

Guidelines for the Delivery of Antiretroviral Therapy to Migrants and Crisis-Affected Persons in Sub-Saharan Africa

September 2014





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Acronyms

AIDS	acquired immunodeficiency syndrome
ART	antiretroviral therapy
AZT	Zidovudine (also known as ZDV)
CD4	T-lymphocyte cell bearing CD4 receptor
CNS	central nervous system
CRC	Convention on the Rights of the Child
d4T	stavudine
EFV	efavirenz
HIV	human immunodeficiency virus
HTC	HIV testing and counselling
IASC	Inter-Agency Standing Committee
ICRMW	International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families
IDP	internally displaced person
IOM	International Organization for Migration
MHPSS	mental health and psychosocial support
MISP	minimum initial service package
MSF	Médecins Sans Frontières
M/XDR	multidrug or extensively drug resistant tuberculosis
NGO	non-governmental organization
NNRTI	non-nucleoside reverse transcriptase inhibitor
PEP	post-exposure prophylaxis
PMTCT	prevention of mother-to-child transmission
SADC	Southern African Development Community
SSA	sub-Saharan Africa
STI	sexually transmitted infection
TB	tuberculosis
TDF	tenofovir disoproxil fumarate
UN	United Nations
UNDP	United Nations Development Programme
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations International Children's Emergency Fund
WHO	World Health Organization
WFP	World Food Programme

Acknowledgements

Steering Group (in alphabetical order):

Laurie Bruns (University of California, Los Angeles, Center for World Health), Francesca Conradie (University of the Witwatersrand (Wits University)/Southern African HIV Clinicians Society), Maysoon Dahab (United Nations High Commissioner for Refugees (UNHCR)) Consultant, Sathyanarayanan Doraiswamy (UNHCR), Tom Elman (Médecins Sans Frontières), Lauren Jankelowitz (Southern African HIV Clinicians Society), Marlise Richter (Wits University), Barbara Rijks (International Organization of Migration), Paul Spiegel (UNHCR), Marian Schilperoord (UNHCR), Jo Vearey (African Centre for Migration and Society, Wits University), and Francois Venter (Wits Reproductive Health and HIV Institute/Southern African HIV Clinicians Society).

Secondary Reviewers:

Kweku Ackom (International Medical Corps), Kofi Amekudzi (International Labour Organization), Ludo Bok (United Nations Development Programme (UNDP)), Joanmanuel Claros (World Food Programme), Nanzneen Damji (UN Women), Abdelhadi Eltahir (International Rescue Committee), Alice Fay (Save the Children), Susana Fried, (UNDP), Sarah Karmin (United Nations International Children's Emergency Fund), Chewe Luo (United Nations International Children's Emergency Fund), Miriam Maluwa (the Joint United Nations Programme on HIV/AIDS), Gitau Mburu (International HIV/AIDS Alliance), Davide Mosca (International Organization for Migration), Nenette Motus (International Organization for Migration), Alice Ouedraogo (International Labour Organization), Dhammika Perera (International Rescue Committee), Fatiha Terki (World Food Programme) and Douglas Webb (UNDP).

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Foreword

In 2007, the United Nations High Commissioner for Refugees (UNHCR) and the Southern African HIV Clinicians Society released the *Clinical Guidelines for antiretroviral therapy management for displaced populations in Southern Africa*.^[1] Its aim was to provide guidance to clinicians, non-governmental organizations (NGOs), and governments on the provision of antiretroviral therapy (ART) among displaced populations. Specific guidance was deemed necessary not only due to the unique characteristics of these populations, but also due to their specific vulnerabilities and frequent exclusion from human immunodeficiency virus (HIV)- and acquired immunodeficiency syndrome (AIDS)-related services. It was widely recognised at the time (and still is) that the failure to provide HIV prevention and care to displaced persons not only undermines effective HIV prevention and care efforts, but it also undermines effective HIV prevention and care for host country populations.

What has changed since the issuance of this guidance, the first of its kind?

Millions of people are now successfully taking ART in a variety of different and complex environments. Concerns regarding poor adherence and subsequent increase in resistance in low-income countries have abated. In fact, studies have shown that persons in such settings have as good or better treatment outcomes than those in stable settings and that it is feasible to provide ART in humanitarian settings.^[2-7] ART regimens have been simplified and such treatment has been shown to reduce secondary transmission.^[8] As more people have access to ART, issues of equity have grown; those populations left out are often harder to reach and marginalised. Finally, the World Health Organization (WHO) released its new consolidated guidelines on the use of ART for treating and preventing HIV infection in 2013.^[9]

What is new in this guidance?

The guidance has been broadened to include all types of migrants and crisis-affected populations, including those forcibly displaced. Most of the rationale for providing ART to these populations as well as the potential barriers and solutions are similar, including their mobility, lack of legal residence status or work permit, cultural and language barriers, and lack of access to affordable and acceptable health services and social protection (e.g. health insurance). The previous guidance provided a rationale for providing ART to displaced persons. This update stresses that migration and forced displacement must NOT be used as an excuse to deny treatment. Clear recommendations are provided for states, clinicians and programme managers, civil society, donors and United Nations (UN) agencies.

Persons on the move and those with a history of mobility have a right to receive HIV care, including ART. Provision of HIV care has a strong legal and ethical rationale and is increasingly regarded important from a public health perspective. We hope that everyone reading these operational guidelines will join us in ensuring that migrants and crisis-affected persons have access to ART and the continuity of treatment that they deserve.



Paul Spiegel
United Nations
High Commissioner for Refugees



Francesca Conradie
Southern African HIV
Clinicians Society



Francois Venter
Wits Reproductive Health
and HIV Institute

Definition of Key Mobility Terms

MIGRANTS

Although no universally accepted definition for 'migrant' exists, the UN defines a migrant as an individual who has resided in a foreign country for more than one year irrespective of the causes, voluntary or involuntary, and the means, regular or irregular, used to migrate. As such, those travelling for shorter periods such as tourists and businesspersons would not be considered to be migrants. However, common usage includes certain kinds of short-term migrants, such as seasonal farm workers who travel for short periods to work planting or harvesting farm products.^[10]

- **Internal migration:** a movement of people from one area of a country to another area of the same country for the purpose or with the effect of establishing a new residence. This migration may be temporary or permanent. Internal migrants move but remain within their country of origin (e.g. rural to urban migration).
- **International migration:** Movement of persons who leave their country of origin, or the country of habitual residence, to establish themselves either permanently or temporarily in another country. An international frontier is therefore crossed.
- A **migrant worker** is a person who is to be engaged, is engaged, or has been engaged in a remunerated activity in a state of which he or she is not a national.^[11]
- Migrant workers and members of their families are considered (a) **documented** or **in a regular situation** if they are authorized to enter, to stay and to engage in a remunerated activity in the state of employment, pursuant to the law of that state and to international agreements to which that state is a party; and (b) They are considered **non-documented** or **in an irregular situation** if they do not comply with the conditions delineated in subparagraph (a) (Article 5 of the ICRMW).^[11]
- More generally, a migrant **in an irregular situation** is a person who, owing to unauthorized entry, breach of a condition of entry, or the expiry of his or her visa, lacks legal status in a transit or host country. The definition covers, inter alia, those persons who have entered a transit or host country lawfully, but have stayed for a longer period than authorized or subsequently taken up unauthorized employment (also called 'unauthorized/ clandestine/undocumented migrant or migrant in an irregular situation'). The term 'irregular' is preferred over 'illegal' because the latter carries a criminal connotation and is seen as denying migrants' humanity.^[10]
- A **cross-border trader** is a person who moves across an international border for the purpose of trade.
- **Seasonal migrant worker** is a migrant worker whose work, or migration for migration employment, is by its character dependent on seasonal conditions and is performed only during part of the year.^[11]
- **Victims of human trafficking** are those persons recruited, transported, transferred, harboured or receipted, by means of threat or use of force or other forms of coercion, abduction, fraud, deception, abuse of power or of their position of vulnerability, or of the giving or receiving of payments or benefits to acquire their consent to be under the control of another person, for the purpose of exploitation. Exploitation shall include, at a minimum, the prostitution of others or other forms of sexual exploitation, forced labour or services, slavery or practices similar to slavery, servitude or the removal of organs.^[12]

CRISIS-AFFECTED PERSONS

- A **refugee** is a person who flees his/her own country because of race, religion, nationality, membership of a particular social group, political opinion or civil unrest/war, and who cannot return home for fear of persecution.
- An **asylum seeker** is someone who claims refugee status, but whose claim has not yet been definitively evaluated.
- An **internally displaced person (IDP)** is someone who has been forced to flee his/her home suddenly or unexpectedly due to armed conflict, internal strife, systematic violations of human rights or natural disasters, and who is still within the territory of his/her country.
- A **non-displaced crisis-affected** person is someone who has been affected by either conflict or natural disaster but has remained living in his or her community of origin.

