UNHCR's HIV and AIDS Policies and Programmes

HIV Report 2006

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Publications of the UNHCR HIV/AIDS Unit can be obtained from hivaids@unhcr.org.

Acronyms

ADB	African Development Bank
AIDS	Acquired Immune Deficiency Syndrome
ART	Antiretroviral Therapy
ARV	Antiretroviral
BSS	Behavioural Surveillance Study
CAR	Central African Republic
CASWANAME	Central Asia – Southwest Asia – North Africa – Middle East
DFID	Department for International Development
DRC	Democratic Republic of Congo
GFTAM	Global Fund to Fight AIDS, Tuberculosis and Malaria
GLIA	Great Lakes Initiative on AIDS
HBC	Home-Based Care
HIV	Human Immunodeficiency Virus
HIVIS	HIV Information Systems
IASC	Interagency Standing Committee
IDP	Internally Displaced Person
IEC	Information Education and Communication
IFCOC	Oubangui Chiari Initiative
IP	Implementing Partner
NGO	Non-Governmental Organisation
MAP	Multi-Country AIDS Programme
M&E	Monitoring and Evaluation
MoH	Ministry of Health
MRU	Mano River Union
MSF	Médecins sans Frontières
NAP	National AIDS Programme
NSP	National Strategic Plan
NWFP	North Western Frontier Province
OCHA	United Nations for the Coordination of Humanitarian Affairs
OFID	OPEC Fund for International Development
OVC	Orphans and Vulnerable Children
PEP	Post Exposure Prophylaxis
PLWHA	People Living with HIV/AIDS
PMTCT	Prevention of Mother-to-Child Transmission
PEPFAR	President's Emergency Plan for AIDS Relief
PPASA	Planned Parenthood Association of South Africa
ROC	Republic of Congo
SAHCS	Southern African HIV Clinicians Society
SGBV	Sexual and Gender Based Violence
STI	Sexually Transmitted Infection
UBW	Unified Budget and Work Plan
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNFPA	United Nations Population Fund
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
UNODC	United Nations office on Drugs and Crime
USAID	US Agency for International Development
VCT	Voluntary Counselling and Testing
WFP	World Food Program
WHO	World Health Organization

Executive Summary

The United Nations High Commissioner's (UNHCR) HIV and AIDS programmes continue to become more comprehensive while increasing their geographical coverage and covering internally displaced persons (IDPs) as well as refugees and other persons of concern to UNHCR. As a result of the increased support to broad based HIV programmes, significant positive contributions were made to the protection, health, nutrition and education sector as well as community development initiatives.

In 2006, UNHCR received funding for HIV from numerous donors at global, regional and country levels. In addition to the core funded UNHCR programmes that constitute the basis of our HIV programmes, UNHCR received additional earmarked contributions and in kind donations of over 2 million USD.

UNHCR expanded its HIV and AIDS programmes to the Americas, Europe and the Middle East. Six full time HIV/AIDS Coordinators and two part-time long term consultants provided technical support to country programmes and undertook numerous field missions to assess and monitor the programmes. Detailed regional and country HIV programmes are described in this report.

With UNHCR's expanding role for IDPs and its designated role as lead technical agency for refugees and IDPs within the UNAIDS division of labour, the HIV Unit expanded technical support and conducted HIV and IDP assessment missions in Colombia, Eastern Europe and Nepal.

As a Joint United Nations Programme on HIV/AIDS (UNAIDS) cosponsor, UNHCR has been actively involved in the joint programme. An important policy brief on HIV and refugees, focusing on actions required to address the spread and effect of HIV on refugees and their surrounding communities was published. In 2006, significant focus has been given to the inclusion of conflict-affected and humanitarian emergencies in several high level meetings such as the AIDS review 2006 by the General Assembly and the UNAIDS Programme Coordination Board meetings.

UNHCR together with 10 other UN agencies was an active partner in the United Nations System-Wide Programme on HIV/AIDS in Populations of Humanitarian Concern. Key initiatives such as the assessment and programming of substance abuse and HIV in humanitarian settings began under this programme. Numerous strong and dynamic partnerships continued including our long standing cooperation with UNFPA in the field

of sexual and gender-based violence (SGBV) and provision of condoms.

The Great Lakes Initiative on AIDS (GLIA), continued to develop. The work plans and joint planning for refugees and surrounding communities were finalised and UNHCR received the first disbursement of funds at the end of 2006. Programme implementation will start in January 2007.

HIV and AIDS clearly became a core protection priority for UNHCR. Efforts to build capacity as well as to monitor and respond to HIV-related human rights violations were intensified. Training and orientation on HIV and protection for UNHCR staff were conducted in many offices, with a specific workshop in the Middle East and North Africa operations. UNHCR and implementing partner (IP) staff became more conversant with protection issues such as confidentiality and disclosure, mandatory HIV testing, and access to HIV related services. The HIV Unit works closely with protection and gender advisors in UNHCR to address transactional sex work and other HIV vulnerable and risky behaviour.

Numerous HIV/AIDS and refugee publications were released in 2006. These include a UNAIDS/UNHCR best practice collection: *The development of programme strategies for integration of HIV, food and nutrition activities in refugee settings";* UNHCR field experience entitled "*Introduction of female condoms in refugee settings"* and a cartoon booklet on "*HIV and AIDS, Human Rights for Everyone".* With UNESCO, a discussion paper for decision makers on educational responses for HIV and AIDS was published.

Behavioural surveillance surveys (BSS) were conducted in Southern Sudan, Uganda and Zambia. Furthermore, the results from the 2005 BSS in Nepal, Mozambique and Tanzania were published. Refugee sites in Kenya and Uganda have been included in the national HIV antenatal clinic sentinel surveillance surveys.

