



Report

**First Global Consultation on
HIV and Internally Displaced Persons**

24 and 25 April 2007

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List of Acronyms

ANC	Antenatal Clinic
AIDS	Acquired Immunodeficiency Disease Syndrome
ART	Antiretroviral Therapy
AVSI	Association of Volunteers in International Service
BCC	Behavior Change Communication
BPHWT	Back Pack Health Worker Team
BSS	Behavioral Surveillance Survey
CBO	Community-Based Organization
DDR	Disarmament, Demobilization and Reintegration
DOT	Directly Observed Treatment
FGD	Focus Group Discussions
HIV	Human Immunodeficiency Virus
IASC	Interagency Standing Committee
IDPs	Internally Displaced Persons
IDU	Intravenous Drug User
IEC	Information-Education-Communication
IOM	International Organization for Migration
KDHW	Karen Health and Welfare Department
MOH	Ministry of Health
MSF	Médecins sans Frontières
MSM	Men who have sex with Men
NACP	National AIDS Control Programme
NGO	Non-Governmental Organisation
NSP	National Strategic Plan
OHCHR	Office of the High Commissioner for Human Rights
OI	Opportunistic Infection
PEP	Post Exposure Prophylaxis
PLWH	People living with HIV
PMTCT	Prevention of Mother to Child Transmission
PRSP	Poverty Reduction Strategy Plans
PSI	Population Services International
RAP	Rapid Assessment Process
RH	Reproductive Health
SGBV	Sexual and Gender-Based Violence
STI	Sexually Transmitted Infection
TB	Tuberculosis
TBA	Traditional Birth Attendant
UNAIDS	United Nations Joint Programme for HIV/AIDS
UNHCR	United Nations High Commissioner for Refugees
VCT	Voluntary Counselling and Testing

1. Executive Summary

The HIV Unit of the United Nations High Commissioner for Refugees (UNHCR) hosted the first global consultation on HIV and Internally Displaced Persons (IDPs) in Geneva on 24 and 25 April 2007.

There were 45 participants from United Nations (UN), non-governmental organization (NGO) and donor agencies in attendance. All were encouraged to actively contribute through presentations, plenary sessions and working groups.

The objectives of the meeting were:

1. Review current concepts and knowledge on HIV and IDPs
2. Document current HIV and IDP assessment tools and programmes
3. Chart future needs and action

In addition, the following subjects were also discussed:

1. The need for a general tool for HIV and IDP needs assessment tool for high and low HIV prevalence settings
2. Documentation of lessons learned from field
3. Plan of future action

During the course of the consultation a wide-range of presentations were given with wide ranging discussions highlighting the current IDP situation in various countries as well as the overwhelming need for more qualitative and quantitative research on HIV and IDPs. The participants expressed interest in developing a working group to address some of the key issues discussed. Overall it was concluded that the meeting was a good beginning but that more work need to be done in order to move the IDP agenda forward.

The following next steps were agreed upon in five key areas of discussion:

I. Assessment

- 1) UNHCR will continue to work on the assessment tool with other interested partners to create two to three different versions.

II. Programming

- 1) Access and Equity – will be discussed further (e.g. user fees).
- 2) Existing activities to be enhanced for IDPs
- 3) New activities for IDPs not applicable to host

III. Coordination

- 1) The process is ongoing.

IV. Advocacy

- 1) It has been suggested that the proposed working group on Advocacy be combined with the related policy and strategy working group for HIV and IDPs.

Action: UNHCR will send an email requesting participation

V. Programmatic Research

This area will be discussed further. It was agreed that more qualitative and quantitative research among HIV and IDPs is needed.

2. Welcome Address

Ms. Judy Cheng Hopkins, the Assistant High Commissioner of UNHCR opened the meeting by welcoming the participants. Ms. Hopkins spoke of UNHCR's role as the lead technical coordinating organization as defined by the UNAIDS division of labour. She stated that IDPs were still not consistently included in country plans and proposals, despite being at increased vulnerability. She also remarked on the importance of ensuring that inequities between IDPs and the local communities are kept to a minimum. She emphasized the critical role of multisectoral and interagency meetings within this settings and the need for specific assessment tools to be developed.

Mr. Elhadj As Sy, the Director of Communications and External Relations at UNAIDS, welcomed the participants on behalf of Dr. Peter Piot, UNAIDS' Executive Director, who was unable to attend. Mr. As Sy acknowledged UNHCR's leading role in coordinating technical support for HIV to displaced populations. He highlighted how little is known about the risk and infection rates among IDPs, stating that UNAIDS fully supports UNHCR in the development of specific assessment tools. He said that even in the absence of large amounts of data, there is no doubt that internally displaced people are a unique group with special HIV needs – many having suffered from trauma and violence, including sexual violence, during conflict. He emphasized the need for HIV policies and programming from the outset of an emergency and throughout the displacement cycle. He finished by saying that UNAIDS looks forward to supporting UNHCR in establishing ongoing consultation and coordination mechanisms in order to move forward with this important agenda.

3. HIV and IDP Overview

Dr. Paul Spiegel, Chief, HIV Unit, UNHCR reviewed the objectives and proposed outcomes of the two-day consultation. He provided relevant background regarding HIV and IDPs. He gave an overview of the situation, highlighting the effects of conflict on HIV prevalence, the obstacles to providing interventions and the current lack of data on IDPs. He emphasized the need to examine all vulnerability and risk factors for conflict-affected populations to ensure that a “one-size fits all” approach is not taken. He stated that IDPs were frequently not included in country programmes and proposals, and listed some of the reasons why providing HIV interventions for this population have been difficult. Dr. Spiegel mentioned the numerous actors involved and the timeliness of the meeting, as those involved seek new ways to integrate HIV into both cluster and non-cluster approaches, such as the Interagency Standing Committee's (IASC) Task Force on HIV in Emergencies. He stated that a further review and discussion needs to be had to ensure that the approaches include surrounding populations, ensuring equity and thereby limiting increases in stigma and discrimination.

Discussion:

Do you feel comfortable that we can move into the IDP world?

Do we have the resources?

The two year evaluation by UNHCR and OCHA was mentioned, stating that this evaluation could be used to encourage an increase in resources by donors.

Emergency and development responses are currently separate, though we recognize the need for better coordination. How can we ensure a stronger national government response. How can we best strengthen it with regards to HIV? What can or is being done?

In response to a statement regarding the need for better transition between emergency and development response, it was suggested that without the availability of sufficient services during this period refugees and IDPs might be reluctant to return to their place of origin. It was also stated that it was important that situations not be viewed as short-term, and that programmatic approaches, particularly in areas of sexual and gender-based violence (SGBV), provide longer-term responses.

Some national as well as regional programmes have started providing support to IDPs, such as the Great Lakes Initiative on AIDS. The performance and results of the initial efforts will help to determine the level of resources that might be made available. Countries need to demonstrate results.

The need to make services available to all those living in the setting was emphasized. It was emphasized again that it was both a relief and development issue and that there is a time period of rebuilding that differs from development settings.

4. HIV and IDP Assessment Tool

I. Introduction

Dr. Michel Carael, a consultant for UNHCR, provided an overview of the assessment methods and tools used in three countries and shared some of his experiences with the assessment in Nepal. The main focus of his presentation was the pros and cons of the Rapid Assessment Process (RAP) as well as the benefits and constraints of using qualitative research methods. He spoke of five different mainly qualitative tools: district assessment tool (the only quantitative part of the RAP); semi-structured interviews with key informants; semi-structured interviews; focus groups; and semi-structured observations developed for the Nepal assessment. He provided details on using these tools. Dr. Carael also discussed the qualitative data collection process, stating that although it can be a very rich source of data, it can be harder to harmonize and analyze than quantitative data. He stated that it was important to analyse the data as it was being collected, and that the teams meet nightly to triangulate the data as well as to determine if it was necessary to change tactics midway during the assessment.

