

UNICEF and HIV in the context of El Niño in Southern Africa

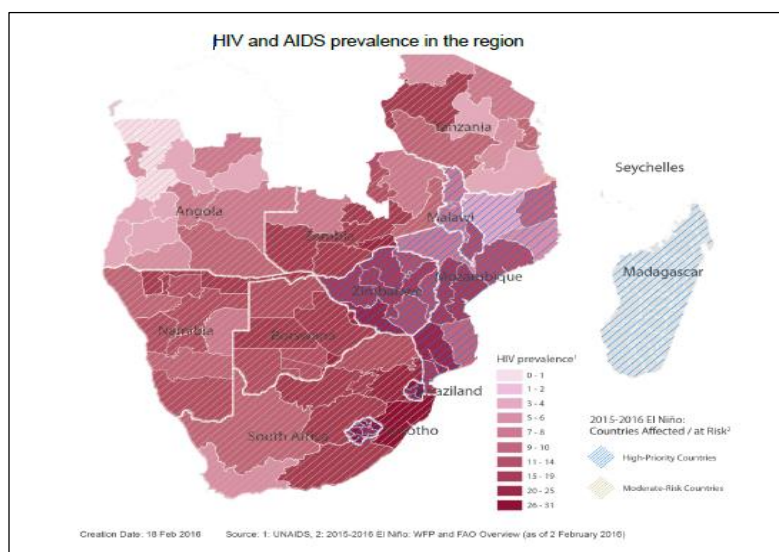


El Niño is affecting countries in Southern Africa with the highest burden of HIV. Aligned with the Core Commitments for Children (CCCs)ⁱ, UNICEF works in humanitarian settings to ensure that children, young people and women have information as well as access to HIV and AIDS prevention, care and treatment services during a crisis. UNICEF also commits to ensuring, at a minimum, continuation of ARV treatment for those already on treatment.

This brief is intended for colleagues in UNICEF country offices working on El Niño response plans in order to make appropriate links to HIV and ensure that risks are mitigated and addressed. It highlights the effects of El Niño's impact on HIV-related vulnerabilities and services, and on people living with HIV. This brief can also be used for advocacy with governments, development partners and donors.

El Niño is affecting countries with a high HIV burden

The effects of El Niño, including water shortages, drought, hunger and disease are impacting populations in the sub-region that is the global epicenter of the AIDS pandemic. Due to the global financial crisis, high food prices and the overall economic downturn in many countries, available resources are further strained by the impact of the drought. These added stresses can force families, especially adolescent girls and women, to adopt coping mechanisms (such as transactional sex), which increase their vulnerability to HIV infection and have an impact on adherence and retention to treatment. Nine countries in Southern Africaⁱⁱ have adult HIV prevalence of over 10 per cent. At an estimated 26 per cent, Swaziland has the highest HIV prevalence in the world, followed by Botswana (23.4 per cent) and Lesotho (23.3 per cent). South Africa has the world's largest epidemic with 5.6 million people living with HIV (17.3 per cent of the population). All are part of the 35 UNAIDS priority 'Fast-Track' countries for scaling up treatment and ending AIDS globally by 2030. These same countries have been extensively affected by El Niño.



Risk to treatment enrollment, adherence and retention: The income shocks and hunger associated with El Niño are occurring at a crucial time – when many countries are preparing to roll out the policy of “test and treat”ⁱⁱⁱ putting more patients onto lifesaving treatment. We know that access to and availability of food is critical for adherence and retention in care. Mortality is two to six times higher for children living with HIV who begin treatment when they are severely malnourished than for those who are not malnourished^{iv}. Food insecurity also affects adherence to anti-retroviral therapy (ART) as patients do not like to take treatment on an empty stomach. Lack of food also affects access to health services as many people prioritize the few financial resources they have to buy food rather than pay for travel to a health facility. Poor feeding practices resulting from lack of food will also further compromise the immune system and increase the risk of infection due to water scarcity as well as increases in vector borne diseases.

In some countries, there is reported closure of health facilities due to a lack of water supply as a result of the drought. This will affect ART access and may reverse the gains made in the prevention of mother to child transmission (PMTCT).

Evidence that El Niño will likely increase the transmission rate of HIV in endemic areas that are affected by the drought: A 2014 study of 18 countries^v in sub-Saharan Africa, including Swaziland, Lesotho, Zambia, Zimbabwe, Malawi, and Mozambique among the El Niño-affected countries in Southern Africa found that infection rates in HIV-endemic rural areas increased by 11 per cent for every recent drought. Income shocks further explained up to 20 per cent of the variation in HIV prevalence across African countries.

El Niño increases vulnerabilities of adolescents: Emergencies can increase vulnerability to high-risk behaviours and negative coping strategies, including transactional sex. Gender-based violence (GBV) can increase with drought and food and water scarcity. Survivors of sexual assault, the majority being adolescent girls and women, are at risk of HIV and STI transmission, and unwanted pregnancies. For adolescent girls, such experiences and income shocks produced by drought, often lead them to drop out of school which is another risk for HIV.