Data were collected and analysed from 25 countries in Africa and Asia, representing 106 refugee sites, 4 urban sites and 12 areas of return. Universal precautions (e.g. sufficient needles/syringes, gloves and blood transfusion screened for HIV) was 100% in East and West Africa. In Central Africa, Southern Africa and Asia, there were shortages of such key supplies. In a minority of countries, there was a lack of HIV test kits for safe blood. Condom distribution was insufficient to meet emergency levels in most refugee sites in East and Horn of Africa and Asia. Sexually transmitted infection (STIs) related issues (e.g. sufficient condoms, sufficient STI drugs, and use of syndromic approach) was 100%

in East, Southern and West Africa, 94% in Asia and 80% in Central Africa. Access to voluntary counselling and testing (VCT) was widespread in Southern Africa (100%), acceptable in East and Horn of Africa (71%) and poor in Asia (53%), West Africa (45%) and Central Africa (30%). Access to prevention of mother-to-child transmission (PMTCT) programmes was 89% in Southern Africa and 51% in East and Horn of Africa. The access in Asia, Central, and West Africa was below 30%. Refugees had equal access to antiretroviral therapy (ART) compared with surrounding national populations in Southern and West Africa while refugee had only 57% access in East and Horn of Africa, 47% in Asia and only 30% in Central Africa. Finally, rape survivors had access to post-exposure prophylaxis (PEP) in > 50% in Central and East and Horn of Africa. In Southern Africa and West Africa, PEP access was low at only 33% and 18%, respectively.

Background

In line with the UNHCR's Strategic Plan for Refugees, HIV and AIDS 2005–2007 (annexes 1 and 2), the overall objectives of the HIV programmes are to combat HIV and AIDS among refugees, internally displaced persons (IDPs) returnees and other persons of concern, as well as to ensure that the human rights of these persons who are infected or affected by HIV and AIDS are duly respected.

In Geneva, an HIV Unit was established with three staff members; Head of HIV Unit, Senior HIV/AIDS Coordinator and a Liaison Officer to UNAIDS. Five Senior Regional HIV/AIDS Coordinators continued working in Africa and Asia based in Accra, Kinshasa, Nairobi, Pretoria and Bangkok. Numerous missions to the field to provide technical support and monitor the HIV programmes were undertaken by these persons. Furthermore, the unit recruited two consultants to support the expanding HIV interventions in the Americas and Asia.

In addition to UNHCR's annual budget for HIV programmes under the country programmes, HIV and AIDS earmarked contributions were allocated to support global, regional and country programmes. These funds were used to further enhance and support the development of comprehensive HIV and AIDS programmes and to meet the objectives and strategies outlined in the UNHCR's Strategic Plan for Refugees, HIV and AIDS 2005 - 2007.

Contributions to the global HIV programme were received from Australia (earmarked for Asia), Denmark (earmarked for Africa), Canada and the United States of America. Additional earmarked contributions have been received from the OPEC Fund for International Development (OFID) for the Central Africa region, the World Bank funded Great Lakes Initiative against AIDS (GLIA), and the World Bank, Multi-Sectoral AIDS Programmes (MAP) for the Democratic Republic of Congo (DRC). Contributions in kind were received from USAID and UNFPA. UNHCR was successful in receiving funding from the President's Emergency Plan for AIDS Relief (PEPFAR) for the refugee programmes in Botswana and Zambia. In addition, PEPFAR provided direct support to UNHCR's implementing partners (IPs) in Ethiopia, Rwanda and Uganda.

I) Protection

HIV and AIDS are clearly positioned as core protection priorities for UNHCR. Efforts to build capacity to monitor and respond to any HIV-related human rights violation were intensified. A note on HIV/AIDS and the protection of Refugees, Internally Displaced Persons and Other Persons of Concern was released in April 2006 (annexes 3-6). The note discusses 10 key areas related to (1) discrimination; (2) access to HIV and AIDS health care; (3) access to asylum procedures and protection from expulsion and refoulement; (4) protection from arbitrary detention and unlawful restrictions on freedom of movement; (5) respect for confidentiality and privacy; (6) Provision of HIV voluntary counselling and testing (VCT); (7), freedom from mandatory HIV testing; (8) access to durable solutions; (9) HIV-protection related needs of women and children; and (10) access to HIV information and education. The note is available in Arabic, English, French and Russian. Information posters and leaflets were developed for UNHCR offices, Governments, IPs and operational partners (annexes 7, 8 and 9).

Training and orientation on HIV and protection for UNHCR staff were conducted in many offices, with a specific workshop for Middle East and North Africa operations held in Tunis. UNHCR and IP staff became more conversant with protection issues such as confidentiality and disclosure, mandatory HIV testing, and access to HIV and AIDS related services.

In an effort to address the intersection of sexual violence, protection and HIV, the HIV Unit expanded its support to all countries in Central and Southern Africa with the provision of post exposure prophylaxis (PEP) following rape. Training of trainers courses were organised using the 2004, WHO/UNHCR Clinical Management of Rape Guidelines.

Following HIV assessment missions in the field, the HIV Unit is working closely together with protection and community services to address issues related to transactional sex work and increased HIV risks. As a UNAIDS cosponsor, UNHCR provided extensive inputs into a position paper on HIV and sex work.

In addition, the HIV Unit participated in four regional resettlement workshops. The problems associated with HIV testing in the context of resettlement were discussed and field experiences were solicited in order to inform higher level negotiations on how to improve the practice.

II) UNHCR's Populations of Concern

UNHCR undertook a detailed review of the HIV/AIDS National Strategic Plans (NSPs), approved HIV proposals by the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFTAM) and the World Bank's Multi-country HIV/AIDS Programme for Africa (MAP) for a select group of countries hosting refugees and/or IDP populations of 5,000 or more. A total of 56 NSPs out of a possible 69 have been reviewed. Thirty-two of the 56 (57%) mentioned refugees while 24 (43%) did not. Of those countries that submitted plans, 22 (39%) described particular activities for refugees, while 34 (61%) did not. In 2006 UNHCR advocated successfully for the inclusion of refugees in the National Strategic Plans of Egypt and Pakistan. IDPs were included in 19 of the NSPs (34%) and 10 (18%) included specific activities.

A total of 91 GFTAM proposals have been reviewed from rounds one to five. Overall, the proposals included refugees 31 of 91 proposals (34%). By round, the figures varied from a low of 17% in the first round to a high of 48% in the fourth round. However, a total of only 20 (22%) proposals described activities for refugees; the rest simply mentioned them as vulnerable groups, often putting them together with intravenous drug users, commercial sex workers and men having sex with men. IDPs were mentioned 13 times (14%) with specific activities included 12 times (13%).