Discussion:

Regarding saturation of data collection and triangulation, it can be difficult to know about the validity of the responses. What do you feel are the key issues in how things could go wrong? Was pre-testing done on the tool? Sampling bias?

There are no good sampling frames available when the population is not visible. It is difficult to undertake quantitative surveys. We were not looking for representative sampling or for figures. There will be biases that can be minimised through use of different teams, triangulation of data, and the use of key informants to assess the hypothesis; the team can stop when agreement is reached. It requires practical experience and strong communication. It is best to have a mixed group of professionals and non-professionals, who can learn on the spot and bring their own expertise and experience to bear. The rapid assessment works with different formats, so it is possible to have professionals and non-professionals. Evaluation is more difficult. RAP has been used in different settings, e.g. Intravenous Drug Users (IDUs). It helps one to try to understand the various needs of the groups.

The tools were rapidly pre-tested in Nepal. This was followed by a 2 day training to ensure group understood. Perhaps with a less experienced group 3-4 days might be needed.

How did you deal with problems of access and restrictions?

Access to IDPs can be difficult. In Democratic Republic of Congo (DRC), most persons are in the forests and cannot be easily reached. It was difficult to gain access to these areas. Access could only be gained with the help of the police and soldiers, the very same people who are harassing the IDPs.

In Côte d'Ivoire they recently signed a peace agreement, so follow-up is now possible. It was important to explain what you are doing and why, before and during the mission. There were initial concerns about the nature of the mission so we needed to be clear about the specifics of the procedure.

Were there issues around asking questions of children under the age of 18 years?

In Nepal, we did not ask questions regarding sexual behavior to those under age 15 years. In Côte d'Ivoire there was a 2 day briefing on the tools including a review of ethical issues. We had originally planned to interview children, but later decided to interview agencies working with children instead.

To what extent does this procedure differ from the World Health Organisation's (WHO) RAP tool?

The difference between this tool and the tool developed by WHO, is that their tool looked at specific target groups, like IDUs. IDPs may have nothing in common such groups or have multiple vulnerabilities and risks which must be examined. Our missions were less scientific assessments. Rather, they focused more on programmatic needs.

In response to statements from Cote d'Ivoire and DRC that they were unable to include questions regarding Men who have sex with Men (MSM)?

Access and security is critical. HIV relevant behaviors are often illegal. One has to address how to work with authorities since working with IDPs can already be a very sensitive issue. However, it is still possible to do an MSM assessment.

Other general comments:

Aside from the logistical challenges, the tools were quite heavy. It was not clear how different teams would be analysing the data. The assessment created expectations, but feedback was not always planned into the process.

Many groups benefited from the preparation at the local level. This would not be possible in a precarious security situation.

The tools are long. We would recommend that the teams will quickly delete many unnecessary questions after a few interviews, and focus on what is necessary. The teams did not always give feedback to the local authorities or general follow-up. This is still in an exploratory phase. It should be included in final protocol.

The authorities were all very much involved in the assessments. A background paper was developed and presented in Nepal. The local context was considered. A plan of action is being developed, recommendations made and money is available for follow-up

Tools were developed based on existing tools by UNHCR and other sources, including IASC guidelines for HIV Interventions in Emergency Settings.

Côte d'Ivoire - The team carrying out the assessment had minimal experience and the preparation and training time was too short. There were a lot of questions and the teams were overwhelmed by the different tools. Analysis had to take place in the field and people were unsure how to deal with certain aspects of it. The report and recommendations remained general. In general, the expectations and outcomes should be in line with the team's experience.

II. Nepal Experience

Mr. Prakash Kumar Pathak, Ministry of Home Affairs (MHA), Nepal and Dr. Ann Burton, UNHCR, presented their experiences using the assessment tool in Nepal. They provided background on the current conditions in Nepal, the history of conflict and the HIV prevalence, including the higher rates of HIV among seasonal labor migrants. They discussed the months of preparatory work and the process that went into developing and implementing the assessment methods and tools (see presentation by Dr. Michel Carael). They stated that during the assessment, the team met nightly to analyse the data as it was being collected. A standard format was used to summarize the interviews. At all stages, the information collected was fed back to the teams.

They found that the impact of conflict on HIV vulnerability and risk varied considerably from site to site. In general, there were a variety of issues that affected migration/displacement amongst the populations assessed. These varied from increases in rural-urban migration/displacement (particularly for young people), increased migration to India and elsewhere (mostly of males), and the long periods of time people stayed away while waiting for to be peace restored. Other topics highlighted included poor coordination around HIV programmes; lack of protection particularly for women and children; an increase in the presence of uniformed forces, which led to increased demand for sex work; limited/inadequate HIV prevention programmes for at-risk populations (including IDUs, uniform forces); and a lack of care, support, and treatment.

The key recommendations included developing a more coordinated and multi-sectoral response to HIV, ensuring stronger protection mechanisms for the most vulnerable in conflict-affected settings, promoting HIV prevention among migrant populations by using a multi-sectoral approach, strengthening HIV prevention in uniformed services at district level, integrating HIV into post-conflict planning, and improving care, treatment and support of People Living With HIV and AIDS (PLWH) and their families in districts with a higher HIV burden. A full list of the recommendations and next steps are included in the attached powerpoint presentation.

III. Côte d'Ivoire

Dr. Josephine Conombo Diabate, Inspectrice, Ministère de la Lutte contre le SIDA and Ms. Esmee de Jong, UNHCR provided background on the current situation in Côte d'Ivoire, including current HIV prevalence rates, the national AIDS control framework and the history of conflict in the country. Four sites were assessed. The tools and process for analysis used were similar to Nepal, with teams meeting at the end of each day to debrief and summarize findings. They found increased vulnerability to HIV due to impoverishment, increased unemployment, family fragmentation and disruption of social networks, and dependence. The assessment also found that there was an increase risk of HIV due to increases in sexual trading for financial support, sexual exploitation, early sexual relations and unsafe sex (documented by a growth in the number of child mothers). Additionally, only minimal health services were available at most sites, since the many of the health workers had gone to Abidjan to work.

Key vulnerability and risk factors and corresponding recommendations were highlighted during the presentation, including the need to develop a strategy to ensure social and economic independence among IDPs, targeted HIV prevention for children and increased prevention interventions for students, improved quality and dissemination of information on HIV, increased availability of condoms, improved voluntary counselling and testing (VCT) access, quality, confidentiality and referral, and ensured access to treatment, care and support for PLWHs. Dr. Diabate stated that there were no specific programmes for IDPs, and that in many instances the IDPs had integrated within the existing populations, making existing services insufficient to cover the overall needs of the community. She also noted that issues of stigmatization and discrimination had left many fearful of

seeking services. She emphasized the need for services to be distributed fairly within the community.

In response to these issues as well as other findings, several practical steps were suggested, including specifically addressing IDP problems in the country's national HIV strategic plan and national framework, and creating specific laws on HIV/AIDS, health reproduction and gender. Ms. De Jong stated that several workshops have been planned for the coming months in order to help respond to the findings of the assessment report. Additional information on the findings, recommendations and next steps of the Côte d'Ivoire assessment team can be found in their attached presentation.