Summary

The guidance set forth in this document applies to migrants, both internal and international, as well as populations affected by humanitarian crises. The former includes migrant workers and job seekers while the latter include refugees, asylum seekers, IDPs, stateless persons as well as non-displaced crisis-affected persons. These populations will henceforth collectively be referred to as ***migrants and crisis-affected persons***.

MIGRATION AND FORCED DISPLACEMENT MUST NOT BE AN EXCUSE TO DENY TREATMENT

Migrants and crisis-affected persons living with HIV often face enormous challenges in accessing lifesaving HIV treatment and care in sub-Saharan Africa (SSA).

Given the primarily internal nature of migration in SSA, as well as the growing evidence base around the ability of migrants and crisis-affected persons to successfully adhere to HIV treatment (especially in a context where adherence in non-crisis settings can often be sub-optimal), the focus for HIV practitioners should be on improving treatment access and supporting adherence and retention for all patients, regardless of their migrant status. ***No one should be denied care and appropriate support simply because they have moved in the past or may move in the future.***

This is especially true given that SSA, and southern Africa in particular, has witnessed significant advances in HIV policies and expansion of HIV treatment that can facilitate more equitable access to ART.

A CLEAR WAY FORWARD

With a few simple adaptations to the most recent policy and practice, and with minimal additional burden or cost, treatment access and continuity among migrants and crisis-affected persons can be improved. To address these issues, the following actions should be considered:

STATES

1. *Enforce existing laws, policies, and practices that are inclusive of equitable and robust treatment approaches and that address the needs of migrants and crisis-affected persons living with HIV (e.g. simple, regionally harmonised, non-toxic fixed dose combination regimens, extended drug refills, decentralised treatment provision that is free to all at point of delivery).*

2. *Remove exclusionary laws, policies, and practices* that deny migrants and crisis-affected persons HIV-related prevention, treatment, care and support services including lifesaving ART.
3. Adopt and ensure recognition of simple, '*health travel cards*' by all actors in SSA to guarantee the right for treatment without further HIV testing or staging requirements. Measures should also be taken to ensure that those without such cards are also able to rapidly access essential care.
4. Reinvigorate prior commitments to African unity by identifying and addressing xenophobic sentiments and attitudes that lead health care personnel to limit treatment access and health services
5. Strengthen *monitoring and evaluation systems* to improve follow-up of patients who move between different treatment sites (e.g. through the use of unique patient identifiers).
6. Support the *integration* of ART distribution with other support programmes (e.g. prevention, psychological support as well as food and nutrition support).

CLINICIANS AND PROGRAMME MANAGERS

1. Prioritize their patient's welfare, thereby *ensuring that all who need treatment receive treatment*, regardless of their mobility history or migrant status.
2. *Prepare contingency plans* for ART provision, especially in emergency-prone settings and in migrant-sending areas. Plans should include the use of health travel cards and extended drug refill times between visits.
3. *Advocate for non-discriminatory medical practices* and play an active role in reducing and censuring discriminatory attitudes and dispelling myths regarding migrants and crisis-affected persons.
4. *Document and report any exclusionary practices or policies and laws* that counter national legislation protecting the right of international migrants, refugees, asylum seekers, IDPs and stateless persons to access health care.
5. *Ensure linkages with other programmes to ensure continuum of care.*

CIVIL SOCIETY

1. Strengthen the capacity of patient groups and their leadership, including those living with HIV, to advocate for their own rights.
2. Collaborate with migrants and groups advocating for their rights to raise awareness of and speak out against xenophobia and other forms of discrimination in relation to access to health care in general and HIV treatment in particular.
3. Advocate and support governments to meet their international obligations under international human rights laws and to implement strategies that reflect best practices for all HIV patients regardless of their migrant status or displacement history.
4. Increase networking and information exchange between community groups and policy makers.

DONORS AND UN AGENCIES

1. UN agencies that are directly responsible for providing care to migrants and crisis-affected populations must ensure that all who need and want treatment receive treatment, regardless of their mobility history or migrant status.
2. Advocate and support governments to meet their international obligations under international human rights laws and to implement strategies that ensure best practices for all HIV patients regardless of migrant status or their displacement history.
3. Encourage governments to consider the needs of migrants and crisis-affected persons in funding proposals and provide resources for incorporating these needs into national HIV policies and programmes.
4. Support governments in norm setting and identifying packages of services for refugees, migrants, asylum seekers, IDPs and stateless persons and in developing effective systems for data collection and analysis and using data to inform policy and programming.





Introduction

Introduction

SCOPE OF APPLICATION

This guidance is an update of the 2007 *Clinical Guidelines for antiretroviral therapy management for displaced populations for Southern Africa*.^[1] They are presented in three parts. **Part one offers clinical guidance to health care practitioners** on the provision of ART to migrants and crisis-affected persons. These guidelines do not replace national clinical guidelines, but complement them by clarifying specific options for treatment in these groups. **Part two provides guidance to ART programme managers** on responding to patient mobility and priority setting in crises, as well as strategies to maximize patient adherence and retention. **Part three offers guidance to policy makers and civil society advocates** to support the development of quality HIV care that maximizes treatment access among migrants and crisis-affected persons.

RATIONALE

This updated guidance takes into account two main developments in SSA and globally. Firstly, the growing body of evidence on adherence to ART and HIV-related risks and vulnerabilities among migrants and crisis-affected populations; and secondly, the recent policy and treatment developments as represented by the dramatic scale up of ART treatment in the region as well as the development of WHO's 2013 *Consolidated guidelines on the use of antiretroviral drugs for treating and preventing infection*.^[9] Moreover, in recognition of the interrelated migration and displacement patterns in SSA, the scope of these guidelines has expanded to include migrants and crisis-affected populations whether or not they are displaced. Migrants and displaced people do not always fit into mutually exclusive categories (e.g. in a complex crisis, a regular migrant might also become an IDP or a refugee).^[13]

In the context of existing ART guidelines, it is perhaps most important to delineate how this guidance complements the WHO's 2013 ART guidelines.^[9] Whereas the WHO's guidelines provide a menu for when to start treatment, what regimens to use, what clinical criteria to follow for treatment provision, and how to monitor treatment response, this guidance aims to operationalize these recommendations in settings servicing migrants and crisis-affected populations in SSA. More specifically, here, we focus on supporting the clinician through the patient treatment process (from preparedness and treatment initiation to adherence and treatment continuity) with detailed reference to a patient's travel history or intention, as well as supporting programme managers to improve the resilience of service provision in crisis situations.

MIGRATION AND DISPLACEMENT PATTERNS IN SSA

In this guidance, we refer to migrants and crisis-affected populations. Generally, migrants can be defined as those who migrate internally and/or across international borders, with or without documentation, and largely for economic reasons. We define crisis-affected populations as those who are affected by war, conflict, and/or natural disasters whether they are displaced from their homes (i.e. refugees, asylum seekers, and IDPs) or not. The reality is, however, that many times people move and migrate for a host of reasons that can include a combination of economic, security and other reasons.

