INTRODUCTION

Since its emergence, Human Immunodeficiency Virus (HIV) infection has been one of the most challenging issues for health workers. AIDS is now a pandemic with major medical, social, economic, demographic and political consequences. In most of the regions where we work the disease is largely endemic and war, population displacements, rural exodus, urban health problems, social and economic disruption are known potential risk factors which can increase the spread of the infection. They also make AIDS prevention and care even more difficult to achieve.

As medical humanitarian organization MSF has the responsibility to resolutely face the public health and ethical problems raised by the epidemic, as well as to tackle its human individual consequences.

The objective of this paper, intended for MSF and our partners, is to establish, as clearly as possible, a general policy on AIDS, common to all MSF sections. Basically, it aims to define a general framework for our interventions. It is recant particularly for the people in the field, and should be practical enough to say what has to be done and what should be avoided. MSF works in different types of situations with different opportunities or limitations in actions. Therefore this policy document will outline the possibilities of action within MSF projects and also define a minimal response required in all situations. This paper, hence this policy, will obviously evolve and will be adapted to include progress made in the various fields of AIDS control, and reeect our own expertise, experiences and possibilities.

There are several important constraints which have to be considered when dealing with AIDS. So far AIDS has no cure, there is no vaccine to prevent it and prospects for major improvement in control possibilities are still limited. As such, it is one of the hardest challenges to all health workers, everywhere in the world. Because it has to do with blood, with sex. and so much with death, it is much more than a single, dreadful, medical problem. Also because it is associated with a number of subjective, affective and socio cultural feelings. It can be hard to talk about and can lead to stigmatization and neglect. There is also

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a tendency in many countries to underestimate the magnitude of the problem and under-reporting of AIDS is frequent.

Within its field activities, especially in relation to emergency interventions, MSF faces other, more specific constraints.

- A large number of MSF interventions are emergency programmes for disasters, famines and assistance to refugees. In such situations, AIDS remains in the background of more obvious health problems and is not perceived as a priority that calls for immediate intervention. Human and material resources are sometimes limited in the first phases and devoted to more urgent interventions.

- Often health workers lack awareness of the importance of the HIV problem and/or expertise to identify priorities in terms of AIDS interventions, for the immediate, intermediate and long term plans. Information on the epidemiology and management of AIDS in crisis situations is still scarce.

- Emergency interventions are by definition short-term and thus health education programmes are difficult to plan and implement in a satisfactory way.

However knowing the potential detrimental effects of crisis situations on the transmission of HIV, while taking into account the constraints and difficulties outlined, we consider the following steps as priorities. They apply both to emergency situations and to rehabilitation or longer term projects.

**PRIORITY INTERVENTIONS**

The cornerstone of these interventions should remain based on our medical knowledge and on our humanitarian vocation. (Technical details on these interventions are provided in other documents as mentioned.)

1. Rational indications for transfusions. (see also MSF transfusion guideline) Transfusion of blood or blood products are still important routes of transmission of HIV in many developing countries. Even with correctly screened blood, blood transfusion remains a risky procedure, especially in high prevalence areas. Frequently blood is being used inappropriately: its use should be restricted to "life or death" emergencies.

Decision on transfusion should be taken based on clinical signs of decompensation rather then on lab results. Clear protocols should be used that define which patients are eligible for transfusion.

Prevention of anaemia and training of personnel in the use of alternatives to blood transfusions (use of macromolecules, autologous transfusions..) are also most important factors in limiting the number of unnecessary transfusions.
2. Safe transfusions, when transfusions are really necessary.
(see also MSF transfusion guidelines)
All blood samples must be screened before transfusion, whatever the circumstances. There should be no exception to this rule in any MSF mission.
Clear testing procedures must be established in each mission, with special attention to the following points:
- Quality of the test itself and of the procedure to perform the test.
- The results should not be given to the donors if it is impossible to confirm the first test and in the absence of counselling services.
- Care should be taken not to attract to a transfusion centre, people at risk who wish to know their HIV status.
- Confidentiality, which is a key issue in any case, must be ensured and be constantly emphasized to all health-workers (see transfusion guidelines).