IV. Democratic Republic of Congo (DRC)

Dr. Dieudonne Yiweza of UNHCR provided background on the DRC and presented the experiences, findings and recommendations for the assessment. Dr. Yiweza spoke of the massive displacement within the population, with an estimated 1.1 million IDPs in the DRC. He stated that it was difficult to distinguish IDPs from the host population, particularly since the large majority estimated at 90% of IDPs lived with host families, forced to share despite the precarious situation. He spoke of the widespread human rights violations in DRC, which left women and children most vulnerable. The overall HIV prevalence in the country as of 2005 was 4.2%, with an estimated 1,230,000 million PLWHs. He stated that most services are located in the capital cities and that based on the current National Strategic Plan (NSP) less than 5% of those in need have access to anti-retroviral Treatment (ART).

The assessment areas were chosen due to the high numbers of IDPs and returnees living there. However, it was often difficult to reach the IDPs since many were hidden. The assessment team consisted of 20 people making five interagency teams, with 2-3 facilitators from local NGOs and government in the field. Each assessment lasted 7 days. The analysis was based on the summarized interviews and site observation notes. The needs of those interviewed were identified in terms of HIV prevention, treatment, care and support, protection, coordination, monitoring and evaluation and the impact of conflict on HIV in terms of vulnerability and risks. The findings showed that there were few VCT or Prevention of Mother-To-Child-Transmission (PMTCT) services, and that uptake was low, blood safety was still an issue in some areas, universal precautions was not systematically followed, condoms use was minimal, and stigma and discrimination was high. Additionally, protection needs were high, particularly among women and children, with limited services for victims of SGBV and no services for street children in Bunia. In general, there was very limited access to services for IDPs.

The team made several recommendations, including increased community awareness and empowerment through "community conversations"; the establishment of a minimum essential package using IASC on HIV in emergency settings guidelines; and the implementation of "community assistance approaches", e.g 1-2 Health facilities per

province. Additional information on the assessment team's findings, recommendations and next steps can be found in their attached presentation.

Discussion:

Was it difficult to identify IDPs to participate in the assessment?

How will this feed into the operational responses?

Was there a comparison between IDPs and non-IDPs?

The term IDP was highly stigmatised and there was no incentive for individuals to register their status. The assessments tended to focus on conflict-affected populations in areas known to have IDPs. We changed how IDPs were identified, looking at those who had moved within the last 5 years.

The usefulness of the assessment can help in planning for the response. IDPs are not the same as other poor and deprived populations. We tried to separate out the vulnerability and risk behavior due to conflict, which was difficult. In Nepal there was already migration, which increased due to conflict. We looked at the impact of the insecurity. In the findings we addressed both the conflict and underlying issues. The involvement of persons from capital and regional and district levels was very helpful.

The service needs of IDP and non-IDP populations differ during emergency situations. In theory, if there is a humanitarian crisis, there are additional vulnerability factors that must be addressed among conflict-affected populations.

5. HIV Programmes for IDPs

I. Uganda

Mr. Filippo Ciantia, The Association of Volunteers in International Service (AVSI), presented his experiences working with IDP populations in Uganda. He said that the 20 year conflict had left an estimated 1.6 million people displaced, 1.4 million of whom were living in IDP camps. The current HIV prevalence rate in Uganda was 6.4%, and that only 13% of the total population was aware of their status. Urban areas were found to have a slightly higher risk of HIV infection, with the disparity increasing among women and children.

Mr. Ciantia noted that the number of active ART sites had increased from five in 2004 to 35 in 2006; however, the vast majority of these sites were located in urban areas in the north. He said that there is a need to scale up prevention, counseling and testing, as well as care and treatment, particularly in the areas of return in the north. He also said that the PMTCT programme received a great response by the communities, and especially by internally displaced women (the HIV test counselling acceptance rate was more than 90%, testing 100%). He noted that the HIV prevalence was not significantly different between conflict-affected (6.9%) and peaceful regions (6.7%), and that PMTCT uptake was higher in conflict-affected (close to 100%) than in peaceful regions (75%). Additionally he noted that HIV prevalence was lower in internally displaced camps

(4.6%) than outside (6.0%) and that internally displaced camps had higher rates of pre-test, test and post-test counseling than other centres in the north.

Mr. Ciantia also highlighted the silent epidemic of sexually transmitted infections (STIs), in particular herpes, which had prevalence levels ranging from 29-52% across the country. He made several recommendations, including using and building on the capacity of the existing structures, e.g. the existing reporting system, creating responsibility at government and district level, and using the National Committee on AIDS in Emergency Settings to help identify and harmonize indicators to be collected to monitor impact. He stated that the country was utilizing the Three Ones approach, with One framework, One coordinating body and One monitoring tool.

II. Democratic Republic of Congo

Dr. Daniel O'Brien of Médecins Sans Frontières (MSF) –Holland provided an overview of the organisation's programmes in Eastern DRC. He stated that the DRC had been in a state of chronic war from 1996-2007 which had left approximately 3.2 million people displaced. He said that MSF had four projects in eastern DRC and that though the programmes were not IDP specific, they were in areas where there are IDPs and that all that come will be treated. The programmes provide free medications and care as well as generic fixed dose combination ART. Some of the challenges the programme faces are, low HIV/AIDS awareness/knowledge, an unstable setting, mobile populations, sustainability, stable housing, food and PMTCT.

He said that counselling and testing was on the increase, specifically targeting high-risk groups. The programme sought to address the needs of mobile populations, to help them access ART. MSF provides housing for those getting stabilized on antiretroviral medications (ARVs) and a consistent food supply for host families of PLWH to help counter impoverishment. Dr. O'Brien then discussed issues surrounding ARV adherence during conflict situations. He spoke on the importance of advanced planning in such circumstances, which included patient education, human resource capacity (ensuring that those able to stay can take on necessary tasks), decentralization of care, cooperation with neighbouring HIV treatment facilities, secure drug stock, and the importance of an emergency drug stock. The next steps for the programme are integration with The National AIDS Control Programme/Ministry of Health, handover of activities and dealing with non-naïve patients. Additional information regarding background on the programme, its activities and findings can be found in the attached presentation.

III. Liberia – Dr. Bility, NACP Liberia

Dr. Bility spoke about the development of Liberia's national AIDS framework (see appendix 3), highlighting policy options, interventions and strategic actions. He stated the importance of developing a plan that keeps both the context and history of Liberia in mind. In the 1980s, Liberia changed from a stable country, with a stable government to

one of unstable and largely debt-ridden country, which due to brain drain as well as other factors now has a poor healthcare delivery system. He also mentioned the importance of not repeating the mistakes of other countries. The next steps are to develop four projects to address the complexities of the different regions, to build on previous experience in order to ensure ART and VCT is made available in cities.

Dr. Bility then related the story of Josephine, a widow, whose husband died of AIDS. Josephine's husband was a school teacher, but later became a soldier, because it paid better and he needed to provide for his family. During his time as a soldier, he contracted HIV, and later infected his wife. Her husband died. Josephine was left displaced, stigmatized and discriminated against, even by her own family, as she sought treatment and care.

Discussion:

What has been the impact of periods of insecurity on services? Have you started PMTCT? What happens afterwards?

During a period of acute instability, only 5 people in DRC to interrupt their treatment. Some of the nursing staff ran de facto clinics from home. PMTCT is a priority, but it has been difficult on an operational level. Most patients cannot cope with much more than a 1 to 3 month supply.

