible countries/ PMTCT programmes shift to the new test and treat protocol. Risk-prone and fragile settings should be considered priority areas for roll-out. Where test and treat is not yet country policy, implementing NGOs in agreement with the national HIV control programme can consider piloting the protocol.</li> <li>▶ <b>Where access to laboratories is limited/impossible, clinical monitoring or simpler methods can replace laboratory tests.</b> For example, if early infant diagnosis is not possible HIV-exposed infants can be monitored closely and those with clinical signs of HIV infection immediately put on ART. HIV antibody testing at nine months and 18 months using rapid tests for HIV-exposed infants without clinical signs of HIV infection is used to confirm the HIV negative status of an HIV-exposed infant. <i>See 2013 WHO Guidelines, Annex 5.</i> (WHO, Consolidated guidelines on the use of antiretroviral drugs for treating and preventing HIV infection. Recommendations for a public health approach, June 2013). Depending on patient volume and available funding, upgrading local laboratory capacity may be an option.</li> </ul>	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A
<b>Addressing human resource challenges.</b>	<ul style="list-style-type: none"> <li>▶ <b>Task shifting to lower-level</b> qualified health workers and from qualified health workers to lay staff (CHWs, mentor mothers) is a viable solution. Theoretical and practical training is needed. Task shifting also requires regular mentoring and supervision to ensure quality of care. Where national policies do not allow task shifting, implementing organizations can advocate with the national HIV control programme for permission to undertake a pilot, notably in risk-prone areas.</li> <li>▶ <b>Hiring of additional qualified staff</b> is often still needed to cover essential staffing needs. Where qualified staff is scarce in country, international staff may have to be recruited. It is recommended that implementing NGOs appoint one <b>HIV/PMTCT focal person in charge of each project</b> and an <b>HIV/PMTCT technical advisor</b> for training and monitoring at country level. Depending on the size of the supported programme, this may be combined with the NGO's long-term medical coordinator position. It is advisable to hire a temporary technical support in country and keep these positions separate during the start-up phase and for larger programmes.</li> </ul>	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A

<sup>6</sup> Option B: Triple ART for all HIV positive pregnant and breastfeeding women until cessation of breast feeding and lifelong ART for eligible women after cessation of breastfeeding; Option B+: Lifelong triple ART for all HIV positive pregnant and breastfeeding women. (1) See table for overview on PMTCT ARV protocols in Section 1.

ACTION	DETAILS	COMPLETED
<b>Enrollment in long-term HIV treatment (HIV+ mothers and HIV+ family members)</b>	If long-term HIV services are not available at the same health facility, patients should be referred to the closest ART facility. Mechanisms to support transport costs should be considered. Decentralization should be advocated. PMTCT should be integrated into an existing basic health care programme even when the health facility does not have ART services.	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A
<b>Sustainability of PMTCT programming beyond the emergency period should be a goal, even if a medical relief organization, not a long-term development partner, started it.</b>	Future handover options should be explored and pursued from the beginning of the project. Planning of handover to MOH and/or long-term development partners should start well in advance of the handover period. If no handover partner can be identified, focus on preventive action (option B) and provide ARVs to the mother until the end of the breastfeeding period.	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A
<b>Funding opportunities for PMTCT integration can be explored with humanitarian donors (e.g. ECHO) and HIV development donors (e.g. GFATM, PEPFAR) and other development partners.</b>	<i>See Section 3.4.</i>	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A

## 5.5 Integration of services

As in stable settings, integration of PMTCT into MNCH and reproductive health services, linkage with HIV care and treatment and nutrition programmes is key to maximise entry points, increase ART for PMTCT coverage, early infant diagnosis and referral to care and treatment.

In humanitarian settings, food support and nutrition programmes can be important entry points. Malnourished pregnant and breastfeeding women who receive food support should be referred to HTC/ PMTCT. HIV testing is recommended for malnourished infants and children who do not respond to therapeutic feeding.



## SECTION 6

### MONITORING OF PATIENT COHORTS IN HUMANITARIAN SETTINGS

Monitoring of PMTCT/ART programmes can face serious challenges during emergencies where access to services is hampered and/or the population is displaced.