SSA is a region characterised by a variety of migration configurations. Migrant workers, job seekers, skilled professionals, refugees and displaced persons — in regular and irregular situations — all move within a continuum of internal, intra-regional and international circulation, with most countries serving at a single time as places of origin, transit, and destination.^[14] Within these complex and interrelated patterns rural-to-urban migration, including seasonal mobility, emerges as one the most dominant migration pattern in SSA.^[15] Due to a mixture of political conflict, war, and/or natural disasters, the region also hosts more than 3.6 million refugees constituting over 35% of the world's refugee population. There are also more than 6.8 million IDPs in the region.^[16]

HIV AMONG MIGRANTS AND CRISIS-AFFECTED POPULATIONS

Data on the proportion of refugees and crisis-affected populations living with HIV are scarce, and even less are available on the ART needs in these populations. A recent review by Suphanchaimat et al. (2014) found only three publications that reported HIV prevalence among international migrants and refugees in SSA.^[17] In South Africa, an estimated 22%–29% of migrants were infected with HIV between 2003 and 2007. In other countries — Kenya, Uganda, Rwanda, Sudan, Tanzania, and Zambia — a variety of HIV rates were observed, ranging from 0.6% to 5% in refugees residing in different camp sites during 2001–2005.^[18–20]

THE RIGHT TO HEALTH

Providing HIV services to migrants and crisis-affected persons is firmly rooted in international humanitarian and human rights laws, policies as well as medical ethics (Box 1).^[21] Protection offered under these laws and, in particular, article 12 of the International Covenant on Economic, Social and Cultural Rights,^[22] and article 16 of the African Charter on Human and Peoples Rights confirm 'the right of everyone to the enjoyment of the highest attainable standard of physical and mental health'.^[23] Interpretation of these laws has also further expanded the standard of 'accessibility, acceptability, affordability and high quality' in relation to health care services, without discrimination (including on the basis of sex, sexual orientation, nationality, ethnic origin, language, health status, etc.). Moreover, the 1951 Refugee Convention^[24] stipulated that states cannot limit the enjoyment of any human right or discriminate against non-nationals on the grounds of 'race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status' and that nationality must not be used as a ground for discrimination in relation to health care and other rights in the Covenant. The 1951 Refugee Convention also states that refugees should enjoy access to health services equal to those of the host population. This law has been reinforced by the 2008 World Health Assembly (WHA) Resolution that stressed the need to avoid disparities in health status and access to health services between migrants and the host population. Moreover, it clarified that ensuring migrants' health rights entails limiting discrimination or stigmatization, and removing impediments to migrants' access to preventive and curative interventions, which for the host population are basic health entitlements.^[25]

It is clear that clinicians and health workers who treat migrants and crisis-affected persons should be guided by the same principles that govern the treatment of any patient before them, irrespective of nationality or ethnic origin; this includes an intrinsic respect for human life and an oath to act in the patient's best interest when providing medical care.

THE REALITY OF ART ACCESS

Despite international laws protecting the universal right to health and the growing consensus that migration and humanitarian crises should not affect one's access to HIV services as an inalienable human right, members of these groups are often denied treatment, even in settings with good access to treatment. They not only have to negotiate common logistical barriers to treatment access such as travel costs that apply to many host populations as well, but also systemic ones such as exclusionary treatment policies, and uncertain legal status leading to fear of identification in government structures.

POLICY AND TREATMENT DEVELOPMENTS

Efforts to improve treatment access and to support ART adherence among individuals living with HIV, regardless of their migration or displacement status, have been facilitated by recent developments in policy and HIV treatment (see Box 2). Although these advances do not exist in all SSA countries, there is an increasing positive trend, particularly in the member states of the Southern African Development Community (SADC).

Box 1: Other international and regional human rights treaties relevant to migrants' right to health care^[21]

The International Covenant on Civil and Political Rights^[26] and the International Convention on the Elimination of All Forms of Racial Discrimination,^[27] both of which have been ratified by most SADC member states, prohibit discrimination based on race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status.

The African Charter on Human and Peoples' Rights,^[23] which has been ratified by all SADC member states, prohibits discrimination on the basis of various grounds, including race, ethnic origin, language, social status and other status. Of significant importance, the Charter provides that every individual has the right to enjoy the best attainable state of physical and mental health, and that state parties shall take the necessary measures to protect the health of their people and to ensure that they receive medical attention when they are sick.

The Convention Relating to the Status of Refugees,^[24] which has also been ratified by all SADC member states except Mauritius, contains important international standards and norms that apply to refugees. The Convention obliges state parties not to discriminate against refugees on the basis of religion, race or country of origin.

Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW)^[28] Article 12 establishes the obligation to adopt adequate measures to guarantee women access to health and medical care, with no discrimination whatsoever, including access to family planning services. It also establishes the commitment to guarantee adequate maternal and child health care.

Convention on the Rights of the Child (CRC)^[29] Articles 23 and 24 recognize the right to health for all children and identify several steps for its realization.

The International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families^[30] unequivocally states the right to equal treatment regarding access to social and health services for documented migrant workers and members of their family and nationals.

In 2008, the WHA adopted Resolution 61.17 on the Health of Migrants.^[25] A report prepared by the WHO Secretariat in support of the WHA resolution identified the following four basic principles for a public health approach to address the health of migrants and host communities: (1) disparities should be avoided in health status and access to health services between migrants and the host population; (2) limit discrimination or stigmatization, and remove impediments to migrants' access to preventive and curative interventions, on an equal basis as the basic health entitlements of the host population; (3) reduce excess mortality and morbidity associated with migration and displacement from disaster or conflict areas with lifesaving interventions; and (4) minimize the negative impact of the migration process on migrants' health outcomes.

Box 2: Recent HIV policy and treatment developments in SSA

1. Expanded health infrastructure and systems for ART delivery.
2. Large and established ART patient cohorts and good mechanisms for improving retention.
3. Simplified recommendations allowing ART initiation regardless of CD4 cell count for expanded number of patient populations.
4. Newer drugs and fixed drug combinations that are simpler to take.
5. Robust evidence base showing that with appropriate support migrants and crises affected populations can adhere well to treatment even in difficult circumstances.
6. Task shifting to promote treatment provision by nurses.
7. Simplified recommendations for ART initiation.
8. Increasing recognition and acceptance of longer drug refill times between 1–6 months.
9. Regional commitments to harmonize health documents and drug regimens.
10. Recognition of the effectiveness of ART in preventing ongoing HIV transmission and the human and financial costs associated with new infections.

FACTS ABOUT MIGRATION, DISPLACEMENT AND ART

Decisions about providing access to ART must be informed by evidence on how migrants and crisis-affected persons live, travel, take treatment and seek health care. This section presents the best available evidence on migration and displacement related to ART provision:^[31]

Internal migration is a dominant pattern in SSA

- Migration is a complex phenomenon that is not limited to international movement across borders. In SSA, a large proportion of migrants are in fact nationals who move within their own country.^[32] While internal migrants do not face the same health challenges as non-nationals in the country, they can face certain barriers to access health services due to their mobility, lack of familiarity and language differences with their community of origin.

Migrants can be healthier than the populations in their destination country and do not have to place a heavy financial burden on the host society and the state's health system^[21]

- It is not the migrant status, but rather the presence of structural constraints during the migration process and barriers in the country of destination that put migrants at a higher risk of adverse health. In the case of HIV, care and treatment is increasingly available in SSA and there is no evidence of mass movement of people across borders to access ART.

Travel among regular and seasonal migrant workers is often predictable and can be planned for

- Most travel plans among migrants are predictable and follow seasonal patterns (e.g. end-of-year holidays, planting seasons, and religious festivals) and show differences according to gender.

Despite being displaced, refugees who are settled in camps tend to have similar levels of HIV behavioural risk compared with the surrounding host communities

- Although displaced persons are vulnerable to exploitation and abuse, evidence suggests that there are 'protective' factors (e.g. better and more secure access to health care services) especially in a refugee camp setting that may reduce HIV transmission risks.
- Persons in refugee camps and nationals in surrounding villages report similar levels of risky sexual behaviour and vulnerability to violence, including gender-based violence.^[33]

Treatment outcomes among crisis-affected persons are similar to those of unaffected populations^[2-7]

- Clinical outcomes (e.g. virological suppression and mortality reduction) in displaced persons are similar to non-displaced persons.^[2, 3, 4, 6]
- Self-reported adherence and retention in care among displaced persons, once they reach their destination, are similar to non-displaced persons.^[2, 5, 7]
- Disruption of clinic services and treatment during acute crises is most frequently limited in duration.^[3, 34]
- Treatment discontinuation levels are low after acute crisis situations.^[34, 35]

Migrants and crisis-affected persons develop alternative support structures

- There are often tight and extensive support networks of similarly affected people among migrants and displaced persons as there are within the host community. Although these may not always involve the more traditional support networks, they offer alternative ways of ensuring adherence to ART, such as using clinical staff, counsellors and support groups, which have proven effective.^[6, 36]

ART regimens are increasingly being harmonized in the region

- In many of the sub-regions of SSA, there is a movement toward harmonizing ART regimen choices, which would improve the chances for patients on the move, across or within international boundaries, to remain on the same ART regimen once they arrive at their destination.