3. Proper sterilisation/disinfection and proper disposal of medical waste.
(see 'Hygiène dans les soins de santé en situation précaire' by MSF or AIDS series no 2 by WHO)
Sterilisation and disinfection are the basis of the prevention of iatrogenic transmission (protection of patients). These measures have long been a MSF priority, even before the AIDS epidemic. It is our duty to reinforce it and to provide the proper resources to maintain high standards of quality. When single use materials is not available, disinfection, rigorous cleaning and sterilizing techniques are compulsory. When single' use material is available, make sure that it is completely destroyed after use.

4. Reduction of injections
Although frequently regarded by patients, and sometimes prescribers as a more valuable type of treatment. use of unnecessary injections (in or outside health structures) must be strongly discouraged. Reduction of injections can only be accomplished if both health workers and the general public can be convinced that risks by far outweigh the benefits in most cases. It should be avoided that patients seek unsafe injections from untrained commercial injectors after having been turned away by a clinic.

5. Reduction of HIV transmission through sexually transmitted diseases (STDs) control (see also WHO/GPA manual on Management of STDs)
It is now clear that there is a strong association between the occurrence of HIV infection and the presence of other STDs. Impact of improved STD control on HIV incidence was
demonstrated in rural Tanzania (H. Grosskurth and al., aug 1995). Early diagnosis and treatment of STDs is therefore an important part of the strategy to reduce HIV transmission. Measures for preventing sexual transmission are the same for both. Thus, patients presenting with STDs are good entry points, both for diagnosis/treatment and for education. This specific aspect of the health care system must be reinforced everywhere, including crisis situations. Adequate drug regimens, partner treatment, early case finding, health education and condom provision are important elements. STD control should be integrated in every general health care programme.

6. Protection of health workers
(see also MSF Document on protection of staff against infection with HIV and Hepatitis)
Education on the precautions to be taken to reduce risk of HIV infection through exposure to blood, body fluids and tissues, should be addressed to all health personnel, and to all other personnel working in health structures.
It should be kept in mind, however, that the risks of professional contamination are low. Besides that the risk of incidents can be substantially reduced by respect of basic and universal precautions. Any discriminatory measures from the personnel towards these patients is neither ethically acceptable nor scientifically justifiable.
Protective materials (gloves etc) of good quality must be provided everywhere in appropriate quantity.

7. Medical management of AIDS cases
(see also Guidelines for the clinical management of HIV infection in Adults/.. Children, by WHO)
Given the relative low efficacy of AZT given as monotherapy and the high cost, this treatment cannot be introduced routinely in MSF projects. Instead we will have to concentrate on a better approach to the symptomatic treatment of AIDS cases: these patients need basic curative services to treat opportunistic infection and AIDS related symptoms (diarrhoea, pain, fever..) that can be frequently improved by basic drugs. Confirmation of the suspected diagnosis of AIDS will not change the curative medical management of the patient and therefore is not a priority, certainly not in situations with limited resources. If a test is considered it should be done following the conditions as outlined below under 'ethical considerations regarding HIV testing'.

Interrelations with tuberculosis and malnutrition, whose clinical features frequently overlap that of AIDS, will have to be specifically addressed (which is partially done in specific guidelines): There is no indication for HIV screening in these two pathologies, because it would not change treatment with current level of knowledge. Preventive chemotherapy for tuberculosis in HIV positive patients can only be considered in areas where tuberculosis programmes are achieving the global targets (successfully treating 85% of detected smear positive patients and detecting 70% of existing new smear positive cases) and where voluntary testing and counselling for HIV infection is available (see MSF Tuberculosis policy paper).
8. Promotion of safer sex (including condom distributions)
Education about the disease and promotion of safe sexual behaviour, for health workers' and for the population, should be part of MSF programmes everywhere and integrated into the other usual health education activities.
Use of condoms, which are the most effective means to reduce sexual transmission during penetrative sex, should be encouraged; they must be widely available in all MSF health programmes. Distribution of condoms, either through free distribution or a special social marketing programme should be done in accordance with local policies.

9. Counselling and social support
This is an essential part of the management of the HIV+/AIDS patient, in which the counsellor helps the client, to make his or her own decisions regarding his health status. We should seek to collaborate as much as possible with local counselling services and use local support structures. wherever available. In the meantime MSF will have to develop further expertise in this field in order to be able to facilitate the training of counsellors and, the formation of support mechanisms where they do not yet exist.