What has been the donor reaction to ART for mobile populations? Have there been any objections?

The World Bank responds to the government's priorities. There are no negative or positive policies with regards to ART. We look at sustainability and handover, as well as the need to cost activities and plans.

What are the mechanisms to promote adherence, are they only for IDPs or for the whole population?

The main issue has been education. Nutritional support is also provided to those getting ART, which has also helped adherence. Additionally, the free housing in Bukavu, DRC, has also helped.

To MSF: What kinds of information do you have with regards to costing the activities you have identified to handover to the government?

It will be a slow handover of activities. We have not costed out the programme, but we try to get funding from groups, such as the Global Fund to provide ARVs. Also, not everything done by MSF will be given to the Ministry of Health. The major costs are the drugs. The biggest difference is quality, human resource costs and costs of good supervision and monitoring. We need to develop simple tools. We need to think about the exit strategy at the onset.

What do you think should be done regarding HIV prevention in IDPs?

Getting community involvement with a message that is understood and communicated, providing support to women and increased political awareness

6. Division into Working Groups

Participants were asked to sign up for one of four working groups. Groups one and two worked on Situational Analysis and Assessment Tool. They were led by Dr. Ann Burton and Dr. Michel Carael.

The questions to be answered were as follows:

1. Examine tools and make specific recommendations for improvement.
2. Do we need separate tools for:
 - a. Low and high prevalence settings?
 - b. Different contexts (e.g. natural disaster, conflict, acute emergency, protracted emergency)
 - c. Different regions/countries (e.g. low income, middle income)

Groups three and four worked on HIV Programmes for IDPs. They were led by Dr. Hilary Homan and Mr. Filippo Ciantia

The questions to be answered were as follows:

- What are specific considerations, similarities and differences in providing HIV interventions provided to IDPs:
 - a. Compared with those provided to national country programmes or populations other than IDPs affected by emergencies?
 - b. In key programmatic areas: Protection, Prevention, Care and treatment, and monitoring and Evaluation
 - c. Among women and children
 - d. Groups at risk (e.g. IDUs, MSM, commercial sex workers (CSWs))

7. Group Presentation and Discussion

I. Group 1 – Situational Analysis

Key findings/recommendations

- 1) Need for protocol:
 - Staff recruitment - Level of experience, pair experienced/with non-experienced
 - Training - Know how to probe
 - Recruitment of respondents - Go beyond NGO identified informants, Persons with poor access to NGOs, snowball methodology can be used
 - Analysis - identify themes, frequencies/priorities
 - Socio-cultural adaptation - Need focus groups and not just NGOs
 - Time/Resource/Staffing needs
- 2) Debate on length of tool - Need 3 tools
 - Short for rapid assessment for immediate situations
 - More in-depth/intermediate
 - Current tool for longer situations with existing programmes
- 3) Outcomes

- Varies with tools above
 - Do not create expectations among populations which cannot be fulfilled
 - Do not create survey fatigue
- Raise awareness/attention/advocacy
- Improve access
- Change policy
- Develop programmes

4) Definition of target populations

- IDPs vs. groups most affected by conflict
- Group defined by context of conflict

Most important – no universal tool/one is needed which can then be modified according to the situation.

Discussion:

How can we be more specific in disaggregating the data?

The big problem with disaggregating data is that it is difficult to capture. It is something to think about, but may not be realistic. Obviously this tool could be used for all conflict-affected populations; IDPs were targeted because they were seen as neglected.

II. Group 2 – Tools

Key Findings/Recommendations

1. Translation and back translation in appropriate languages needed
2. Ensure research questions clearly defined
3. “Memory check” incorporated into training
4. The tool needs instructions on how to undertake each section
5. Focus group discussions (FGD) need to be shorter
6. Make some questions more structured to ensure consistency of responses to make coding easier
7. Check reproducibility
8. Provide debriefing at the end to the participants and those interviewed when possible

Recommendations:

1. Base tools that form standard package in all settings consisting of:
 - General assessment tool (more quantitative in nature)
 - Focus groups discussions with young people
 - Focus group discussions with the general population (males and females of different ages)
 - Key informant interviews (district leaders, community leaders, young people representatives, police officers/army, service providers)
2. The same tools can be adapted to the context with add-ons or optional sections for different setting (e.g. natural disasters, post conflict, low or middle income countries)

Discussion:

Has it been decided that there will not be a quantitative part?

The first part of the RAP, called the general assessment tool, is primarily quantitative in nature and examines at baseline data. However, surveyors may eventually consider next steps after rapid assessment, which could have more quantitative data included. If quantitative data is available, it should be used. Limit the yes/no questions, but include why/how? The reproducibility is often based on who undertakes these RAPs. The questions were constructed in a way that if different people ask the same questions they will have a similar of understanding of the questions and get similar data from the respondents.

Did you have a chance to discuss the amount of inform to be gathered in the case of an acute emergency? What is the minimum information required?

It was not discussed in groups. Not sure if the tool was created for all phases. Some of the questions were too open. Some of the questions would benefit from a more closed format to make coding easier. Some questions might lend themselves to that format.

The tool is a first assessment of a situation. When the programme matures, you can rely on monitoring data with increased quantitative information. It is a preliminary assessment that will generally not be repeated. The data are to be used to plan for the following months or year.

III. Groups 3 +4: HIV programming for IDPs

Key findings/recommendations

IDP situations

- Camp-based
- Scattered - intermixed with host population or separate from host population
- Urban-based – intermixed, collective or homeless

Phases

- Emergency (ER)
- Post ER
- Protracted

Themes

Equity/Access

- Barriers to access of services
- Government barriers – UNHCR advocacy
- How do you know IDPs are accessing services?
- Balance stigma of being an IDP versus recognizing needs
- Avoid creating negative reaction by host community
- Payment for services—how to address issues with IDPs without discriminating against host populations
- Proposals of scenarios: free for all; waive fees for IDPs temporarily; sliding scale

Accentuate existing HIV services for IDP-related issues

- SGVB services
- Psychosocial services
- Cultural, language, accessibility of existing services
 - Partnership with IDP Community-based organizations (CBOs)

New services specifically for IDPs that may not be applicable to host populations

- Housing/Shelter
- Food, Non-food items
- Legal and Protection services (ID cards, etc.)
- Rights, Advocacy training
- Psychosocial services
- Income generation

Further Considerations

Distinguish services based on

- Stage of epidemic: low-level (<5 % in any defined population), concentrated (>5% in at least one defined population and is <1% in pregnant women in urban areas), or generalized (established in general population, >1% in pregnant women)
- Population demographics – age, sex, diversity (IDP/ethnic, rural/urban)
- Risk behaviours by IDPs - transactional sex
- Risk determinants of IDPs - gender/power issues, legal status

Some Key Questions

- To what extent do IDPs engage in high risk behaviours due to their circumstances?
- To what extent does the National AIDS Control Programme address IDP issues?
- What access do IDPs have to government, NGO or private services?
- What do the IDPs perceive as their needs?
- What does this mean for HIV programming?

Discussion:

General discussion regarding the issue of specific services for IDPs as well as the waiver of fees.

There may be a negative reaction from the host population, if services for IDPs are of better quality or if services are free to IDPs and not for host community. Perhaps a sliding scale or percentage fee could be used.

Waiving fees for IDPs may cause more problems than it solves. However, could advocate for no fees for everyone in the community. However, IDPs arrive have nothing and no way to pay for anything, whereas the host community may have resources, but they may become depleted over time.