ISSUE	ACTION	COMPLETED
<p><b>Patient tracking is difficult with population displacement.</b> A large number of missed appointments and lost to follow-up cases from pre-existing PMTCT/ART sites suggest treatment interruption, while some patients may have accessed ARVs elsewhere. Performance targets for retention in care for ART/PMTCT programmes in areas affected by displacement may be lower than in stable situations. The causes have to be taken into consideration when interpreting patient outcome data.</p>	<p><b>Introducing patient passports with a unique national ID number can help track patients who have changed treatment sites within the same country, when patients cannot be reached by phone or other means.</b> This can be explored as a preparedness measure. However, it cannot solve the problem of tracking in case of cross border movement.</p>	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A
	<p><b>Patient passports serve as a portable patient record.</b> They should contain the current ARV regimen, laboratory results and essential medical information for women enrolled in the PMTCT programme and their HIV-exposed infants. Tell patients to carry them at all times notably when they move. This will facilitate follow-up treatment including at an alternative treatment site in case of displacement. . Patient passports introduced in all settings nationwide can serve as a preparedness measure. Where there are no nationwide patient passports, PMTCT/ART facilities can design one as an interim solution.</p>	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A
	<p><b>In protracted crises and chronic fragile settings, collect routine data that enables the follow-up of cohort outcomes.</b></p>	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A
	<p><b>Temporarily shift to a simplified paper-based data recording system for ARV dispensing in acute emergency situations where use of routine systems is not feasible. The facility record should include: the date, the number of patients who accessed ARVs, the quantity of ARVs and other drugs dispensed to enable drug forecasting. The facility record is to be combined with the patient passport that serves as a portable patient record. Design and disseminate the form before a predictable emergency. If this is not possible, it can be improvised at facility level.</b></p>	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A

# SECTION 7

## RESOURCES

- Inter-Agency Standing Committee. Guidelines for addressing HIV in humanitarian Settings. 2009. [www.unaids.org/en/media/unaids/contentassets/documents/unaidspublication/2010/jc1767\\_iasc\\_doc\\_en.pdf](http://www.unaids.org/en/media/unaids/contentassets/documents/unaidspublication/2010/jc1767_iasc_doc_en.pdf)
- Inter-agency Working Group Reproductive Health in Crisis. Inter-agency field manual on reproductive health in humanitarian Settings. 2010. [www.who.int/reproductivehealth/publications/emergencies/field\\_manual\\_rh\\_humanitarian\\_settings.pdf?ua=1](http://www.who.int/reproductivehealth/publications/emergencies/field_manual_rh_humanitarian_settings.pdf?ua=1)
- Southern African HIV Clinicians Society, UNHCR, Wits Reproductive Health and HIV Institute et al. Guidelines for the Delivery of Antiretroviral Therapy to Migrants and Crisis-Affected Populations in Sub-Saharan Africa. 2014 <[www.unhcr.org/541fe8a19.html](http://www.unhcr.org/541fe8a19.html)> accessed 10/3/2014.
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- WHO. Consolidated guidelines on the use of antiretroviral drugs for treating and preventing HIV infection. A public health approach. 2013 [http://apps.who.int/iris/bitstream/10665/85321/1/9789241505727\\_eng.pdf?ua=1](http://apps.who.int/iris/bitstream/10665/85321/1/9789241505727_eng.pdf?ua=1)
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- The Global Fund to Fight AIDS, TB and Malaria. The Global Fund operations policy manual. 2013 [www.theglobalfund.org/en/documents/operational](http://www.theglobalfund.org/en/documents/operational)
- Médecins sans Frontières, UNAIDS. Closer to home. Delivering antiretroviral therapy in the community: Experience from four countries in Southern Africa. 2012. <<http://samumsf.org/dossiers>>
- Inter-Agency Task Team on the Prevention and Treatment of HIV Infection in Pregnant Women, Mothers and Children. <<http://www.emtct-iatt.org/>>
- ICAP. Prevention of Mother-to-Child transmission resources. <<http://icap.columbia.edu/resources/detail/prevention-of-mother-to-child-transmission-pmtct-of-hiv-resources>>



# SECTION 8



## REFERENCES

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- <sup>2</sup> Inter-Agency Standing Committee. Guidelines for addressing HIV in humanitarian settings. 2009. [www.unaids.org/en/media/unaids/contentassets/documents/unaidspublication/2010/jc1767\\_iasc\\_doc\\_en.pdf](http://www.unaids.org/en/media/unaids/contentassets/documents/unaidspublication/2010/jc1767_iasc_doc_en.pdf). accessed 10/3/2104.
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