10. Protection of the patient against discrimination
In many countries, HIV+ and AIDS patients are socially rejected, and frequently even denied basic health care and social services support. HIV status can be particularly critical for refugees, fundamental rights may be seriously at stake in the case of known seropositivity. Whatever the situation, it is obviously our role as a medical and humanitarian organization to strictly defend these individuals, if need be through active advocacy.
The role of MSF in the protection of human rights starts within our own programmes. (This means amongst others that MSF as employer will protect HIV positive employees and will never dismiss them on medical grounds.)

- The extend of AIDS intervention/prevention activities will depend on the type of projects. areas and resources. As a rule, the seven first points are the obvious priorities; they are compulsory and must be implemented in any MSF mission from the start and further improved as the project develops over time . We cannot consider that these aspects are already perfect everywhere.

- Promotion of safer sex and HIV/AIDS patient counselling/social support are essential interventions which cannot be neglected. They should be developed progressively and carefully, according to local needs, resources and capacities.

- Protection of the HIV/AIDS patients against discrimination, at all levels and by all possible means, is not exactly an 'intervention'; it is simply our duty, whatever the circumstances.
It is important that the above AIDS interventions are fully integrated into the MSF programmes and not started as separate vertical programmes. An integrated approach will be easier and in the long run more sustainable.

There may be other interventions, such as specific prevention programmes for special target groups, home based care programmes or projects for infra-venous drug users. AIDS pilot projects, within this general framework, will be encouraged. They will enable us to learn and to further improve our knowledge and expertise in order to adapt our strategies.

Lastly, it should be kept in mind that, as far as possible, all these interventions must be adapted to local contexts - epidemiological, cultural and political (national policies).

**ETHICAL CONSIDERATIONS REGARDING HIV TESTING**

- In no circumstance a person should be tested without his informed consent. The only exception to this rule is in blood transfusion when there is no possibility of confirmation or counselling services, because in that case the first priority is to protect the receiver.

- Information to the blood donor about the result of the HIV test is only possible, as already mentioned, if confirmation testing and adequate (pre and post-testing) supportive services are available. If that is not the case, anonymous unlinked testing must be the rule.

- One single test is sufficient to discard blood for transfusion but should never be used as a diagnostic tool in our missions. Testing for diagnosis is only acceptable when proper laboratory confirmation is possible, when the patient is informed and has given consent, and when pre- and post-test-counselling services are available. Laboratory confirmation of a suspected case, only for the information of the medical staff; is not justifiable if it cannot be followed by appropriate action.

- Voluntary testing. Generally speaking every person has the right to know his HIV status. However in areas with limited resources priority will have to be given to other interventions (eg health education, condom promotion, care programmes).

- Home testing. A quick test based on antibodies in saliva or urine will probably become available soon for individuals to test themselves at home. Although this way of testing could have the advantage of quick result and guaranteed confidentiality, for a person who feels to be at risk, it has several disadvantages as well. These vary from the lack of counselling, misinterpretation of a single positive result, or a negative result during a potential window period, to the fact that protective behaviour of the individual will not improve. Also this type of tests when available could ensile be mis-used for instance at borders, people applying for jobs etc.
For all these reasons MSF does not support the principle of home testing, but when this device becomes available it is our duty to outline to policy makers and the population, the potential risks and provide recommendations on how to limit possible negative effects.

- The use of HIV testing and other laboratory findings for epidemiological surveillance and/or research purposes must be avoided. The rationale for such studies, under specific circumstances (sentinel surveillance among for instance ante natal clinic attendees or TB patients) should be discussed with MSF (HQ) and with National AIDS Programmes. Especially in refugee or displaced persons areas, the matter must be discussed carefully, as it may be very sensitive and jeopardise the rights of the patients or the refugees as a group.

- Informed consent (of the individual to be tested), anonymous sampling/notification and absolute confidentiality are obviously the ethical basis of any intervention when dealing with AIDS patients and HIV testing. Strict respect of these rules is mandatory everywhere.

**RECOMMENDATIONS**

These priority interventions and constraints are listed in view of the needs faced by MSF workers; in most situations; needs that call for action. MSF is aware that in a limited number of cases there are feasibility constraints. However, these actions represent a reasonable minimum and it is the responsibility of everybody to effectively implement this policy.