In the DRC, we promote a community assistance approach, assisting the host as well as returnees. We help the existing facilities (e.g. give support to the hospital, provide

drugs). During first six months, the returnees have access to services without paying and we ask the facilities to reduce the price for local populations.

IDPs may not always lack resources. In East Burma IDPs had significant resources. Some have been IDPs for 30 years. We decided it was best to leave the decision to locals, since they better understand their own situation.

User fees can be complex. It really depends on each situation. Where health workers are underpaid, there may be fees being paid under the table. A formal system may serve as a deterrent. We need to understand the existing arrangement and work from there to increase fairness.

Summation

Paul Spiegel summarized the finding of the working groups as follows:

I. Assessment Tool

There is a purpose for the tool, but it still needs some work

- 1) It needs to fit into the overall processes (e.g. IASC working group or HIV and emergency cluster assessment tools)
- 2) Needs proper protocol
- 3) It should be three-tiered: immediate, medium-term, longer-term

II. Programmes

This could be looked at within the context of the IASC HIV and emergency meeting tomorrow. IDP programme issues raised here could be included with a bullet point or two in the section on protection, among others in the upcoming revision of the IASC guidelines. Perhaps a broader working group could look at the various IDP issues.

Discussion

This is not meant to be a standardized tool for all conflict-affected populations. This tool could move the IDP agenda forward. Complementarity, how it fits with other tools needs to be discussed further. This process is ongoing.

There seems to be some agreement that the tool provides a basis from which we can work across clusters. There are many existing tools, but this seems to go the furthest.

It is important for advocacy and programme purposes that we are able to document the link between displacement and HIV, particularly in conflict-affected populations. We can look at the wider community, but we may miss an opportunity to demonstrate the link between displacement and HIV.

In order to move the agenda forward, Dr. Spiegel suggested that this tool be examined within existing systems. UNHCR and anyone else interested should continue working on the tool. We should avoid that this tool gets caught up in any political process. It should be examined and improved, in order to develop an acceptable HIV and IDP tool; modifications may be made for other conflict-affected populations.

8. HIV Programmes for IDPs

I. Eastern Europe

Dr. Hilary Homan from UNHCR provided an overview of the current HIV situation among displaced populations in the Southern Caucasus, Turkey and South Eastern Europe. In the six countries assessed, the percentage of the total population who were IDPs ranged from <1% to 8%. Dr. Homan stated that as of 2006, there were approximately 1.7 million PLWH living in this region, and that prevalence rate had increased by 20 times in less than a decade. Currently the main mode of transmission is non-sterile injecting drug equipment; however, heterosexual transmission is on the rise, with the ratio of male to female cases changing from 4:1 to 2:1. She also stated that approximately one-third of all new cases are aged 15-24 years.

Dr. Homan said that only Georgia had IDP-specific data available for HIV prevalence. She noted that poverty and migration had been closely linked to HIV risk behaviour in S. Caucasus with up to 45% of PLWH having a history of migration to countries with higher HIV prevalence. She went on to say that increased vulnerabilities, particularly among young Roma IDPs were linked with high risk behaviour. She then highlighted the link between level of/access to education and knowledge of HIV, commenting that displacement may disrupt education. She referred to a reproductive health survey conducted in Azerbaijan in 2001 in which IDP women had slightly lower knowledge of HIV than non-IDP women, and that non-IDP and refugee women living in conflict-affected areas were the least likely to be aware of HIV and STIs.

Dr. Homan said that the needs of IDPs are much broader than HIV and should be seen in the context of their overall socio-economic status, well-being and future uncertainty. She spoke of the many challenges related to providing HIV interventions for IDPs, such as burn out of donor funding and protracted situations. She also provided examples of lessons learnt from the Armenian government's response. These included commitment to Three Ones, an emphasis on risk and vulnerability in national HIV prevention programme, 100% safe blood and a willingness to focus on IDPs in collective centres engaging in HIV risk behaviour. Among the next steps mentioned were mainstreaming HIV into Poverty Reduction Strategy Plans (PRSP), addressing stigma and discrimination in health and related workers and increasing collaboration with other agencies.

II. Zimbabwe –

Dr. Islene Araujo from the International Organization for Migration (IOM) spoke about the situation in Zimbabwe from 2005 to 2006. During this time there was much displacement due to farm evictions as well as arbitrary evictions/demolitions of “illegal urban structures”, which left an additional 700,000 persons homeless. These evictions caused significant crowding and family separations; many were forced to sleep in the open and some went to holding camps. After these evictions, the informal economic sector was temporarily wiped out and the livelihood of millions was affected. All of this had a massive impact on HIV vulnerability and services.

Dr. Araujo stated that a rapid assessment was conducted and through anecdotal reports information was gathered regarding increases of rape, forced prostitution and unsafe sex. During this period, condom programmes had also been disrupted, when thousands of male condom outlets and most female condom outlets were destroyed. Sex workers, street children and those suspected of being, were rounded up. Home-based care (HBC) services suffered as some NGOs lost contact with 50% of their clients and up to 30% of their volunteers. Additionally, there was some disruption of ART services.

One to two questions on HIV/AIDS were incorporated into general humanitarian needs assessments. The IOM and UNICEF engaged all of their humanitarian partners to conduct a nationwide HIV/AIDS assessment. A joint work plan to address HIV was developed. Partners worked together to mobilize additional resources. Dr. Araujo said that the IASC HIV in Emergency Settings guidelines were fundamental in the design of the response. She also stated that specific programmatic trainings were conducted and staff was seconded to key agencies to respond to the crisis. The response was a joint collaborative effort led by UNAIDS, UNFPA, UNICEF and IOM with Population Services International and more than 40 national NGOs, and many church-based organizations involved.

Dr. Araujo went on to say that the HIV prevention programmes, such as Behavior Change Communication (BCC), Information-Education-Communication (IEC), Condoms, and VCT were all part of the response. She said that HIV was mainstreamed into food security, as food distribution sites were used to raise awareness on HIV and AIDS, and SGBV, as well as to promote and distribute IEC materials and condoms. Additionally, she stated that referrals for SGBV treatment were also provided to a counselling service unit. The lessons learnt included: defining the division of labour as soon as possible; taking into account the comparative advantage of agencies; bringing players together; utilizing non-traditional humanitarian partnerships; using the IASC guidelines; offering HIV testing even during an emergency; providing specific capacity building of humanitarian staff in child protection; SGBV is critical; and adapting its service delivery model, like HBC, VCT and condom programming.

III. Columbia

Ms. Linda Erikson from the IOM gave an overview of her field experiences working on a programme in Colombia to prevent HIV and AIDS among adolescents and young adults in contexts of internal displacement. Colombia is a low prevalence epidemic, with a rate 0.7 percent (0.4 – 1.2%), concentrated in vulnerable groups. The gender ratio is 2:1, men to women. The majority of cases have occurred through heterosexual transmission. Results from a Knowledge, Attitude and Practices Survey (KAP) study showed that IDPs have lower condom use and more partners than non-IDPs. IDPs were included in Colombia's National Strategic AIDS Plan (2007-2010) as a vulnerable group. Indicators have shown that they have greater vulnerabilities than the host population. Ms. Erikson said that IDPs remain for long periods in the host community. It was estimated by CODHES, a local NGO, that between 1985 and 2004, more than 3,400,000 people were displaced in Colombia.