The World Bank's MAP has funded 26 country specific and regional HIV Projects in 23 African Countries hosting 5,000 or more refugees or IDPs. Within that group, 13 (50%) included refugee issues with 11 (42%) of those including specific activities for refugees. IDPs were mentioned in 11 projects (42%) of which 9 (35%) included specific activities for IDPs (annex 10).

III) HIV Programmes

A) Africa

The programmes in Africa continued to focus on the development of comprehensive HIV and AIDS response including the scaling up of universal access to prevention, treatment and care with a strong focus on the development of HIV Information Systems (HIVIS); the latter allowed a prioritisation and allocation of scarce resources based on evidence. In 2006, two HIV sentinel surveillance surveys and three behavioural surveillance surveys (BSS) were undertaken. Specific community-based training on stigma and

discrimination was piloted in Malawi and Zimbabwe; these trainings will be expanded in 2007. In Southern Africa, UNHCR worked closely with the Southern Africa HIV Clinicians Society to develop guidelines for antiretroviral medication for displaced populations. The development of HIV programmes has had a positive impact on public health, reproductive health and nutrition services to these populations.

The Positive Lives Exhibition, photographic stories of the lives of people living with HIV AIDS (PLWHA), was shown in a number of countries in the West African Region. The exhibition was aimed at addressing the stigma and discrimination against HIV and AIDS.

Standardised assessment missions provided a picture of the current situation and enabled further planning for and follow up of programme activities. The HIV/AIDS regional coordinators of Central and East and Horn of Africa continued to support countries with the intensive planning phases for the Great Lakes Initiative against AIDS (GLIA) programme.

i) Central Africa

In March 2006, a consultation was convened by the African Union with support from the World Health Organization (WHO) and the Joint UN Programme on AIDS (UNAIDS). Conflict and displaced persons were included in the **"Brazzaville Commitment on Scaling Up Towards Universal Access to HIV and AIDS Prevention, Treatment, Care and Support in Africa by 2010"** (annex 11).

In **Burundi**, the HIV and AIDS prevention and care interventions were sustained; HIV awareness, condom distribution, treatment of sexually transmitted infections (STIs) programmes are ongoing. In addition, urban refugees and those in Gasorwe Refugee camp have access to VCT, prevention of mother to child transmission (PMTCT) programmes and antiretroviral therapy (ART). The main obstacles remain the access to additional support such as transport and nutritional supplementation for PLWHA and the threat of shortage (stock outs) of anti retroviral medications (ARV) in the country. UNHCR, though challenged, strives to ensure that returning refugees from Tanzania who are HIV positive will have continued access to support, care and treatment services.

With the closure of almost all camps in 2006 in **DRC** and the return of refugees from neighbouring countries, HIV and AIDS interventions in DRC has shifted from the traditional camp-based assistance interventions with well defined target populations in a

given area to more diffuse HIV activities targeted towards returnees in transits centres and in areas of return. While UNHCR successfully negotiated management contracts with the World Bank funded MAP, security constraints hampered the start of HIV intervention among IDPs and returnees. UNHCR's HIV and AIDS interventions focused on HIV awareness, condom distribution and referrals of PLWHA to Government health facilities close to areas of return. Refugees repatriating from Republic of Congo (ROC) to the Equator Province have been supportive in establishing and continuing HIV awareness activities in areas of return. Since November 2006, UNHCR DRC has been chairing the HIV in humanitarian situation working group under the UN Country Team.

Improved medical response and prevention of HIV post-rape

In partnership with UNFPA, UNHCR continued to ensure that PEP is made available to all rape survivors that report to the clinic within 72 hours after the incident. Joint UNFPA/UNHCR training of trainers on improvement of the clinical management of rape took place in Southern Africa in July and in Central Africa in November 2006. Sixty (60) clinicians from UNHCR's implementing and operational partners as well as UNFPA country staff from their respective regions received intensive training on medical examination, forensic evidence and treatment post rape with a strong focus on minimising the risk of STIs and HIV transmission through timely provision of PEP.

The precarious security situation in **Chad** hindered the relatively basic HIV programmes provided to refugees. An HIV coordination structure was established in the East. The OFID programme, implemented by UNHCR in close collaboration with the Reproductive Health Coordinator from one of the implementing partners began. The team supports the partners working at camp level with the development of comprehensive HIV and AIDS programmes integrated int0 existing social and health programmes. The programme activities in Chad have a strong capacity building component and much emphasis has been on basic skill building and awareness on HIV with a strong focus on stigma and discrimination.

The HIV/AIDS programmes in the **Central African Republic** (CAR) focused on strengthening the basic HIV package in the camps as well as among urban refugees. Special attention was given to HIV awareness for the Sudanese refugees' repatriation from CAR. Since November 2006, an HIV national consultant was hired to ensure comprehensive HIV coordination and technical support.

The repatriation from the **Republic of Congo** to DRC was intensified in 2006 with the goal of completion in early 2007. HIV awareness sessions and condom distribution were undertaken in the transit centres. The "Community Conversations", initiated in 2004, were strengthened in 2006 and remains one of the best practices of UNHCR in the region. This approach aims to empower the community by reinforcing HIV and AIDS knowledge of a core group in a community that brings their peers together to consider the problem and find local solutions. A cross border coordination system was established to trace people who have been trained as community conversations facilitators to ensure that they become an important resource in their localities of origin. Activities under the OFID programme were implemented in and around the settlements in Betou and Impfondo and have been implemented in close partnership with the district authorities. The programme focused on intensifying the HIV awareness activities started under UNHCR's "Community Conversations'" programme and expansion of access to services for both refugees and surrounding communities to more comprehensive prevention, care and treatment programmes.

Rwanda's HIV programmes benefited from OFID and PEPFAR funding that significantly improved the range of HIV and AIDS services available for refugees, making them some of the most advanced among the six GLIA countries in Central Africa. In addition to the minimum HIV package that all the programmes offer, refugees now have access to camp based VCT, PMTCT and ART services. Under the OFID programme, UNHCR's IPs worked in close partnership with the Government of Rwanda as well as local and international non-governmental organisations (NGOs). A multi-sectoral approach was adopted that allows for the integration of the HIV interventions in all sectors present in the refugee sites. During this first phase of the programme, innovative HIV prevention and awareness activities were launched in close partnership with all partners. The programme also focused on strengthening the monitoring and evaluation (M&E) of the HIV programmes and services to ensure quality services. Refugee youth clubs in Kiziba camp were able to produce a music album featuring HIV awareness songs.

