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Actions to Address HIV/AIDS Stigma and Discrimination in Humanitarian Settings

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In Brief

Humanitarian settings occur when armed conflicts, natural disasters, epidemics, or other similar events disrupt the functioning of a region or society and pose a substantial threat to the health and safety of populations (1). During humanitarian settings, health systems are impaired, and service delivery is interrupted which leads to the collapse of care systems and people are deprived of access to primary health care (2). Damaged health facilities and the inability to provide enough medical supplies and equipment hinder access to health care (3). This reduced service capacity takes place despite the increased need for HIV-related services due to the high risk of transmission, continuous care for known cases and requirements for preventive equipment (4).

In addition to the mentioned reasons, stigma and discrimination toward PLHIV negatively impact the HIV/AIDS service provision (5). Stigma and discrimination arise from false attitudes, unreasonable negative beliefs, and subsequent unjust actions (6), which cause reduced prevention and service seeking by patients, insufficient service provision by healthcare providers and eventually increased risk of transmission (7). In times of crisis people are in greater need of medical and health care and therefore prefer the efforts to be put into routine care instead of HIV/AIDS services; in addition, the fear of transmission risk is high. As a result, the stigma and discrimination from society and healthcare workers towards PLHIV in times of crisis are high. Many examples exist during the previous humanitarian crises, when stigma and discrimination hindered access to services; armed conflicts in the Middle East and the COVID-19 pandemic are among the examples (8, 9).

Therefore, we aim to find actions to address HIV in emergency and humanitarian situations with an emphasis on society and healthcare workers' stigma, in addition to the discrimination that arises from stigmatizing beliefs. This study was in line with the 5th HIV National Strategic Plan and UNAIDS human rights program.

This study consists of two steps: 1) conceptualization and literature review 2) semi-structured interviews. First, the main objectives are defined based on the current needs of internal team meetings and reviewing the literature. To determine the theoretical foundations, a review of printed and

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↑What is "already known" in this topic:
Stigma and discrimination hinder the HIV/AIDS care provision in humanitarian settings, where care is more needed due to the newly emerged needs. This derangement could have a drastic impact on people living with HIV/AIDS. However, there are no clear guidelines on stigma and discrimination-free responses in these crises.

→What this article adds:
The proposed actions are divided into four categories: preparation, response, recovery, and evaluation. These actions should be carried out by trained and trusted personnel who used to deliver routine services before the crisis. Also there is also no need to disclose the HIV status to general emergency workers.

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electronic sources was performed. To review the existing literature, Google, Google Scholar, PubMed, Cochrane Library, ProQuest and WOS databases were searched. Search keywords included the following:

"Human Immunodeficiency Virus (HIV), acquired immunodeficiency syndrome (AIDS), stigma, discrimination, humanitarian, disaster, crisis, emergency, prevention, mother to child transmission, harm reduction, preparedness, reproductive health, prediction, resilience"

We also manually searched the references of selected search results, and the most relevant ones were added to the review. Websites of relevant medical or humanitarian and emergency response organizations, such as the Joint United Nations Program on HIV and AIDS (UNAIDS), the United Nations Population Fund (UNFPA), the World Health Organization (WHO), and similar organizations were searched.

In the second phase, the best way to gather data was chosen as semi-structured interviews. Questions of these interviews were about the existing programs and structures for service delivery, strengths, and weaknesses during the previous disasters, the experience of witnessing stigma or discrimination, and the most effective way to deliver stigma and discrimination-free HIV/AIDS services. These interviews were conducted with different experts and stakeholders up to the point where no new data emerged. Finally, the results were gathered and the actions were proposed.

After conducting a thorough literature review, despite finding existing guidelines on HIV/AIDS response in humanitarian settings, no document was found to be specific about the stigma-free care for PLHIV during crises. Also, based on the literature on response to humanitarian settings, we designed the interview questions based on four steps: preparation, response, recovery/rehabilitation, and evaluation.

After defining the questions, 22 interviews were carried out with HIV care service providers, humanitarian/disaster or emergency care providers such as the Red Crescent, charities, or non-governmental organizations that provide humanitarian HIV care and PLHIV with previous disaster experience. Recommended actions are listed in Table 1.