Part 1- Clinical Guidelines for the Health Care Practitioner

Part 1 - Clinical Guidelines for the Health Care Practitioner

As noted in the Introduction, these guidelines complement national clinical guidelines by clarifying options for treatment in the context of migration and crisis. Specifically, these guidelines focus on supporting health workers through the patient treatment process (from preparedness and initiation to adherence and treatment continuity) with detailed reference a patient's history of or intention to travel.

OVERALL PRINCIPLES

- ART is a lifesaving intervention. As with all patients, regardless of migration or displacement status, *ART should be initiated based on the national guidelines or otherwise the WHO's 2013 guidelines if treatment is clinically necessary and the patient is ready and motivated to adhere to treatment.*
- A history of displacement or the possibility of travel should not be a reason to deny or delay treatment, although there may be modifications to the treatment plan.
- At follow-up, as with all patients, the focus should be on supporting the patient's ability to adhere to treatment.
- Among those patients whose treatment has been interrupted, the focus should be on preventing treatment interruptions in the future and re-initiating treatment as quickly as possible. Moreover, the absence of laboratory facilities should not be a reason to delay restarting treatment. Follow the WHO's 2013 guidelines for recommendations on when to use the test-and-treat approach and rapid tests that do not require laboratory facilities.

STARTING ART TREATMENT AND RECOMMENDED REGIMEN

ART NAÏVE ADULTS

Patient preparedness

- The patient must make a fully informed decision to begin ART.
- As with all chronic illnesses, proper counselling is essential. This should include how to take treatment, maximize adherence, minimize interruptions, and what to do in case of interruption.
- To ensure that the patient understands the information provided, counselling should be provided in the patient's native language and in a culturally sensitive manner. This is the case for refugees and international migrants, but may also be important in the case of IDPs and internal migrants from other parts of the country. UNHCR has translation resources available for refugees and other persons of concern.
- In the event of informed refusal of ART, continued counselling is required. Importantly, access to other interventions including prophylaxis and treatment of opportunistic infections or malnutrition should not be withheld.

Choice of regimen

- Follow national guidelines in your country. In the absence of national guidelines, refer to the WHO's 2013 guidelines.^[9]

Reasons for advising the patient to remain within your care for a specified period of time once s/he starts ART

- If travel is imminent and there is a strong likelihood that ART is not available at the intended destination, encourage the individual to remain in your care for at least three months so that you can monitor potential side effects and adherence. Subsequently, if travel is still necessary, you should provide him/her with a stock of medication for 3–6 months if possible. You should then strongly advise the patient to go to a nearby ART site, which is usually available in a large city or capital city even in the poorest countries. If the patient insists on migrating imminently to a place with no ART access, then the risks and benefits of deferring treatment must be carefully weighed against immediate initiation.
- If the patient has just started treatment and is clinically unstable (including anyone with severe opportunistic infections or those with severe anaemia, hepatic or liver dysfunction) encourage him/her to remain in your care for 3 months if at all possible so that you can monitor the response to treatment and manage any immune reconstitution syndromes that may arise.
- A patient with tuberculosis (TB) including multi-drug and extensively drug resistant (M/XDR) TB should be strongly encouraged to stay where s/he can receive treatment, as s/he presents an infection risk while travelling. Referrals have to be made for the patient to access relevant TB treatment services. Not all national TB programmes provide M/XDR TB treatment; therefore, it is important that the patient is referred to a service that provides the relevant treatment.

Reasons for advising the patient to seek treatment upon arrival at final destination

- If travel is imminent, but treatment is not urgent (e.g. high T-lymphocyte cell bearing CD4 receptor (CD4) count and/or not meeting any of the immediate treatment criteria) and you can confirm that this person can access ART at his/her destination, then it may be most prudent to advise him/her to seek treatment upon arrival in the new destination.
- For pregnant women, patients with TB and hepatitis co-infection and children, treatment should be initiated according to national or WHO's 2013 guidelines.^[9]

FOR ADULTS ALREADY ON ART

Patient preparedness

- Obtain a complete medical, ART and social history (including review of the patient's referral letter, pill box, and health travel card if available).
- Determine reasons for treatment interruption, if this has occurred.
- If available, conduct a confirmatory HIV test if a patient has no evidence of status or treatment.
- Support the patient to make an informed decision either to continue or to restart ART. As with other illnesses, providing counselling in the patient's native language and being culturally sensitive is crucial.

Treatment initiation

- Since the individual is currently on ART, make every effort to continue antiretroviral medications (see choice of regimen below) without delay.
- If possible, conduct a viral load test during first visit, but do **not** delay treatment continuation for the viral load results.
- Adherence counselling and support should be undertaken at the new site to apprise the patient about local support resources.

Choice of regimen

- In general, try to match the regimen and drug formulation to the one the individual is most likely to be on over the next year, if that flexibility exists. If travel is likely to occur soon, try to match the drug regimen that is available in the area the person is traveling, again if that flexibility exists.
- Increasing harmonization of regimen choice across the region is making this easier as in general most patients in SSA are being initiated on fixed dose, one pill, once a day treatment. Second line tends to be more varied, but as long as a protease inhibitor-based regimen is available, transfer between regimens is usually possible.
- Nonetheless, if the patient is on a different regimen from the national programme, ascertain whether this was due to side effects (e.g. not on tenofovir disoproxil fumarate [TDF] for renal dysfunction, not on efavirenz for psychosis or not on Zidovudine [AZT] because of anaemia).
 - If the national guidelines support the patient's current regimen, then continue with this regimen and initiate monitoring according to the local algorithm (the exception to this is stavudine (d4T)-based regimen, where TDF or otherwise AZT is preferred). If possible, when changing from d4T, check the patient's renal function (for TDF) or haemoglobin (for AZT) and viral load.

- If the patient is on an unknown regimen, with minimal history, then in general initiate on the national guideline's first line therapy, and follow closely.
- Finally, the national regimen protocols may offer better or new treatment options, and these cases should be assessed by a qualified professional.
- If ART was interrupted, then determine the cause for the interruption.
 - In the majority of cases, interruption occurs because of stock-outs; in these cases, restart treatment as soon as possible.
 - If adherence is an issue, explore factors that contribute to patient's low adherence and take those issues into consideration when deciding how best to restart treatment. However, generally migrants and crisis-affected persons report similar levels of adherence when compared with non-displaced populations.^[2-7]
 - If due to side effects, subsequent drug choices should be carefully evaluated.
- In many cases, a patient may have been on fixed-dose combinations at his/her previous ART site, and this may mean a higher pill burden in their new site if the fixed-dose combinations are not available. The changes should be carefully explained to the patient during adherence counselling and additional support provided.

CHILDREN

- As with adults, the decision to initiate treatment in children should follow national guidelines or WHO guidelines if no national guidelines exist.
- Syrup formulations have large volumes, and can be difficult to carry and refrigerate. This may be particularly relevant for those travelling long distances and should be taken into consideration when making clinical decisions. Whenever possible, use dispersible tablets, and if unavailable other heat stable formulations.
- For unaccompanied minors, you may need to follow a special legal process or agreed upon guardian/caregiver arrangements. These processes need to be expedited as quickly as possible, to avoid delaying initiation or continuation of ART. For refugee children, contact UNHCR for assistance.

THE ROLE OF THE HEALTH PROVIDER IN ADHERENCE SUPPORT

Adherence levels are generally similar among migrants and crisis-affected persons when compared with those with no mobility history.^[2-7] Therefore, there is no evidence supporting withholding treatment on the basis of a higher risk of non-adherence. The primary adherence barrier reported by migrants and crisis-affected persons, similar to that among the general population, was travel away from home. Other barriers, including food insecurity,^[37-40] hiding medication in front of others, less time on ART,^[41] fear of stigma,^[6, 40] and inability to take time off work to go to the clinic,^[6] have all been previously reported among the general population.^[42] The main reported barriers to adherence that are unique to crisis-affected populations are previous experience of torture^[37] and detention and deportation to countries with no treatment availability.