Prevention of iatrogenic transmission, protection of health workers, early adequate STD treatment, availability of condoms and improved supportive management of HIV patients, associated to the strict respect of the above defined ethical rules, are absolute priorities. Depending on local needs, particularities and constraints, and assuming that basic priorities are fulfilled, other interventions should be envisaged whenever possible and feasible.

In order to correctly address these issues, it is very important that all MSF workers at headquarters and in the field ensure that information is regularly updated and shared, at all levels. MSF should also develop new strategies and improve its knowledge of AIDS, particularly in the context of its rather specific field of intervention: emergencies involving population displacements, unstable areas; war and social disruption. It is also MSF’s responsibility to share the experiences and needs with our partners, particularly those involved in crisis situations, to encourage everyone to take further steps to improve AIDS prevention/care activities as well as to improve knowledge.

Reference documents:

MSF AIDS Policy. 2nd version April 1996
- La pratique transfusionnelle en milieu isolé, MSF guideline (new english version under preparation)
- Hygiène dans les soins de sante en situation précaire, MSF guideline
- AIDS series n4 2; Guidelines on sterilization and disinfection methods effective against HIV. WHO, 1989.
- Management of Sexually transmitted diseases, WHO/GPA, 1994 (plus training programme in 7 modules)
- Protection of staff against infection with HIV and Hepatitis, MSF(H) document, 1995
- Guideline for the clinical management of HIV infection in Adults, WHO/GPA/IDS/HCS/91.6
- Guideline for the clinical management of HIV infection in Children, WHO/GPA/IDS/HCS/93.3
- MSF Tuberculosis policy paper, 1995
- Source Book: for HIV/AIDS counselling training, WHO/GPA/TCO/HCS/94.9
- Statement from the Consultation on Testing and Counselling for HIV Infection; Geneva, 16-18 November 1992, WHO/GPA/INF/93.2

By the MSF AIDS working group; L. Blok (MSF-H), M. Deguerry (MSF-B), N. Sohier (MSF-F).

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In answer to the specific Cambodian needs, MSF is developing strategies to reduce HIV/AIDS impact:

1) PUBLIC HEALTH SECTOR (Sustainability related)
Specific Objective: Provide STD care and prevention services for the general population.

Main Partners: MoH, DPS, STD and AIDS National Programs.

Activities: Implement and/or develop an STD department integrated at the first level (Health Center) in the Public Health System. This department, as defined by the MoH, is part of the Reproductive Health Service including Post and Antenatal Care, Mother and Child Health, Family planning, AIDS and STDs.

2) SOCIAL MARKETING OF CONDOMS. (Sustainability - related)
Specific Objective: Increase the availability, and the affordability of condoms through the private sector.

Main Partners: PSI, Private Sector (pharmacies, bars, market places, ambulatory vendors...), National STD' and AIDS Programs.

Activities: Increase the local distribution network by providing condoms and promotional materials to local partners.

3) EMERGENCY PROGRAMS. (Sustainability - nonrelated)
Specific Objective: Provide STD care and prevention services to specific populations with High Risk Sexual Behavior.

Main Partner: MSF, CUHCA

Activities: ProvideSTD care and prevention adapted to the specific groups. The activities are divided in two: 50% Clinical and 50% Outreach activities
4) AIDS CARE. (Sustainability - nonrelated)

Specific Objective: Provide Health and Social Care to persons with AIDS.

Main Partner: MSF, local NGOs

Activities: Short term development of an exploratory mission to determine the needs assessment and strategie planing.

5) "WITNESSING".

Specific Objective: Human Rights Witnessing, particularly Child Abuse.

Main Partner: To be defined

Activities: To be defined

REFERRAL MANUALS.

1) "The Implementation of STD Control Programs" - MSF Holland

2) "Ethnographic Methods in AIDS Intervention Programs" - UNAIDS (ONUSIDA)

3) "MSF AIDS Policy Paper" - MSF AIDS Group

4) "STD Case Management" (Partial) - WHO (OMS)

5) "Spread no Evil" (Training on the Syndromic Approach and Flow Charts) - AIDSCAP/FPIA in Cambodia.

6) "Guideline for the Clinical Management of HIV infection in children/adults" (To be-adapted to the Cambodian, context) - Ministry of Public Health of Thailand.
Health Centres will offer the Minimum Package of Activities (MPAJ defined by MoH. Referral Hospital will offer the Complementary Package of Activities [CPA] defined by MoH.