Ms. Erikson discussed the Global Fund financed Project for Colombia. She said that the project is more of a development project, improving HIV and AIDS indicators than an HIV and AIDS project improving development indicators. The main components of the project are public policy, provision of quality services, and to work with adolescents and young adults in contexts of internal displacement. The strategies designed to address these components include, training, empowerment and participation, sex education, condom distribution, provision of VCT and ART, information, monitoring and evaluation, peer education, social marketing and a fund for social, cultural and income-generating micro-projects.

Some of the challenges and lessons learnt from this project are guaranteeing the security of persons wanting to access VCT services or those who have a positive diagnosis, providing security for the personnel working for these programmes, reducing stigma and enhancing the integration process by working in the context of internal displacement rather than solely with internally displaced persons, and providing opportune and flexible health services in order to not lose "the moment". Ms Erikson also noted that one of the most important protection factors against HIV is the reconstruction of social networks and "life" projects

IV. Myanmar

Dr. Tom Lee from the Global Health Access Programme (GHAP) at the University of California spoke about the programme's experiences working with displaced persons in Myanmar. Dr. Lee stated that Myanmar is in the midst of the world's longest civil war, leaving 1-2 million internally displaced, approximately 600,000 of whom live in Eastern Myanmar. Additionally, there are 1.2-1.6 million Myanmarese migrant workers in Thailand (575,000 legally registered) and 150,000 refugees (mostly Karen) in official camps in Thailand.

Though UNAIDS antenatal clinic (ANC) data have placed HIV prevalence in Myanmar at 2.2% in 2000 to 1.3% in 2005, data from the border areas of India and China show higher rates, ranging from 8 - 9%, ANC data from the Mae Tao Clinic in Thailand show rates 2.2%. The National Aids Control Programme budget for Myanmar in 2004 was US \$22,000. Due to restrictions in access, the Global Fund was forced to withdraw their funding. They were soon followed by MSF France, and ICRC. An additional US \$90 million over 5 years has recently been provided by AusAid, DFID, EC, Netherlands, Norway, and SIDA.

Dr. Lee then described GHAP's work in Myanmar, working with IDPs. He stated that in response to the current conditions a novel approach to healthcare delivery and data collection for IDPs had emerged. IDPs have been actively gathering information among themselves. He said that two groups, the Karen Health and Welfare Department (KDHW) and the Back Pack Health Worker Team (BPHWT) have been operating in some of the same areas, but serving different target populations. He said that the KDHW runs 33 mobile health clinics in the Karen area, serving a total target population of over 106,000. He then described the BPHWT, which serves less stable IDP populations in the region. The BPHWT has 76 teams of 2-4 people, handling approximately 80,000 cases per year.

Dr. Lee said that these health workers conducted rapid assessment surveys, but due to security concerns, they were only able to spend a few days in each village. He stated that they had tried to limit the demands on them, so they had them conduct the survey within the course of their regular work. He stated that they had one week to train them and that they also used a training of trainers model. The rapid assessment was purposefully kept simple; only 1-2 pages and it focused on different types of morbidity. In 2004, human rights questions were added to determine their impact on health outcomes. Data showed a clear link between conflict and human rights violations on health outcomes.

With support from Gates Institute for Population and Reproductive Health at Johns Hopkins, the Mobile Obstetric Medics (MOM) was developed. The programme addresses high maternal and neonatal mortality, provides basic emergency obstetric care and other essential reproductive health (RH) services, as well as training for local health workers and traditional birth attendants (TBAs). Dr. Lee suggested that the MOM platform might be used for future HIV-related VCT, PMTCT, and prophylaxis of opportunistic infections. In 2006, survey questions were added regarding HIV/AIDS. The preliminary data showed that two-thirds had ever heard of HIV/AIDS, one-third had never seen a condom and that there was extremely poor knowledge about transmission. They have also recently begun using directly observed treatment (DOT) with malaria and Tuberculosis (TB) in stable areas, with defaulters being monitored.

Discussion:

What kind of partners are involved in developing the social networks in Colombia?

We have up 19 governmental and NGOs and now up to 25 local coordinating groups as well as 115 CBOs.

What is the role of families?

We work constantly with families to get them involved.

What made you decide to implement VCT immediately after the onset of emergency in Zimbabwe as opposed to other services?

We tried to design a comprehensive response. Each agency took a piece of the response. VCT was seen as a piece of the prevention puzzle. Knowing their status was important. It was likely in IDP communities that at least one household member was HIV positive. PSI started a centre for counselling and referral. The ART programme is not reaching all those infected. There are large cues of people waiting for treatment. VCT helps with advocacy for additional ART.

9. Group Presentation and Discussion

I. Policies and Strategies

Key Findings/Recommendations

1) Need to include IDPs

In the existing documents related to HIV and refugees, some include IDPs, while most are specifically about refugees. The documents need to be revised to address the fundamental differences between refugees and IDPs.

- They are citizens as well as IDPs; however, they differ from economic migrants

2) Strategy/plan

The group examined numerous documents including UNHCR's strategic plan for refugees for 2005-2007. It had eleven essential factors that were all relatively applicable to IDPs. Differences included:

- No one agency is responsible for IDPs like UNHCR is for refugees
- No asylum factor
- Refugee laws/convention not applicable
- No sub-regional initiatives specific to IDPs except for the Great Lakes; it mentions IDPs but provides no action at this stage.

Need to revise these documents to include IDPs within national strategic frameworks.

3) Need for specific policy brief for HIV and IDPs.

Considering – scenarios, phases, equity/access, programmes.

4) What next/way forward

The timeframe for the above would be approximately 6 months. A policy working group could revise the existing documents to make them IDP specific.

Final Observations –All of the documents could be useful to countries for developing policies specific for IDPs in their national frameworks.

Comments:

IDPs, as citizens of their country, have no specific international organization that has overall responsibility for them.

The group examined refugee policies for their applicability to IDPs. It was felt that links to refugees were there. The main difference was that they had not crossed a border.

We need a working group with a broad endorsement. It would be relatively simple to modify existing policies.

II. Programmatic Research

Key Findings/Recommendations

1. How would you study relationship between IDPs and HIV infection?

- Population-based testing
- Serial point prevalence
 - Anonymous and voluntary
 - Refusal bias
 - Ethical considerations
- Universal offer for testing
- Use of programmatic data: PMTCT, ANC, other point of access data
- Comparison / Cohort study
 - Which comparison group?
 - How similar are they?
- Retrospective studies
 - Survivor bias N years later
- Importance of defining HIV prevalence in country or area of origin and destination, mixing of populations
- Add conflict-related questions to VCT, ANC, and PMTCT
 - Strong bias for populations that seek VCT
 - Be prepared to offer services for questions asked
- Measure other bio-markers besides HIV (shorter-term, easier to measure diseases, etc.)
- Include and disaggregate host communities in studies of displacement impact
- Importance of qualitative research

2. What is the possible conflict or displacement-related risk factors that increase/decrease risk for HIV?

- SGBV
- Time of displacement
- Indirect (less obvious) risk factors

3. How would you research possible programme interventions?

- Research beyond just vulnerability and risk factors
 - Decide on research priorities first
 - How to design or improve programmes: operational research
 - Randomized trials (perhaps only possible in camp settings)
 - Health-seeking behaviours
 - Making interventions user-friendly
 - KAP surveys
 - Comparison of IDPs vs. non-IDPs
-
- Need for increased funding for operational research
 - Making time/space for operational research in programmes
 - Pairing of NGOs with academic institutions

Discussion:

Behavioural surveillance survey (BSS) implies regular monitoring to assess trends over time; HIV testing and anonymous behaviour studies may not be available in many countries. HIV may still be a rare event in many countries. It may be better to focus on other bio markers, RH and especially for young women, unwanted pregnancies and abortion. IDPs and host population; useful to consider studies with geographical factors.