ADHERENCE BARRIERS

Travel away from home is common in SSA, and a primary adherence challenge both for the general population and migrant and crisis-affected populations.^[42-44] Travel may be foreseen and predicted (e.g. seasonal migration, work-associated mobility, or travelling home for holidays) or unplanned (e.g. conflict and natural disasters that could lead to forced displacement). You should discuss and develop a treatment travel plan with your patient before and at treatment initiation. This plan should be reviewed and updated during every follow-up visit. The plan may include a combination of the following strategies:

- When possible, provide the patient with a **health travel card in different languages** with at least the following information:
 - Name, regimen, last viral load and/or CD4 and date, concomitant medications and date.
 - Health travel cards may be lost so patients should be aware of their basic medical history and be able to relate it verbally or store it on their mobile phones.

HEALTH TRAVEL CARD

Name:

Clinic Unique I.D. Number:

Clinic name:

Clinic location:

Clinic/Pharmacy telephone number:

Current medication(s)	Date started	Date of last refill	#Days given
1.			
2.			
3.			

Last viral load (if available):

Date:

Last CD4 (if available):

Date:

Date:

Clinician's signature:

- Advise the patient to inform the clinic in case of any planned travel so that the following can be provided:
 - A referral letter detailing the patient's condition and treatment history.
 - Note that due to language differences, the health worker at the destination site may not speak or read the referring site's language. Use generic names and terms (e.g. tenofovir, TB, cryptococcal meningitis) and internationally agreed upon abbreviations or acronyms (e.g. PMTCT for prevention of mother-to-child transmission and HTC for HIV testing and counselling).
 - A **refill** of 3 months if possible and perhaps even longer can be provided.
 - Where longer refill times are not possible, consider providing an **emergency supply** of ART to be used in case of urgent travel (2–4 weeks will allow the patient sufficient time to make alternative plans for ART access).^[39, 41, 43, 45, 48] This emergency stock has to be rechecked routinely to examine the expiry date and is much less desirable than longer routine refills.
 - A treatment map detailing alternative sites for ART refill depending on anticipated travel^[41, 47, 49-50] (e.g. Médecins Sans Frontières' (MSF) programme for migrants in South Africa provides beneficiaries with a map of ART sites in Zimbabwe).^[3]
- In case of unavoidable ART disruption, counsel the patient to
 - Seek continued care only through public or reputable programmes and to seek advice on safe interruption.¹
 - Avoid sharing ART and/or reducing or interrupting ART to extend the stock lifespan.

Food insecurity has also been reported to be a major barrier to adherence among migrants and crisis-affected populations. The link between food assistance and adherence has not been formally studied in these population groups. However, a recent systematic review in the general population found that in 8 out of the 10 included studies, the provision of food could improve adherence and/or treatment completion for HIV care and treatment, ART and TB-Directly Observed Therapy Short-course. The authors of the study concluded that food assistance may not only be a critical biological intervention, but also a behavioural one to improve adherence to ART.^[51]

A nutritional assessment as per the national or WHO's 2013 guidelines among both adults and children should be undertaken to assess the need to provide food supplements at treatment initiation. Weight loss or failure to regain or maintain a healthy weight at any stage of HIV infection or ART should trigger further assessment and appropriate interventions.^[9]

¹ In the event of a forced disruption of treatment, patients taking a tenofovir or protease-inhibitor based regimen **can safely stop all drugs** and restart as soon as a reliable supply is available. If feasible, those who are on a dual nucleoside regimen (AZT, d4T or ABC [abacavir] with 3TC [lamivudine] and an NNRTI [non-nucleoside reverse transcriptase inhibitor]) should be provided with a 1-week 'tail' supply of the two nucleosides to reduce the risk of development of resistance to NNRTI. It is important to note that where provision of such a 'tail' is not operationally feasible, patients should simply stop all drugs regardless of regimen.

TREATING CO-INFECTIONS AND OTHER ILLNESSES RELATED TO HIV

Tuberculosis

- National guidelines should be followed.
- There are almost no contraindications for starting standard TB treatment.
- ART should be provided to all patients with HIV with active TB disease including those with drug-resistant TB, irrespective of the CD4 count.
- For a patient who is co-infected with TB and HIV, start TB treatment first. The time interval between the start of TB treatment and ART depends on the patient's CD4 count.
- Transfer of patients with drug-sensitive TB from one site to another can be done relatively simply. However, some countries do not yet have widespread access to second-line TB drugs, including the aminoglycosides and the quinolones. In addition, many countries do not have the laboratory infrastructure to make the diagnosis of M/XDR TB. Thus, it is advisable that you check the status of the multidrug-resistant TB programme in the destination site before recommending transfer of M/XDR TB patients. If there is no access to the treatment where they are planning to go, they should be advised strongly against leaving until their treatment is completed.

Other illnesses

- You may also need to consider and provide appropriate prevention advice on malaria, typhoid, trypanosomiasis, viral hepatitis, cholera, amoebiasis, measles and other diseases that are common in SSA and can affect people living with HIV. Even if malaria or other significant medical conditions are not endemic in certain countries, health providers should consider these diseases in the diagnosis of patients.
- Consider endemic AIDS-defining diseases in other countries that may not be common in the host country (e.g. kala-azar in Somalia and South Sudan; and histoplasmosis in Zimbabwe).
- Assess and be particularly alert to issues related to mental health and psychosocial support (MHPSS) among those coming from conflict areas. Trying to obtain a medical history from the patient may provoke anxiety, depression and stress responses, so make every effort to ensure that appropriate psychosocial support is made available through community-based psychosocial support structures or dedicated MHPSS services.
- For people at risk of unplanned movement, consider providing a contingency stock or longer refills of primary and secondary prophylactic medications (e.g. cotrimoxazole, isoniazid and fluconazole), as done for patients receiving ART.

HIV PREVENTION

- Overall, combination prevention approaches that incorporate complementary strategies aimed at both people living with or without HIV offer the most promising way forward for HIV prevention. These include the dual aims of minimizing infectiousness (e.g. ART, condoms, sexually transmitted infection (STI) treatment for HIV-positive people) and susceptibility (multiple interventions for HIV-negative people).^[52]
- Specifically, in some cases, migrants and crisis-affected persons will be moving into a high HIV prevalence setting, particularly if they move from outside of Southern Africa into the sub-region (e.g. from Somalia to Botswana), but also from rural to urban areas within a country or sub-region. These persons should be made aware of the increased HIV risk as some may have very limited knowledge of prevention methods, such as condoms. Do not assume basic prevention knowledge exists.
- For those already living with HIV, prevention messages must be re-emphasised to avoid further transmission. Prevention messages, verbal or written, must be communicated whenever possible in the person's native language. Also, stress the importance of having sexual partners tested, especially for individuals living with HIV. Be sure to provide the patient with an additional supply of condoms before his/her travel.

Prevention of mother-to-child transmission

- In cases of moving to sites with established PMTCT programmes, pregnant women should be advised to immediately seek out local PMTCT programmes upon arrival at their destination and enough medication for travel should be provided. However, due consideration to duration and mode of travel, and conditions on arrival must be discussed.
- A clear referral letter is important at all times, in both the antenatal and postnatal period, in addition to an individual 'health travel card' that summarizes treatment history, whenever possible.
- In many countries, all pregnant women who test positive for HIV are being initiated on treatment regardless of their CD4 count, and at any point during their pregnancy. However, where this is not the case and the woman is facing imminent travel close to her time of delivery, you should consider providing her with enough PMTCT drugs for herself and her baby, once born, in case she delivers en-route to her destination or she moves to an area where there are no PMTCT programmes. As with all adults facing imminent departure before treatment initiation, careful counselling is highly advised.
- In rare instances, you may have a pregnant patient who has arrived from a site where no PMTCT services were available. For pregnant women the current recommendation, in an increasing number of countries in the region, is to initiate treatment early (as early as 14 weeks). However, in contexts of migration, displacement and lack of access to services, treatment can be initiated at any time of contact. In such circumstances, careful counselling regarding PMTCT is important.

Gender-based violence and post-exposure prophylaxis (PEP)

Sexual violence can increase in the wake of crises (e.g. natural disasters, conflict), and may also be associated with migration. In cases of prior sexual assault, appropriate systematic care and support should be provided as per national guidelines. Most important, PEP should be provided as soon as possible, ideally within 72 hours after possible exposure.