The HIV and AIDS programmes in **Gabon** benefited from financial support from UNAIDS allowing the country to train peer educators to support HIV sensitisation among various refugee groups.

ii) East and Horn of Africa

In 2006, **GLIA** projects in Kenya, Tanzania and Uganda concentrated on the development of detailed work plans and budgets as well as introduced and familiarised UNHCR's operational and IPs to the GLIA M&E requirements.

Refugee sites in Kenya and Uganda have been included in the **national HIV sentinel surveillance surveys**. Final results from both surveillance surveys are expected in the second quarter of 2007.

In **Djibouti**, HIV funds were used to train and pay incentives for two refugee youth as HIV counsellors and peer motivators. Refugees who consent for VCT services are referred to testing facility in Djibouti city. The health unit in Ali Adde was rehabilitated to enhance privacy and confidential access to care; doors and windows were repaired and the consultation clinics partitioned. Health care providers were trained in various aspects of universal precautions including injection safety and medical waste disposal.

In **Ethiopia**, the main objective was to strengthen and scale up comprehensive HIV prevention and AIDS care, treatment and support programmes. Two VCT clinics were opened and over 45 health care providers trained on syndromic management of STIs and clinical management of rape including, PEP. Refugees were included in the national ART programme through the regional hospital. However, ART uptake was hindered by inadequate demand and access to HIV testing. Refugees in all sites, except Karberbeya and Bonga refugee camps have access to VCT services. However, the uptake of VCT is minimal and is mainly hindered by fear, stigma and discrimination. None of the refugee sites offers PMTCT services. UNAIDS and UNHCR co-funded a national HIV consultant. This consultancy supported coordination and multi-sectoral partnership as well to provide technical support to IPs.

In **Kenya**, the HIV programme supported the emergency response in Dadaab refugee camps. Dadaab was faced with an influx of refugees from Somalia, floods, and outbreaks of rift valley fever and polio. To overcome these challenges, the HIV programme focused on strengthening universal precautions; mainly injection safely, human waste disposal, safe blood supply, condom promotion and distribution, reproductive health and access to basic health care and community services. Comprehensive HIV services, including provision of VCT, PMTCT and access to ART are available in Kakuma refugee camp.

The focus of the HIV programme in **Eastern Sudan** is to create HIV awareness among refugees and orient UNHCR and IP staff about the linkages of HIV and related protection and human rights issues. To support HIV awareness creation two youth centres were opened in Umgurgur and Kilo26 refugee camps. The youth centres offer recreational, vocational, and indoor and outdoor sports integrated with HIV awareness and education. Awareness sessions are facilitated by 20 trained peer educators. In addition, 30 health care providers were trained on syndromic management of STIs. Thirty two UNHCR field staff and IPs were trained on HIV-related protection and human rights issues

Substance abuse and HIV

A joint UNHCR/WHO project funded through the Department for International Development (DFID) developed a rapid assessment tool for substance abuse and HIV assessment in emergency settings. The tool has been utilised in Kenya, Liberia and Thailand.

The assessment in Kenya indicated that alcoholic beverages especially, home-based brews and distilled products are the major forms of substance abuse linked to high risk sexual behaviour. In Kenya, female brewers also worked as commercial sex workers and drinking areas are meeting points for sex workers and their customers. In Thailand, alcohol was identified as a significant problem in all 3 assessment sites and contributes significantly to sexual and gender-based violence. In Liberia, the lack of coordination and a national strategy influenced the survey. There are many high risk groups for substance abuse in the country, such as torture survivors, ex-combatants, war affected children and adults, out-of-school youth and women involved in the sex trade. The mission reports are in annexes 14 - 16.

Based on the assessments, interventions started in Kenya and Thailand with external aid by UNHCR. In Liberia, WHO will take a lead role in the development of a National Alcohol and other Drug Misuse Prevention Strategy and set up coordination mechanisms for organisations working on substance misuse prevention activities in Monrovia. UNHCR, however, will ensure programmatic interventions for their populations of concern through their regular HIV programmes.

In **Southern Sudan**, UNHCR provides HIV awareness packages for returnees and other persons. The packages include messages on HIV prevention and condoms to ensure a comprehensive HIV prevention response. Some of the returnees have been actively involved in peer education efforts in the communities where they have returned. Using the ten key points on the note on HIV and refugee protection, over 30 UNHCR protection, community services and field officers and 35 IP and operational partners were trained in Juba. The training was then rolled out to the local community leaders; nine training sessions targeting county local leaders were conducted. UNHCR employed two consultants in Juba to provide support to HIV strategic information in Southern Sudan. One of the consultants focused on the implementation of a BSS; the results will be available early March 2007. The other consultant provided support to M&E of HIV programmes.

The results of the BSS in **Tanzania** were released in early 2006. They show that knowledge about the modes of HIV transmission was good. However, comprehensive knowledge and understanding of HIV and AIDS was limited. For instance, only 33% of respondents in Lukole and 48% in Lugufu were able to correctly identify three prevention or HIV transmission methods and reject two myths. The vast majority of respondents had heard about condoms and identified condom use as a means of HIV prevention. However, condom use with various sex partners was low. In Lukole, of those who had ever heard about condoms, only 8% of camp respondents and 15% in villages had ever used one. This BSS underscores the need to develop comprehensive HIV and AIDS programmes that target refugees and the surrounding host populations in an integrated manner. The BSS is in annex 12.

In addition to the continuation of the prevention, care and treatment programmes in Tanzania there has been a strong focus on advocacy to ensure access for refugees to ART with some success. As of 2007, refugees living in Western Tanzania will have non-discriminatory access to ART, including laboratory services and individual patient monitoring. UNHCR will provide financial support to the Ministry of Health (MoH) to ensure that sufficient training and capacity building of staff will occur. In Tanzania, implementation of OFID project started in 2006. The project aims to strengthen HIV prevention and AIDS care, treatment and support services in the Kasulu and Kibondo refugee camps. HIV and AIDS education has been provided through peer educators, drama and puppetry, films shows and open forum public discussions. Refresher trainings for midwives, laboratory technicians, and medical assistants were provided and community awareness sessions were strengthened.