Lessons learnt with refugees can apply to IDPs. All research needs to be written down and disseminated; there is a lack of research in this area. Studies with areas of lots of IDPs; disaggregate population (host and refugees or IDPs). UNHCR has a robust tool; a modified BSS for host and refugees. It could be used for IDPs for pre-displacement, displacement, and post-displacement situations, examining these phases as well as interactions with surrounding host populations. However it is expensive and should be implemented, with academic institutions or specialised NGOs when feasible.

Different approaches may be necessary and must define the research priorities and for which purpose. There may be a range of approaches and needs. We will not, therefore, make recommendations.

Research priorities should come from the field level. We should consider approaching certain countries. Need to look at what has been done where and then see what the priority is for them.

III. Advocacy and Coordination

Key Findings/Recommendations

Message 1 -IDPs should be included in all programming

- I. HIV integrated into humanitarian action

Preparedness → Programming → M&E

- II. IDPs into national strategic plans, as well as (provincial, and district)
- III. Transitional programming, including early recovery, poverty reduction (PRSP), Disarmament, Demobilization and Reintegration (DDR)

Message 2

- Non-discrimination, (access, protection)
- Know specific needs of IDPs and target interventions accordingly
 - Typology of sex work
 - Educational needs
 - Minors, children

Message 3

- Continuity of services after acute phase (acute, transitional, post-crisis, and when IDPs have merged with local populations)
- Parity of services for host populations and for IDPs-sensitivity to local populations

Target Audience - National, regional level and International

Activities:

- Proposal that UNHCR, IOM and other interested organizations convene strategy session on advocacy for HIV programming for IDPs to determine approach and main activities, with key partners and relevant implementing agencies both at global and national levels. At country level, UNAIDS Theme Group to lead/participate in advocacy for IDPs and HIV

Coordination:

- Humanitarian Coordinator has ultimate accountability with cluster lead responsibilities for HIV as cross cutting issue at country level.
 - Clusters to integrate HIV (including for IDPs) into their work plans, including preparedness, etc.
 - Inter-cluster coordination to make sure gaps are covered, consistency in approach etc.
 - IASC sub-working group on HIV in emergencies (if it eventually exists) could feed into sector/cluster process

Proposal to establish UN Theme Group sub-working group on HIV and emergencies (or IDPs/refugees) at country level; would include government membership. Members to participate in cluster meetings to feed into process. This sub-working group would link with humanitarian coordination mechanism.

Comments:

UNDP is lead for PRSP process. We need to look at the process which involves all these groups staking a claim to resources.

The World Bank has tried to deal with a lot of public sector entities. I would include education and the need to look at capacity. One of the least responsive sectors in countries is the health sector we need to press them to take on available resources.

UNDP just completed a baseline analysis where there are dimensions of IDPs and refugees. UNDP needs to help to mainstream HIV into early recovery.

10. Next Steps and Closure

Dr. Spiegel thanked all of the presenters, stating how much was learned from the diversity of their presentations. He then highlighted main points for five key areas, assessment, programming and coordination, advocacy and programmatic research.

Assessment

1) There is a tool for rapid qualitative assessment for HIV among IDPs with one quantitative sub-component. It needs modification. UNHCR will continue to work on it with other interested partners to create two to three different versions.

Programming

- 1) Access and Equity – still needs further discussion (e.g. user fees).
- 2) Existing activities to be enhanced for IDPs
- 3) New activities for IDPs not applicable to host

We hope it will be reflected in the revised IASC HIV in Emergency Settings guidelines.

Coordination

- 1) It is a long process which is ongoing.

Advocacy

- 1) We hope to combine the proposed working group with the related policy and strategy working group for HIV and IDPs.

Action: UNHCR will send an email requesting participation.

Programmatic Research

1. Needs to be discussed more. Clearly there are countries that need to be examined. IASC and DFID-funded UN system-wide HIV in emergency groups should also be included when considering programmatic research issues. More qualitative and quantitative research among HIV and IDPs is needed. Existing sentinel surveillance studies in countries with IDPs should add questions and/or ensure disaggregation of data for HIV prevalence. We could do more BSS among displaced and non-displaced persons as has recently been done in Juba, in Southern Sudan.

Annex 1 - Programme

Day 1: Tuesday, 24 April 2007

The first day began with welcoming remarks from the Assistant High Commissioner of UNHCR, Judy Cheng Hopkins and Elhadj As Sy, the Director of Communications and External Relations. This was followed by a brief overview of HIV and IDPs, followed by a discussion of the assessment tool and the experiences of the teams who implementing it in the field. The afternoon started with review of current HIV programmes for IDPs, and finished with the participants breaking into working groups.

Time	Topic	Presenter
8:30 - 9:00	Registration	
9:00 - 9:45	Welcome Address	Judy Cheng Hopkins - Assistant High Commissioner UNHCR Elhadj As Sy, Director Communications and External Relations UNAIDS
9:45 - 10:30	HIV and IDP overview	Paul Spiegel
10:30 - 11:00	<i>Tea/Coffee</i>	
	SESSION 1 - HIV and IDP Assessment Tool	<i>Moderator: Paul Spiegel</i>
11:00 - 13:00	HIV and IDP assessment, Introduction Tool	Michel Carael - UNHCR consultant
	HIV and IDP assessment experiences Nepal	Mr. Prakash Kumar Pathak- MHA Nepal & Ann Burton - UNHCR
	Côte d'Ivoire	Esmee de Jong - UNHCR
	Democratic Republic of Congo	Dieudonne Yiweza -HCR
	Discussions	
13:00 - 14:00	<i>Lunch</i>	
	SESSION 2 - HIV programmes for IDPs	<i>Moderator: Marian Schilperoord</i>
14:00 - 15:30	Uganda	Fillipo Ciantia - AVSI
	Democratic Republic of Congo	Daniel O Brien - MSF
	Liberia	Dr. Bility - NACP Liberia
	Discussions	
15:30 - 16:00	<i>Tea/Coffee</i>	
	SESSION 3 - Working Group Sessions	<i>Facilitator working groups:</i>
16:00 - 18:00	Group 1 +2 : Situational Analysis and assessment	Michel Carael and Ann Burton
	Group 3 +4: HIV programming for IDPs	Fillipo Ciantia and Hilary Homans

Day 2: Wednesday, 25 April 2007

The second day began with presentations from the Working Groups. This was followed by presentations on current programmes for IDPs in different regions. Afterwards, participants divided into three Working Groups and reported back to the larger group in the final session. The consultation closed with a discussion on next steps.