- If national guidelines exclude migrants and or persons affected by crises, treatment should be accessed elsewhere (e.g. rape crisis centres, NGOs, faith-based organisations, and private practitioners). For refugees who cannot access PEP through a local service, contact UNHCR.
- In addition to PEP and as part of a clinical package of health services for rape survivors, appropriate wound care, including immunization against tetanus, STI presumptive treatment (within 2 weeks) and hepatitis B vaccination in line with national protocols should be provided. Emergency contraception (within 120 hours) to prevent pregnancy should be offered. Rape management services should include provision of, or referral for, safe abortion to the full extent allowed by the applicable law.
- Forensic specimen should be collected where facilities exist to conduct an analysis.
- Psychosocial interventions (e.g. psychological trauma counselling) and referral for provision of social and legal assistance is critical.^[53]

Testing and counselling

All people, especially where the epidemic is generalized, should be encouraged to regularly test for HIV in a voluntary and confidential manner. Although early diagnosis of HIV status should be pursued at every opportunity there are some caveats:

- HIV status does not have an impact on the legal status of a migrant or displaced person in the region. Despite this, many may be anxious about disclosing their HIV status or choose to remain anonymous for a myriad of reasons, including security concerns. Health workers should deliver care in a manner that does not put patients or their patients' families in danger. Also, health workers must reassure patients that their privacy and confidentiality will be respected.
- In case an HIV test is a mandatory requirement, health care workers should ensure counselling and informed consent and explain possible consequences of a positive HIV test result.
- In acute emergencies, the rationale for focusing already limited resources on HTC campaigns should be balanced against other immediate health needs (e.g. diseases outbreaks, low HIV prevalence area).

REPRODUCTIVE HEALTH

Migrants and crisis-affected populations should have prompt and uninterrupted access to comprehensive reproductive health services.

Comprehensive reproductive health services include safe, effective, affordable and acceptable methods of family planning of choice. Access to services that facilitate safe pregnancy and childbirth, allowing couples the best chance of having a healthy infant and a healthy family, must also be made available. Where the national population has access to cervical cancer screening or human papilloma virus vaccines, migrants and crisis-affected populations will need to have the same access. Such equal access should also be available in the context of safe abortion services to the full extent allowed by the applicable law.

The minimum initial service package (MISP) for reproductive health in crisis should be followed when health structures and systems have been destroyed or are not operating at scale.^[54] The MISP includes a set of priority practices for health care professionals that are designed to prevent and respond to sexual violence; prevent excess maternal and newborn mortality and morbidity; reduce HIV transmission; and plan for comprehensive reproductive services in a coordinated manner.

Positive prevention should be promoted by equipping HIV-positive persons with information and commodities, including condoms and other prevention services for themselves, their partners and their families.

ENSURING ART ACCESS FOR VULNERABLE SUB-GROUPS OF MIGRANTS AND CRISIS-AFFECTED PEOPLE

Women and girls

It is widely recognized that the lower social status and unequal power relations between women and men increase the vulnerability of women and girls, particularly those outside of family units. Specifically, women and girls are often at greater risk of sexual violence, exploitation and HIV infection; this may be exacerbated in crisis situations. Therefore, specific efforts to protect women and girls, as well as ensure their access to information and services, are required.^[55] This can be achieved in part by (1) advocating for the implementation of domestic legislation protecting the rights of women and girl migrants; (2) granting women migrants, independent legal status, rather than keeping their status dependent on male relatives or husbands, can provide important protection; (3) increasing access to confidential health care services; (4) where appropriate and feasible, having female health workers available to provide services to women and girls; and (5) strengthening services for hard-to-reach groups such as recent migrants and those with disabilities by conducting outreach programmes.

Orphans, separated and vulnerable children

The nature of displacement often results in families being separated. There may be an increase in orphans, unaccompanied and separated children because of conflict and possibly a related increase in endemic communicable diseases. Displaced children may also be accompanied by a relative or another adult who is not a relative. If there are any concerns regarding care arrangements for the child, refer directly to social services for assessment. Specialised counselling may be required for these children. Red Cross/Red Crescent, UNICEF and other organisations facilitate family tracing and reunification, or temporary foster family care, and return of children to their country of origin.

The 1989 CRC is the main legal instrument on the protection of children and stipulates that the best interest of the child shall be a primary consideration governing in all actions affecting children. A best-interest determination in the case of an unaccompanied migrant and a refugee child should ensure adequate input from the child without discrimination. It should also allow the views of the child to be given due weight in accordance with age and maturity. Furthermore, a best-interest determination should include decision makers with relevant areas of expertise such as child protection specialists, and balance all relevant factors to assess the best option.^[56]

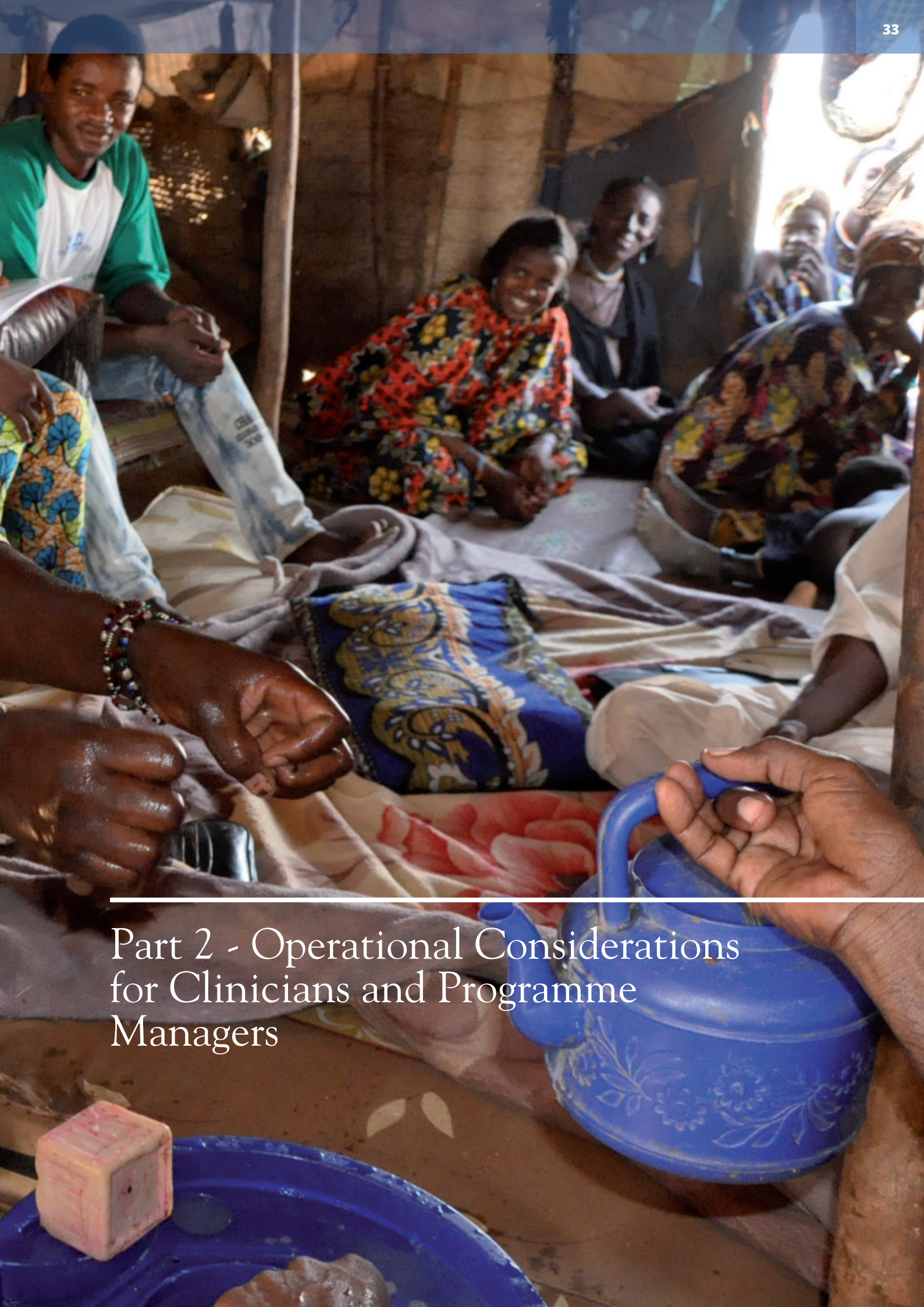
Detained or deported persons

Either as a result of HIV-related restrictions on entry, stay and residence, or as part of deportation proceedings commenced on immigration-related grounds, HIV-positive migrants or asylum seekers may be taken into custody and detained pending the outcome of an immigration case, deportation or refugee status determination. Many states do not have adequate systems in place to ensure ART continuity for detainees pending deportation or to protect their rights against unlawful return.^[57] Advise patients to share the contact details of the clinic with their family, in case they can carry ART to the detainee during detention and/or prior to deportation.^[57, 58] NGOs such as MSF or the Red Cross/Red Crescent often provide health services to migrants, asylum seekers and refugees in immigration detention centres. These NGOs can play an important role in ensuring (continued) access to ART in this setting.