Possible programmatic interventions

In order to improve health outcomes more broadly, and to achieve HIV targets and commitments more specifically, a multisector response is required with both HIV-specific and HIV-sensitive interventions.

Better integrate the response (food security, health, nutrition and HIV), including through the following:

- Ensure all children admitted into SAM and MAM treatment programmes are tested for HIV^{vi};
- Provide therapeutic foods for young children living with HIV who are under-nourished, and enable referral of their families to food supplementation programmes;
- Measure BMI of all PMTCT clients and children and adolescents on ART and link those with low BMI to food and nutrition support;
- Train community-based cadres (e.g. community health workers, mentor mothers, peer supporters and nutrition workers) to assess food security and address both HIV and maternal and infant nutrition;
- In coordination with other implementing partners including the World Food Programme, advocate that food supplements be provided to clients on HIV treatment, especially in PMTCT sites and for children and adolescents living with HIV.

Strengthen ART adherence and retention strategies:

- Intensify patient counseling to support adherence and retention;
- Strengthen systems and protocols to detect and follow up on missed appointments, including through mHealth, mentor mothers, expert clients and community-facility linkages;
- Provide extra supplies of ARVs for stable clients to reduce the income burden of repeated visits to the clinic;
- Establish community ART distribution through Community Adherence Groups, Community Health Workers or other locally relevant strategies.

Work with others to ensure health facilities are functional or establish alternative service delivery strategies:

- If health facilities are not functioning or if there is a marked reduction in attendance, set up PMTCT/ART services in alternative (temporary) health facilities and/or through community-based mobile outreach / case finding teams as part of an integrated approach (e.g. with health and nutrition interventions);

- Advocate for the prioritization of health facilities in areas seeing a drop off in attendance to be chosen for improved water harvesting and other WASH interventions.

Enhance strategies to prevent HIV transmission, especially among adolescents:

- Introduce or top-up cash transfers to help ensure adolescents, especially girls, stay in school;
- Buttress monitoring systems to detect and respond to instances of GBV;
- Strengthen facility and community-based case management services for survivors of sexual violence;
- Provide outreach and other community-based services for adolescent sexual and reproductive health including family planning and care for survivors of sexual assault
- Procure commodities for clinical care for survivors of sexual assault (e.g., PEP), distribute and train health workers on providing clinical care.

Improve the resilience of vulnerable groups: Strengthening social protection is an important cross-cutting strategy. Social protection can reduce an individual's chance of becoming infected with HIV, improve treatment access and adherence, and reduce the likelihood that HIV will have a damaging effect on individuals, households and communities.

Engage with HIV actors and donors present in country to reprogram and implement HIV prevention and treatment services in humanitarian response by quickly redirecting their activities towards the strategies outlined above.

Other tools and guidance for HIV in humanitarian settings

[Implementation guide](#): PMTCT in humanitarian settings (also relevant for ART more broadly)

[Lessons learned and recommendations](#): PMTCT in humanitarian settings (also relevant for ART more broadly)

[Public health approach](#) to post-exposure prophylaxis (WHO, 2014)

[Checklist for determining HIV status](#) for children (0-59 months) with severe acute malnutrition

[Assessment](#) of HIV in internally displaced situations

[Methodology](#): HIV in Humanitarian Settings Contingency Planning Workshop

ⁱ UNICEF's Core Commitments for Children around HIV in Humanitarian Action are 1: Children, young people and women have access to information regarding prevention, care and treatment. Commitment 2: Children, young people and women access HIV and AIDS prevention, care and treatment during crisis. Commitment 3: Prevention, care and treatment services for children, young people and women are continued.

ⁱⁱ Botswana, Lesotho, Malawi, Mozambique, Namibia, South Africa, Swaziland, Zambia and Zimbabwe

ⁱⁱⁱ Antiretroviral therapy (ART) should be initiated in everyone living with HIV at any CD4 cell count.

<http://www.who.int/hiv/pub/guidelines/earlyrelease-arv/en/>

^{iv} http://www.unaids.org/sites/default/files/media_asset/food-nutrition_en.pdf

^v Swaziland, Lesotho, Zambia, Zimbabwe, Malawi, Mozambique, Tanzania, Ethiopia, Cameroon, Rwanda, Ghana, Burkina Faso, Liberia, Guinea, Sierra Leone, Mali, Congo DR, Senegal https://mpira.ub.uni-muenchen.de/55392/1/MPRA_paper_55392.pdf

^{vi} Mortality from SAM is more than three times higher in HIV-positive children than their HIV-negative peers

<http://adc.bmj.com/cgi/ijlink?linkType=ABST&journalCode=trstmh&resid=103/6/541>