Regional VCT training

Together with the University of California at the Los Angeles Global Health programme, UNHCR organised an eight country workshop to standardise and scale-up HIV counselling and testing programmes in refugee operations. At the workshop, up-to-date technical information was reviewed and successful promotion strategies, including community mobilisation and information, education and communication (IEC) material development, were discussed. Counselling skills, particularly for youth and couples were also presented with a strong focus on communication skills and language. There was also a special interactive session on data M&E. Participants developed a matrix for each country which outlined gaps in delivering quality testing services. The training report is in annex 17.

In **Uganda** a BSS was conducted in May 2006 in Nakivale/Oruchinga and Kyangwali refugee settlements and 49 villages among surrounding host populations (annex 13). Among nationals living close to Nakivale/Oruchinga refugee settlement, 12% reported having had a casual sex partner in the last 12 months compared with 6% among refugee respondents. Access to essential services such as VCT was limited. In the refugee settlement in Mbarara district, only 8% of refugees and 6% of nationals reported having been tested for HIV and receiving the test result in the past 12 months. In Kyangwali, 11% of refugee and 8% of host nationals were tested for HIV and all received their results in the past 12 months. This BSS demonstrates that refugees and their host communities do not have adequate level of HIV knowledge, engage in high risk behaviours and have limited access to HIV services. Implementation of OFID-funded activities began. Refugees were reached with HIV information through peer educators, drama and puppetry, films shows and open forum public discussion. Health care providers were trained on HIV prevention and AIDS care, treatment and support services. Improved home-based care (HBC) programmes have been established focusing on hygiene, nutrition and referral to health services. Ten extremely vulnerable families were supported with income generating activities. The orphans and vulnerable children's (OVC) register was updated and 30 OVC supported with school uniforms, books, bags and shoes.

iii) Southern Africa

In **Angola**, UNHCR continued to support community HIV and AIDS awareness programmes, particularly in returnee areas with UNHCR sponsored women's centres. A group of trained community activists worked in the remote and underserved returnee area of Luau in Moxico province; 95% of the population in this area are returnees from the DRC. HIV and AIDS awareness programmes in southern DRC are nascent and many returnees had not heard of HIV before they returned to Angola. With UNHCR support, 14 HIV community workers held over 400 HIV awareness sessions from February to August 2006. Awareness events were held in communities, market places, the hospital and all secondary/ technical schools in the area. Sixty percent of the beneficiaries were women, including those linked to the UNHCR sponsored women's centre under development in Luau. Community workers distributed HIV and AIDS educational materials in Portuguese and local languages, conducted condom demonstrations and distributed over 30,000 condoms. Unfortunately, UNHCR and partner efforts to raise funds to continue to support this programme were hampered because Luau is a remote, difficult to reach area with very little infrastructure and as such is not a priority region under the national HIV and AIDS programme. Although the community workers received their last stipends in August 2006, many continue to conduct informal awareness sessions on a voluntary basis.

With support of PEPFAR funding, UNHCR **Botswana** has been able to boost HIV prevention, care and support programmes in Dukwi camp, which hosts 3,000 refugees. Many of the refugees originate from the Caprivi Strip of Namibia, where HIV prevalence is higher than 40% among the adult population. As there are many faith-based organisations in Dukwi, a basic training for 18 religious leaders in the camp was conducted, exploring new ways to enlist their support to promote VCT and stigma reduction in the community. The office continued with advocacy efforts to secure refugee access to the national ART programme, together with partners such as UNAIDS and the US Centers for Disease Control and Prevention. Since 2005, in addition to ongoing HIV and AIDS community awareness activities conducted by IPs and refugee community groups, VCT centres were established in both camps. Clinical services were strengthened through the training of staff on management of STIs and opportunistic infections. Youth-friendly services were also introduced in the camp clinics. This was all achieved with limited funding.

Minimal additional financial support was provided to the smaller country programmes in **Malawi, Mozambique, Namibia and Zimbabwe**, while country level partnerships with other UN agencies such as UNICEF and UNFPA were pursued. Programmes in these countries focused on HIV prevention education, increasing access to local services including VCT and ART, integrating services such as antenatal care and PMTCT, and reducing community level stigma and discrimination in both refugee and host populations.

UNHCR **South Africa** continued to support the Sediba Hope Centre, a local HBC provider in Pretoria. Three trained refugee carers provided information, referral, care and support to an average of 20 chronically ill refugees per month in the Pretoria area. Planned Parenthood Association of South Africa continued with their refugee life skills programme, employing four refugee programme staff to conduct HIV awareness training in the refugee communities in Cape Town, Johannesburg and Pretoria. A new HIV awareness programme was integrated under an existing social services implementing partner, Mennonite Central Committee, in Durban.

In 2006, UNHCR **Zambia** received funding from PEPFAR to strengthen HIV awareness programmes in Kala and Mwange camps in northern Zambia. Each camp hosts approximately 20,000 Congolese refugees, many of whom have expressed the interest to return home following the October 2006 presidential elections in the DRC; so this is a critical period to increase HIV-related awareness and to promote HIV VCT. In addition, a BSS was conducted in Kala and Mwange refugee camps (annex 18). The BSS found that male circumcision rates were very high among refugees (88-91%) while low among locals (4-8%); general HIV knowledge among both communities was high (over 90%) although myths and misperceptions were higher among refugees than in the surrounding host communities; condom use among non-regular partners was lower in the refugee community; and there was a high level of interaction between refugees and locals. This information gathered through the BSS will not only assist UNHCR and its partners to more appropriately programme for HIV prevention, care and treatment in Zambia, but will also guide programme development in areas of return in the DRC. It will also provide important information to the Government of Zambia on levels of HIV knowledge among the host communities surrounding the camps. The 2006 mission reports for Angola, Botswana, Malawi, Mozambique, Namibia and Zambia are attached in annexes 20 – 25.