Time	Topic	Presenter
8:30 - 10:00	SESSION 4: Group presentation and Discussion	Chair: Richard Seifman
10:00 - 10:20	<i>Tea/Coffee</i>	
10:20 - 12:30	SESSION 5 - HIV programmes for IDPs	<i>Moderator: Tom Ellman</i>
	Eastern Europe	Hilary Homans - UNHCR
	Colombia	Linda Erikson - IOM
	Myanmar	Tom Lee - University of California
	Zimbabwe	TBC
	Discussions	
12:30 - 13:30	<i>Lunch</i>	
13:30 - 15:00	SESSION 6 - Working groups	<i>Facilitator working groups:</i>
	Group 1: Advocacy and Coordination	Karl Dehne - UNAIDS
	Group 2: Programmatic Research	Ed Mills - BC Centre for excellence
	Group 3: Policies and Strategies	Marian Schilperoord - UNHCR
15:00 - 15:30	<i>Tea/Coffee</i>	
15:30 - 16:40	SESSION 7: Group presentation and Discussion	<i>Chair: Karl Dehne</i>
16:40 - 17:00	Next steps and closure	Chair: Paul Spiegel

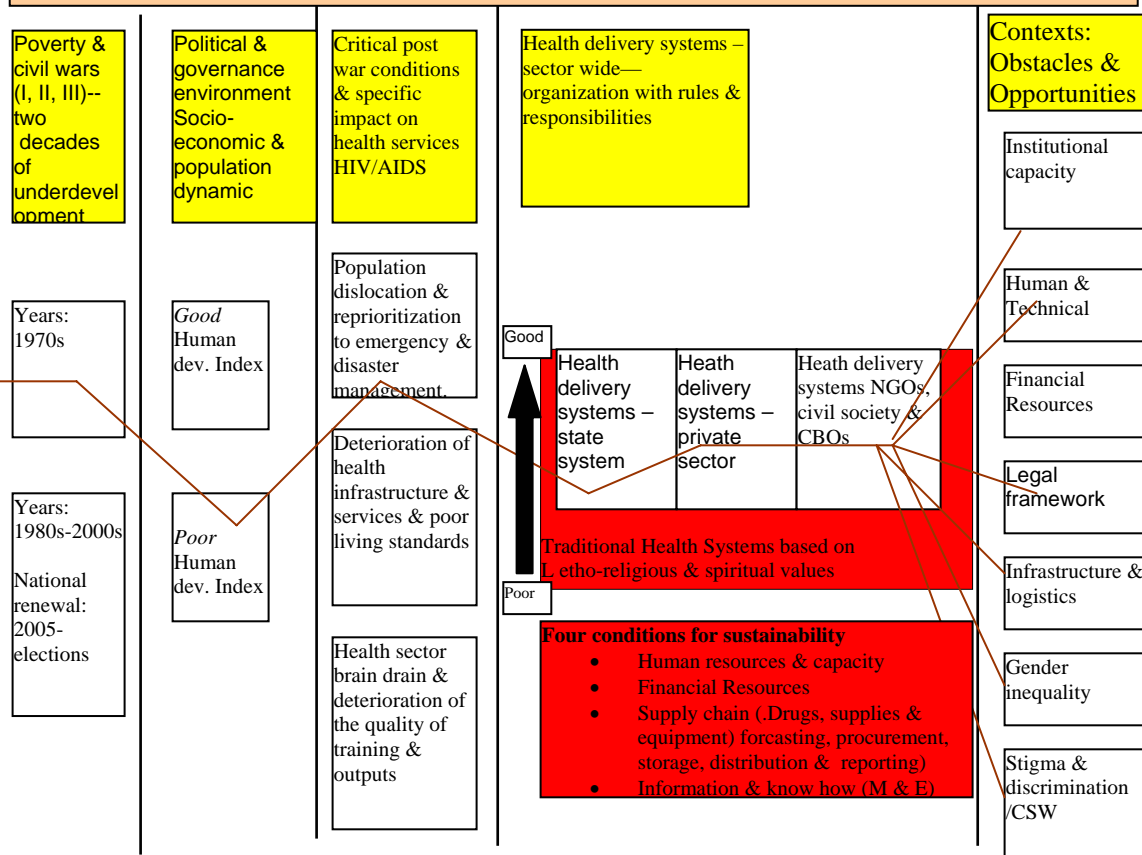
Annex 2 - List of Participants

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Annex 3: Summary diagram of main factors in assessing a prevention, treatment and care response in Liberia

Liberian context: factors affecting the national response to HIV/AIDS prevention, treatment and care



Policy options: interventions and strategic actions

Elements of an effective national response to prevalence >5%

PROBLEM: National HIV/AIDS prevalence rate in 2006 >5% gen. pop.

PREVENTION

- **Targets for 2012 in Round 6 proposal**
- Abstinence promotion (Age >15-20)
- STIs treatment (from 5,000-30,000)
- Condom distribution (60% of pop)
- Prevention and treatment of opportunistic infections from (5 – 25 sites)
- VCT (>1%-25% of population) (IEC/BCC) 70% 15-35yrs olds
- Prevention of mother-to-child transmission plus from (PMTCT- >1,00-15,000)
- Blood safety & supply (banks – 3 additional facilities in the 5 regions)
- Advocacy, Legislation & strengthening inst.

TREATMENT

- Anti-retroviral therapy (ART) from (750-12,500)
- Establish Nat'l Ref Laboratory system
- Strengthen JFK & 7 key hospital as hub for prevention & treatment
- Adherence & treatment illiteracy
- HIV/TB integration (from 2-15 centres)

CARE

- Palliative and home-based & psycho-social & spiritual care
- Peer support & counselling
- Support for positive living including nutrition

MITIGATION OF IMPACT

Implementation / strategic actions

Harmonize the National Response

- Re-constitute/strengthen the National AIDS Commission
- One M&E System (ENHR)
- One National Action Framework coordinated by NACP

Strategically strengthen existing capacity within a comprehensive response linking prevention, treatment, care, support and impact mitigation efforts

- Recruit/retain county-level HIV/TB-STIs workforce thru salary support
- Strengthen CHTs
- Select & rebuild capacity at key health facilities
- Strengthen NDS & supply chain management
- Harmonize response at national, county, district levels
- Strengthen County Teams (outreach)

Establish Partnership Forum

Including civil society, private sector, int'l agencies, and government.

- Coordinate & expand support services
- Integrate national response
- Liberia Coordinating Mechanism
- Principal/Sub- Recipients
- Technical Coordinating Committee

Conditions for Success in Resource Poor settings

- Use non-physicians clinicians
- Move beyond the health sector
- Meet people where they are: Liberia seek care first at pharmacist, therefore the pharmacist is your entry point for VCT which is the gateway for everything else

Summary diagram: This summary diagram identifies key factors affecting the overall design of an effective national response the big problem of national HIV/AIDS prevalence rate > 5% of general population. The diagram consists of three parts: part one map the outline of Liberian society in recent times leading to new democratic government in 2005. Mainly, post conflict poverty determines the growth pattern of the epidemic and the impact of the national response to prevention, treatment, care and support. These factors have been identified as: level of economic development; political and governance environment; population dynamics. They necessarily aggregate to create more complex and nuanced factors specific to the form, content and context of health services provided by four types of health delivery systems: (1) state (2) private and (3) non state (NGOs, Faith Based Institutions) and (4) traditional. Part II pertains mainly to the health sector. The specific issues, unique needs and roles of the multiple service providers is considered in relation to (1) institutional capacity, (2) human and technical competence, (3) financial resources, (4) legal frame work, (5) infrastructure & logistics, (6) gender inequalities, (7) stigma and discrimination. While these factors are driving our response to the HIV/AIDS epidemic, they also present opportunities for scaling up national response. To optimize the national response, part III points out the elements of effective interventions identified in the Global Fund Round Six application. *Author: Khalipha M. Bility, Ph.D. Not to be quoted without permission of author*

Annex 4: Presentations

The presentations are included in the document First Global Consultation on HIV and Internally Displaced Persons, Presentations.