Sex workers

Studies have highlighted the strong overlap between sex work and migration.^[59] Health status and HIV risk among male, female and transgender sex workers are contingent on the economic dependence on sex work, the safety of the work environment and the degree of responsiveness of health services. Studies have shown that cross-border migrant sex workers have less health care contact than their non-migrant counterparts,^[34, 35] and face more discrimination and additional barriers accessing health, social and legal services.^[60, 61] Therefore, to facilitate prevention of HIV and other STIs, health services programming should be developed to specifically address health needs of migrant sex workers. Moreover, migrant sex workers should not only be actively engaged in the design and planning of health programming, but should also serve as peer educators and outreach workers.





Part 2 - Operational Considerations for Clinicians and Programme Managers

Part 2 - Operational Considerations for Clinicians and Programme Managers

This section primarily focusses on humanitarian emergencies and also includes information relevant to migrant settings. The information is aimed at programmers who are involved in the design of ART programmes to:

- Set priorities in ART delivery.
- Support adherence and retention in care.

PRIORITY SETTING

The priorities for the HIV response depend on the displacement context and the type of ART programme available to migrants and crisis-affected populations. Below, we provide programmatic recommendations based on whether a patient receiving ART is moving into a setting with an established ART provision system or not.

ESTABLISHED ART PROGRAMMES WITHIN STABLE HEALTH SYSTEMS

For established programmes where services are uninterrupted and where the larger health system is stable, the focus should be on treatment continuity, adherence support, as well as on reducing barriers to treatment access. Moreover, a focus on service integration and linkage is key. In generalized epidemic settings, ART should be provided in antenatal care and in TB clinic whenever possible.^[9]

WEAK OR NON-EXISTENT ART PROGRAMMES

During the acute emergency phase resulting from conflict or natural disaster, mass displacement may occur with persons migrating toward safe areas where ART delivery may not be well established or where treatment is completely non-existent. Fortunately, the latter has become less common in the last five years with the dramatic scale up of ART programmes throughout SSA. Even in settings with limited or no ART services (e.g. Liberia, Democratic Republic of the Congo, South Sudan, and the Central African Republic) strong and rapid coordination could ensure that quality ART services are quickly established. The priority for HIV programming should be to ensure continuity of care to those already on ART as well as treating symptomatic HIV and providing PMTCT.

The Inter-Agency Standing Committee (IASC) Guidelines for Addressing HIV in Humanitarian Settings outline the following minimum set of HIV prevention, treatment, care and support services for people affected by humanitarian situations: (1) the prevention of HIV transmission in health care settings; (2) provision of access to good-quality male and female condoms; (3) provision of PEP for occupational and non-occupational exposure; (4) management of STIs; (5) PMTCT; (6) provision of care for people with HIV-related illnesses; and (7) provision of ART to those in need.^[62]

Specifically, activities related to the provision of ART in humanitarian settings should be:

Minimum response

- Identify adults and children requiring continuation of ART.
- Provide ART to those previously on treatment.

Expanded response

- Ensure continuation of care services for people living with HIV, including home-based care.
- Provide access to HTC.
- Initiate and scale up ART programmes.

The IASC guidelines also stress that a multi-sectoral expanded response is required to prevent further transmission of HIV. These include HIV awareness raising and community support; protection; food security, nutrition and livelihood support; education; income generation; shelter; camp coordination and camp management; water, sanitation and hygiene; and HIV programmes in the workplace. ^[62]

SUPPORTING ADHERENCE AND RETENTION

Strategies aimed at the individual patient to improve adherence are discussed in the clinical guidelines section (see Part 1). Health systems' factors that limit adherence among migrants and crisis-affected persons are quite similar to those reported among stable populations; these include costs related to treatment, [37, 40] ART stock outs, [44] and limited human capacity to deliver ART. [37, 44] Creating a **contingency plan** is one proven strategy to improve the resilience of the ART programmes in emergencies where displacement is anticipated. [34, 45, 47-49]

The contingency plan could include elements of the following:

- Maintenance of a **buffer stock** of ART in the clinic in case of disrupted drug supply. [47, 48]
- **Stock forecasting** to predict the feasibility of providing longer refills (between 3 and 6 months per patient). This is particularly applicable for migrants around holidays and periods of seasonal migration.
- Identification of **emergency communication** means with patients during periods of instability. [34, 48]
- **Creating a plan for mobilizing health workers** into the community to follow and actively trace defaulters. [44, 49]

Overall, clinicians and programme managers should focus on:

- ***Integrating HIV services*** within national programmes. Services for migrants and crisis-affected populations should be integrated with national programmes whenever possible.^[3, 44, 63]
- ***Improving patient-provider communication.*** Working with family members or community members as interpreters carries risks regarding respect for confidentiality and inappropriate disclosure, and should be avoided when possible. Furthermore, patients may be less willing to provide candid information if s/he knows the interpreter. All efforts should be made to have an independent interpreter who has been trained on importance of maintaining confidentiality. For refugees, do not refer them to their country's embassy, as that may jeopardise their asylum status. This may be an option, though, for other displaced persons (e.g. economic migrants). For help with refugees, contact UNHCR, who may be able to identify suitable interpreters.
- ***Training health workers*** to discuss treatment in a culturally sensitive and non-judgemental manner. Regardless of cultural traditions or practices, ethnicity, or religion, the health worker should maintain professional standards and practices, although this may require additional time and effort.
- ***Addressing issues of food insecurity*** as a major barrier to adherence among migrants and crisis-affected persons.^[37-40] This can be achieved by strengthening the referral system between health point and social protection programmes, including those providing food assistance, or cash or vouchers.
- ***Identifying and providing information to counter any xenophobic beliefs*** among health workers that may result in them denying or delaying appropriate care to migrants and displaced persons.
- ***Recognizing the right of detained migrants*** and advocating for their continuation of ART while in detention.





Part 3 - Advocacy

Part 3 - Advocacy

Ensuring the health of migrants and crisis-affected population is everyone's business. Persons on the move and those with a history of mobility have a right to receive HIV care, including ART. Provision of HIV care has a strong legal and ethical rationale. Everyone reading these operational guidelines should advocate to relevant stakeholders to ensure that migrants and crisis-affected persons have access to ART and the continuity of treatment that they deserve. This section focusses on public health advocates, civil society groups and lobby groups and provides strategies and actions for each stakeholder groups.

STATES

International law obliges governments to protect the rights of all, including the right to health of migrants and crisis-affected persons, such as their right to access quality health services as well as addressing any underlying health conditions. Economic growth, globalization, regional integration and continued crises-induced displacement do and will translate into greater mobility both internally and across borders. Therefore, ensuring migrants' and crisis-affected persons' access to quality health services without discrimination is not only a human rights imperative, but also a public health one.