Stigma and discrimination

In both refugee and host populations, community level stigma prevents uptake of many available HIV and AIDS related services. To explore the roots of such attitudes, existing stigma reduction modules were adapted to the refugee setting and piloted in refugee camps in Malawi and Zimbabwe. The response to these initiatives was overwhelmingly positive, with refugee representatives reporting that they had not recognised the extent to which stigma and discrimination were affecting their communities. The training also included representatives from surrounding host communities and provided an opportunity for refugees and locals to discuss broader issues related to refugee interaction and integration. Key to the success of the two pilot programmes was the use of experienced trainers who employed very participatory and interactive approaches which ensured that the training outcomes came from participants themselves and were specific to each location. The training report is attached in annex 19.

iv) West Africa

The **Benin** programme showed an increase in HIV-activities among the approximately 26,000 primarily Togolese refugees. VCT services started at the major camp in the country and are available every Thursday afternoon. Community awareness campaigns were organised.

In **Côte d'Ivoire**, outbreaks of violence interrupted HIV programming in Guiglo town. Activities were resumed in May 2006, when CARITAS trained groups of HIV peer educators in both Guiglo and Tabou. Few refugees are accessing treatment services due to the large distance to both VCT and treatment centres (services are equally accessible for refugees and local population). In general, refugees are referred to HIV testing facilities when they are suspected of being HIV positive by clinical diagnosis. HIV activities and information remain limited for the population at large. Some of the refugees testing positive have started ART. In the latter half of 2006, new patients were admitted to the ART programme.

In **Ghana**, Buduburam camp developed an extensive HIV-programme offering a variety of services including HIV-education, condom distribution, PMTCT-services, VCT-services, STI treatment, support to people receiving ART through referrals as well as an HBC programme. Following the training on clinical management of rape in 2006, PEP

became part of the clinical management of rape. The PMTCT services have been running now for 18 months. VCT services are still underused as a walk-in service; rather, it is most often used for clinical confirmation of suspected HIV persons from the medical staff. HIV positive persons gather regularly in a self-help group. In Krisan camp in Ghana, a large HIV peer educator training programme helped to reduce discrimination. Agreements were made with the district hospitals to ensure that refugees have access to VCT and ART programmes. In the Volta Region, few patients are on ART as treatment sites are situated far away. Peer educator training began in December 2006 and is implemented by the Ghana Health Services. It is envisaged that it will be expanded over seven districts. Food distribution points are the only points being used for condom distribution sites because refuges live over a diffuse area (refugees live in 100 villages across the seven districts of the Volta Region).

Improved access to ART in West Africa

In West Africa, UNHCR actively supported increasing the accessibility of ART to refugees. In Ghana, the number of refugees on treatment increased six-fold after UNHCR assumed responsibility for the payment of the patients' monthly contribution. In Benin, VCT services and the administration of ART was introduced as part of the medical package to refugees in its largest camp.

In **Guinea**, HIV-services are provided in all four camps and include HIV-education (including the preparation of HIV materials), condom distribution, VCT services, PMTCT, and treatment of STIs and opportunistic infections. In Lainé camp, 10 refuges are provided ART is provided by MSF. HIV prevention programme staff implemented activities in the towns of N'Zerekore and in the Kouankan I, Kouankan II, Laine and Kola refugee camps (up to mid-November). These activities were for both refugees and the Guinean host population. The UNHCR Representative for Guinea is the chair of the UN theme group on HIV and AIDS.

Nigeria is working closely with the Government and UNAIDS Nigeria to integrate HIV-activities for refugees. A workshop on care for vulnerable children was held in November where a wide range of HIV prevention topics were discussed.

Senegal focused on HIV among Mauritanian refugees in the Vallée des Fleuves. In collaboration with UNFPA and the MoH, a work plan was drafted for the training of peer educators in several villages in the north. Previous efforts to include refugees in peer educator programmes for the Senegalese were not successful; therefore, a separate programming has been suggested. A team of MoH staff visited the area and provided recommendations on the adaptation of existing Senegalese HIV materials for refugees and migrants. The MoH will also support the implementation of the programme which will start in 2007.

In **Sierra Leone,** all district hospitals offer, in principal, VCT, PMTCT and ART services. However, in practice, these services are hampered by lack of qualified staff and proper laboratory facilities. Refugees have equal access to these services. In the camps, UNHCR is providing HIV education, condom distribution and training of peer educators. Condoms are supplied by UNFPA and USAID.

The mission reports from Côte d'Ivoire, Ghana, Guinea, Liberia and Sierra Leone are attached in annexes 26 – 31.

B) Americas

The HIV Unit expanded its support to the Americas in the last quarter of 2006. The UNHCR office in Brazil was actively involved in the development of an HIV and sex work paper lead by UNFPA. An HIV assessment mission occurred in **Colombia** (annex 32). The assessment revealed some serious protection issues related to HIV and IDPs. A plan of action for 2007 was developed. Assessment missions for Costa Rica, Ecuador and Venezuela are planned for 2007.

C) Asia

Considerable progress was made in HIV and related activities in the Asia region in 2006. The finalisation of the Asia Regional HIV Strategy combined with experience gained from implementation of activities in 2005 and 2006, continued assessments and follow-up missions and the first Regional HIV workshop have laid the foundations for further consolidation and strengthening of the programme in 2007. The Australian Government provided earmarked HIV funds through the global annual budget for continuation of HIV programmes in 2006.

UNHCR in **Bangladesh** is working under a number of constraints and this is reflected in the quality of services provided to the Rohingya refugees. However, considerable progress had been made in the provision of health and HIV-related services since 2005. In 2006, activities focused on strengthening infection prevention in the health care setting with refresher training of staff and the introduction of a monitoring checklist for camp-based supervisors; strengthening the syndromic management of STIs, expanding access to IEC materials, and strengthening support for community health workers who are a prime source of information and condoms. In addition, clinical protocols for post-rape management were developed and staff trained in these. Efforts were made to better target groups at higher risk of infection.

UNHCR is providing protection and assistance to approximately 11,500 urban refugees in Delhi, **India**. The office focused on advocacy for inclusion of UNHCR's concerns in the National HIV Strategic Plan and National AIDS Control Programme III. As a result, there is a specific reference to refugees and displaced populations in the revised plan. The Don Bosco Association, a UNHCR IP, developed and conducted training in substance use and harm reduction, including alcohol, and HIV awareness and stigma reduction for social workers, refugee staff and the community. HIV information was also provided through sessions with the youth training groups and at the Afghan youth centres and the local language Tuition classes.