Among the responses, two points were key takeaways:

• The continuous service delivery by trusted and local personnel who used to provide routine services before the disaster.

• There is no need to disclose HIV/AIDS status for general emergency workers as the only responsible for delivering service should be previous HIV center staff.

Delivery of stigma and discrimination-free HIV/AIDS services is crucial during humanitarian settings as it both increases the accessibility of service delivery and reduces transmission. Nevertheless, due to the lack of proper evidence, we proposed the actions mainly based on the Iranian experience of providing stigma-free and people-centered

Table 1. Recommended actions for each phase of the response to the humanitarian setting

Phase	Actions
Preparation	1. Identifying people at high risk and designing a local strategy to answer their needs. 2. Creating a collaborative network among stakeholders and organizations to determine who is responsible for the supervision, management, execution, and financing of each action. 3. All necessary items, including medications, condoms, formula, etc., provided to the PLHIV should be stored in larger amounts. 4. Provision of sterile syringes and methadone. 5. Determining and announcing safe places for service provision 6. Ensuring the collection and updating of the information on the national HIV registry system 7. Investigating and strengthening the infrastructure of HIV care provision centers 8. Removing legal obstacles and executive limitations in the field of providing emergency services by passing related laws. 9. Capacity building on emergencies for both PLHIV and service providers
Response	1. Rapid assessment of the situation, measurement of the disaster scale, and estimation of the number of affected and at-risk populations. 2. ensuring the safety of all medical procedures and donated blood. 3. Providing proper protection for the health care providers (PEP/PrEP). 4. Free, public, and stigma-free access to condoms, syringes, and methadone. 5. Providing free access to HIV counseling, testing, and referral for vulnerable populations. 6. Treatment and control of sexually transmitted diseases in people with high-risk sexual behaviors and advocating for protected and safer sex. 7. Providing security to reduce sexual violence. 8. Using the national HIV registry system to identify all pregnant women living with HIV. 9. Ensuring access to formula and prophylactic medical treatment for babies born from HIV-positive mothers. 10. Follow-up of the patients receiving antiretroviral drugs. 11. Choosing the same local expert personnel who are already known and trusted by the cases to deliver the services.
Recovery and Rehabilitation	• Rehabilitation services after the emergency are necessary for all affected populations, but PLHIV needs stronger and more comprehensive support services.
Evaluation	• Indicators for performance evaluation are the same as the normal situation however, acceptable deviations must be determined regarding the type, extent, and severity of the emergencies individually.

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services during the previous humanitarian settings, considering specific cultural, religious, and social needs of PLHIV and are adaptable to different societies.

The principal idea behind all actions, which the interviewees repeatedly raised, is continuous service delivery by trained personnel who provided routine services before to maximize privacy and reduce the need for disclosure. These staff know the patients, are aware of their needs, and protect confidentiality. It was also highlighted that there is no need to disclose the HIV status to general emergency and field workers as all the procedures are safe and won't lead to transmission.

One of the strengths of the Iranian experience was the provision of PMTCT (prevention of mother-to-child transmission) services for pregnant and breastfeeding women by actively reaching out to them, providing ART for the mother and formula for infants (10). However, the main challenge was observed for the preventive equipment such as condoms, where social barriers and taboos are common.

These recommendations would be beneficial for all the countries during different phases of their disaster management program, especially Iran's neighboring countries that share the same socio-cultural values and natural hazards.

Authors' Contributions

ATB, AHSH and NKH designed the study, AA, EN and ATB carried out the literature review. Interviews were conducted by NKH and MT and the analysis of qualitative data was carried out by AHSH and MT. AA was responsible for drafting the main manusript. all authors read and approved the final manuscript.

Ethical Considerations

First phase of this project was carried out as a literature review and no human subjects were involved. For the second phase, interviews were conducted based on the verbal informed consent from the participants, the transcription was carried out anonymously and the audio files were deleted afterwards.

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Conflict of Interests

The authors declare that they have no competing interests.

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