Strategies of the state to strengthen migrant and crisis-affected persons' access to health care can include the following:^[25]

1. Enforce existing laws, policies, and practices that are inclusive of equitable and robust treatment approaches and that address the needs of migrants and crisis-affected persons living with HIV (e.g. simple, regionally harmonised, non-toxic fixed dose combination regimens, extended drug refills, decentralised treatment provision that is free to all at point of delivery).
2. Make use of the growing body of evidence on migration patterns, risk, and adherence to ART to inform policy decisions rather than rely on unfounded assumptions that position migrants/ crisis-affected persons as a burden.
3. Where there are legal obstacles to access treatment, the state must ensure that laws and policies are in line with their ratified human rights treaties (see Box 1).
4. Proactively identify and remove barriers to the implementation of the regional treaties guaranteeing health, especially in the case of international migrants (see Box 1) and encourage reporting and documentation of abuses and non-compliance with policy.
5. Reinvigorate prior commitments to African unity by identifying and addressing xenophobic sentiments and attitudes that lead health care personnel to limit treatment access and health services.
6. Harmonize patient records, including approval of a regional health travel card, to be used by patients travelling within or across borders.

7. Strengthen monitoring and evaluation systems to improve follow-up of patients who move between different treatment sites.
8. Support the integration of ART distribution with other support programmes (e.g. prevention, psychological support as well as food and nutrition support).
9. Revise national standards on deportation of people living with HIV to ensure compliance with international laws that ensure no person is returned to a country where treatment is unavailable or inaccessible and where his/her life may be threatened.
 - Where feasible, contact health authorities and anticipated providers in each deportee's country of origin, devise a plan for continuing to assure care without interruption, and possibly provide a temporary medication supply if necessary.^[57]

While laws throughout the region support unfettered access to services among migrants and crisis-affected persons, in practice these populations are often discriminated against, including in employment, and denied care that is medically essential.^[21] Staffs representing donor and UN agencies, civil society, as well as clinicians and programme managers should ensure that states comply with these national laws as follows.

CLINICIANS AND PROGRAMME MANAGERS

1. Prioritize their patient's welfare, thereby ensuring that all who need treatment receive treatment, regardless of their mobility history or migrant status. Discrimination on the basis of a person's mobility is unethical and contradicts recent evidence showing comparable levels of adherence among migrants and crisis-affected persons compared with non-displaced populations.^[2-7]
2. Prepare contingency plans for ART provision, especially in emergency-prone settings and in migrant-sending areas. Plans should include the use of travel health cards and extended drug refill times between visits.
3. Advocate for non-discriminatory medical practices and play an active role in reducing and censuring discriminatory attitudes and dispelling myths regarding migrants and crisis-affected persons. Clinicians and programme managers should resist the implementation of access-restrictive policies, and should instead document the practices and report them to local human rights organisations and NGOs.
4. Institute a mechanism for patients to report incidents of abuse and discrimination.
5. Ensure linkages with other programmes to ensure continuum of care.
6. Ensure appropriate capacity building for staff that includes:
 - Training on clinical guidance for ART initiation and support among migrants and crisis-affected persons. This type of training should emphasize that treatment should not be

withheld solely on the grounds of someone's displacement history or future potential to move away from the clinic setting.

- Sensitivity training for staff, including value clarification components, how to address xenophobia and discriminatory attitudes, as well as training on migration patterns in general so that staff develop a core understanding (e.g. understand why people move, who they are, and what services they need). It is important to also include training on gender discrimination and gender-based violence.
7. Maintain confidentiality of patient's medical record.

CIVIL SOCIETY

1. Migrant and crisis-affected persons' rights groups and public health advocates should collaborate with other human rights organisations to raise awareness of rights, advocate against treatment exclusionary policies, and speak out against xenophobia where it occurs.
2. Strengthen the capacity of community groups and leadership, including those living with HIV, to advocate for their own rights.^[64]
3. Advocate and support governments to meet their obligations under international human rights and to implement strategies that reflect best practices for all HIV patients regardless of their migration and displacement history. Increase networking and information exchange between community groups and policy makers.

DONORS AND UN AGENCIES

1. UN agencies that are directly responsible for providing care to migrants and crisis-affected populations must ensure that all who need and want treatment receive treatment, regardless of their mobility history or migrant status.
2. Support governments in norm setting, identifying packages of services for refugees, developing effective systems for data collection and using data to inform policy and programmes.^[63]
3. Encourage governments to consider the needs of migrants and crisis-affected persons in funding proposals and provide resources for incorporating these needs into national HIV policies and programmes.

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Annexes

Annex 1: Case Studies

Case One: THEMBI (Southern Africa)

Thembi is working with a work permit in a country neighbouring her own. She started ART in her home country one year ago. She returns home every 3 months for refills. She can only afford to go home in 6 months time, and has lost her clinical referral letter. She says she is on tenofovir, 3TC and nevirapine, dosed daily, and is considering having a child with her new husband. She previously was on d4T, but developed a peripheral neuropathy and was switched to tenofovir. She has sufficient medication for one more week.

She is refused access to the ART site in the government programme in her country of employment for reasons that appear to be largely xenophobic. Thembi goes to a private practitioner, but does not have money to pay for a creatinine clearance, viral load or CD4 count. The practitioner is unable to obtain the records from her clinic at home. Clinically, she is well. Thembi reports complete adherence and says that her previous viral load, taken 6 months ago, was 'OK'.

The practitioner advises her that introducing a single new drug to replace tenofovir in the face of a virological failing regimen carries the risk of resistance to that drug, if no viral load is obtained to confirm suppression.

The practitioner persuades Thembi to pay for a single viral load, funded through her local church. The result comes back undetectable. He discusses the risks and benefits of switching nevirapine to efavirenz, which is more in line with the national guidelines in the country in which she works. She requests to remain on nevirapine, even though he reassures her that efavirenz is safe, because she does not want to deal with central nervous system side effects. He counsels her that nevirapine is a very safe drug in the long term, and that her choice is not a bad one. He asks her to try to obtain her past medical records as soon as possible. Thembi is advised to return if she experiences any side effects, and is asked to see if the church has further resources to pay for further viral load monitoring.

Case commentary: Xenophobia is a common and harmful attitude among health care workers. Migrants should be encouraged and supported to access health care services, as not all clinics or staff are xenophobic, and policies may be implemented that forbid them from turning people away. Finally, health care workers should report these incidents, as ethical breaches whenever possible to regulatory bodies.

Case Two: MACHOZI (Central Africa)

Machozi is a 28 year-old married woman from a conflict-affected country in Central Africa. Like most of the women in her area, she has never attended school. Four years ago, while working in her fields a group of soldiers moved through the area took her hostage and forced her to carry their goods. They then forced her to 'marry' one of the commanders.

Over the next four months she was repeatedly raped. Finally, Machozi was able to escape her captors, and in fear of being re-captured, she fled to a neighbouring country, seeking asylum. She settled in a small town and made a meagre living selling items in the market. Then over the next several months, she started to lose weight. She also noticed that her skin had broken out in a rash that wouldn't go away. At first she thought she had been poisoned by one of the market women but finally the nurse at the health centre convinced her to get an HIV test. The test was positive and she was referred to the HIV clinic.

The doctor who saw Machozi at the clinic evaluated her clinically at WHO stage 3. He prescribed cotrimoxazole and ordered a CD4 count. The CD4 came back as 124 cells/mm³, and the doctor decided to start preparing Machozi for ART initiation. However, when he discussed this with Machozi, she didn't seem to understand. In fact, she told the doctor that she had decided to return home, and therefore could not come back to the clinic. The doctor explained how important it was to stay in the country of asylum and start ART. Machozi nodded, but still insisted that she must go home. She told the doctor she would take the pills home with her if they were so important.

The doctor considered this option. Machozi was newly diagnosed and while she seemed to understand her diagnosis, the doctor could not be sure, given the language difference and the short time he had known her. A pill count of her cotrimoxazole showed that she had some pills left over. He asked Machozi to describe the health care in her home village. Machozi described the small basic health centre with a single nurse in the town one hour's walk away. She described it was costly to see the nurse and often there were no drugs in the health centre. Considering Machozi's current state of preparedness for ART, the uncertainty that lay ahead when returning home, and the poor level of the local health care system, the doctor decided not to start Machozi on ART before leaving. Instead, he advised her to try and seek out an NGO HIV programme when she returned home. He gave her a 3-month stock of cotrimoxazole tablets and explained how to take the pills correctly. Finally, he wrote a letter describing her medical history and explained to her the contents of the letter.

Case Commentary: Patient care can be very complex in these situations, and there may be no perfect solution. However, giving the patient options and explaining things as much as is possible, while allowing information to flow to the next clinic, often will allow the health workers on the other site to understand this complexity. Hopefully, they will be in a position to intervene effectively.