Indonesia continued activities with urban refugees, asylum seekers and temporary protection cases in Jakarta. The activities focused on training of peer educators and support of subsequent peer education activities; as a result the number of refugees, temporary protection cases and asylum seekers seeking HIV counselling and testing has increased. Activities also focused on raising HIV awareness, especially among women, who have been resistant to attend HIV activities in the past. Innovative training techniques have been introduced, including film, art performance, and field visits.

The first HIV assessment mission to **Malaysia** was conducted in May 2006. UNHCR has registered over 47,000 persons of concern within Malaysia mostly in the Kuala Lumpur/ Kliang Valley area. UNHCR has been successful in advocating for the inclusion of refugees in the revised National HIV Strategic Plan 2006 to 2010; as a result it is expected that there will be greater inclusion of this group in national HIV programming. Recognised refugees receive ART under the same conditions as nationals. HIV funding was provided to address stigma and discrimination and to strengthen HIV prevention through condom promotion and distribution of IEC materials. UNHCR Kuala Lumpur was

successful in accessing condoms through the private sector to provide them free to refugees and asylum seekers. Of concern is that refugees with HIV are presenting with very advanced disease and low CD4 counts. This highlights the need to expand access to VCT and raise awareness of available services.

Regional HIV workshop Asia

The first Asia Regional HIV Workshop was held in Bangkok in November 2006 and attended by approximately 40 UNHCR, IP and operational partner staff from nine countries. The main purpose was to provide an overview of key technical areas in HIV programming in refugees and related populations relevant to the Asia region and to provide an opportunity to share experiences. The workshop consisted of three days of presentations, field experiences and exercises on a variety of HIV topics relevant to the region. The emphasis was on HIV prevention in low level and concentrated epidemic settings. Facilitators were from UNHCR, UNICEF, UNAIDS, Family Health International, UNODC and the Female Health Foundation. Country-specific action plans were developed and will be used to guide funding allocations for 2007.

UNHCR actively participates in the UN Theme Group and the Joint UN Team on AIDS in **Myanmar**. Activities to date have focused on Northern Rakhine State where a joint UNHCR/UNFPA reproductive health and HIV assessment was conducted in March/April 2006. Northern Rakhine State has some of the worst health indicators in Myanmar. Though difficult to quantify, a large percentage of the population has no or minimal access to health services including reproductive health services. UNHCR endeavoured to identify additional sources of funds and to increase the number of partners in order to expand reproductive health and HIV activities.

In the Bhutanese refugee camps in **Nepal,** funds were provided to support mobile HIV VCT; training of staff in post-rape management; introduction of youth-friendly centres as sources of information and referral on reproductive health; and to intensify behaviour change activities targeting mobile males. In addition available context-specific IEC materials were expanded including development of a 2007 calendar of paintings on the themes of SGBV and HIV by refugee children, adaptation of the cartoon booklet entitled HIV and Human Rights into Nepali; and adaptation of the HIV VCT flipchart into Nepali.

The report of the BSS conducted in 2005 was finalised and is being used to guide behaviour change interventions in the camps (annex 33). For example, mobility among males in the refugee and host communities was common. Thus, HIV prevention activities targeting mobile males are being expanded. Furthermore, interaction between the refugee and host community is frequent, highlighting the importance of inclusive and integrated HIV prevention programmes and service delivery.

There are nearly 10,000 Papuan refugees in **Papua New Guinea**, the majority living in the western province. The Representative, through the UN Country Team and the HIV/AIDS Theme Group, has been active in advocating for inclusion of refugees in national planning and implementation. This advocacy includes not only HIV but also encouraging other UN agencies to implement joint projects that address the HIV needs of refugees along with the local population.

As a result of the low prevalence of HIV in **Sri Lanka** and other competing priorities, HIV has received little attention in the conflict-affected areas. There are opportunities for UNHCR and its partners to further develop their strategy of integrating HIV into existing activities such as through human rights trainings. UNHCR supported the development of HIV prevention and awareness materials in Tamil and Sinhalese. UNHCR Sri Lanka also developed a draft HIV policy which will be further refined in 2007.

UNHCR is supporting protection and limited assistance to approximately 140,000 refugees from Myanmar in nine border camps and approximately 900 urban refugees in Bangkok, **Thailand**. Substantial progress was made in Thailand in terms of recognising refugee issues at the national level. The revised National HIV Strategic Plan 2006-2010 was finalised and recognises the vulnerability of refugees and the need to integrate refugees into HIV assessments, planning and implementation at national, provincial and district levels. Although it was not approved, Thailand submitted a proposal to Round 6 of the Global Fund that, for the first time, included HIV activities for refugees. The HIV assessment mission to Ban Mai Nai Soi refugee camp in Mae Hong Son Province identified a number of protection gaps contributing to HIV vulnerability, particularly in women and children. UNHCR will endeavour to address these in 2007. Funding for Thailand was utilised to support HIV activities including prevention, VCT, care and treatment (including ARVs), in 3 camps: Mae La, Umpiem and Nupo, with a combined population of over 70,000 people. In addition, funds were used to strengthen the integration of HIV into substance use prevention and response in three camps and to reproduce IEC materials, such as brochures and flipcharts on HIV prevention, which will be distributed to all camps.

Introduction of female condoms in Nepal

In November 2006, UNHCR, in cooperation with UNFPA and the Female Health Foundation, launched a pilot project to introduce the female condom in the Bhutanese refugee camps in Nepal. Key health staff was trained during a Training of Trainers conducted in Kathmandu by the Female Health Foundation. This meeting also served as a platform for a strategic meeting with Government, local and international NGO partners to discuss the introduction of this method of dual protection in Nepal, where it is not yet available. The project will be implemented in all 7 refugee camps in Eastern Nepal in 2007 following the training of peer educators in the camps. It is envisioned that the female condom will increase the variety of contraceptive and HIV and STI protective choices for women, and improve their negotiating skills in relationships.

The mission reports from Bangladesh, Malaysia, Myanmar and Thailand are included in annexes 34 – 37.

D) Central Asia – SW Asia – North Africa – Middle East (CASWANAME)

The HIV activities in the CASWANAME region had a strong focus on protection, stigma and discrimination reduction and ensuring equal access to HIV services. With support of DFID funding, a regional workshop on HIV and protection of refugees was organised for UNHCR staff members, National AIDS Control Programmes from the region and UNAIDS. The meeting had a strong focus on the 10 key points of HIV and protection for persons of concern to UNHCR and provided tools to the participants to ensure that HIV protection needs are addressed in UNHCR programmes (annexes 38 and 39).

In **Algeria, Egypt, Lebanon, Morocco and Tunisia,** UNHCR has been an active partner in the UN Theme Group activities and participated actively in the joint UN response towards HIV and AIDS.

In the refugee camps in Tindouf, **Algeria**, UNAIDS and UNHCR ensured that blood will be tested for HIV prior to transfusion through the procurement and delivery of 1,300 HIV testing kits to the main/central hospital's pharmacy based in Rabouni. UNHCR facilitated the participation of 3 Sahrawi medical staff in training on HIV in Algiers as well as three young people from the Sahrawi camps in a UNICEF organised training for peer

educators. UNHCR organised the celebration of the World AIDS Day event in the refugee camp of Dakhla. Celebrated under the theme “Stop AIDS - Keep the Promise”, the event was enhanced by the participation of the Sahrawi MoH and all organisations involved in health activities in the camps. UNHCR, together with the Sahrawi MoH, brought together concerned agencies to draft a tentative plan of action for 2007. A VCT centre in the main hospital and awareness-raising among the youth are activities envisaged for 2007. For the urban refugees in Algiers, UNHCR displays HIV prevention posters and brochures in the area of the office where refugee visitors come. Red ribbons and condoms are available for free for visiting refugees.

Information on HIV in Iraq

With support from MERCK foundation, UNHCR ensured the printing of the 10 key points on HIV and refugee protection. These posters and leaflets were adapted and translated into Arabic and distributed on wide scale in the region. In Southern Iraq, these materials are distributed through the legal centres and will help to ensure that persons of concern will have access to vital information on HIV prevention as well as legal rights.

With UNAIDS support, UNHCR worked on building partners’ commitment to support initiatives for HIV prevention programming in **Egypt**. HIV prevention awareness and fighting stigma remain important targets in Egypt. UNHCR continued to advocate within the Theme Group framework for refugees and others’ rights to access AIDS treatment and care services. UNHCR succeeded to include a sub-project component addressing refugees and other persons of concern’s rights to access ART in the Global Fund proposal. Egypt's submission to the Global Fund was accepted on appeal and the review committee highlighted the strength of a rights-based response to refugees and their access to prevention and treatment as an important issue. CARITAS Alexandria, a UNHCR partner, mobilised funds to address an HIV awareness programme for Sudanese migrants and refugees living in Alexandria and Zagazig. Events included awareness sessions and youth-friendly activities incorporating HIV awareness messages in drama and songs reaching out to migrant and refugee communities.

Refugees in **Iran** benefit from an inclusive national approach to HIV and receive HIV-related care and treatment at the same level as the national population, including access to ART. Activities focussed on provision of audio-visual and printed HIV-related information, contributing to UNICEF’s peer education programme which will also reach

Afghan refugees, and commemoration of World AIDS day. During 2006, Iran revised its National HIV Strategic Plan and UNHCR advocated for continued inclusion of refugees in national HIV initiatives. The final version of the plan is pending.

UNHCR Beirut, **Lebanon**, has been a member in the UN Theme Group on HIV/AIDS since 2004. As a result, good working relations have been established with the National AIDS Programme (NAP). Since 2005, refugees have had access to VCT in Lebanon. Refugees can also receive anti-retroviral medication at subsidized costs on a case by case basis through a gentlemen's agreement with the NAP. In 2006, refugees were included in the national protocol for access to PEP post rape, which are provided at designated hospitals in case of emergencies. UNHCR Beirut, through the UN Theme Group, supported the production of publications for the 2006 World AIDS Campaign in Lebanon. In coordination with UNAIDS, UNHCR continued to advocate for access to ARVs for their population of concern.

UNHCR is providing protection and assistance to 1,290,000 Afghan refugees living in camps and approximately 500 urban refugees of differing nationalities in **Pakistan**. UNHCR provided input into the draft of the first National HIV Policy, specifically advocating for the inclusion of refugees as this conforms to best practice in national HIV responses. The final version of the policy is pending. Funds were used to address gaps identified in the 2005 HIV assessment mission. In North West Frontier Province (NWFP), a training of 18 health managers from IP and operational partners was conducted. The training was based on the Manual HIV/AIDS Prevention and Control: A short course for Humanitarian Workers. In addition, 25 Medical Officers from NWFP were trained in syndromic management of STIs. A total of 300 religious and community leaders were trained in NWFP by three IPs in three districts. The training was based on the manual; strengthening the role of religious leaders in preventing HIV/AIDS developed by the National AIDS Control Programme. A project to strengthen infection prevention at Mardan District Hospital in NWFP was implemented by FPHC will continue to monitor this programme in 2007. IEC materials including leaflets, pamphlets, clinical management of rape protocol charts, and universal precautions protocol charts were developed and distributed to the three provinces. Funds were also provided to four IPs in NWFP to undertake activities in commemoration of World AIDS Day. The activities included: walks, seminars, drama, school debates and quizzes and radio shows.

In **Yemen**, PLWHAs are highly stigmatized; they often experience discrimination and human rights abuses. Since 2004, progress has been made at policy level. The National AIDS Programme no longer requires laboratories and health workers to report HIV status

of individuals by name and address and refugees are no longer systematically tested for HIV in national referral health units. Positive steps have been undertaken to develop a national HIV response. Despite this, refugees are still faced with discrimination and human rights violations, much of this related to lack of knowledge and understanding of HIV and AIDS. UNHCR and partners are working in close partnership with others to build capacity and deal with stigma and discrimination. The mission report is attached in annex 40.

E) Europe

Between June and November 2006, four assessments were undertaken by UNHCR to review the national response to HIV/AIDS in **Azerbaijan, Armenia, Georgia and Turkey**, with specific attention paid to the needs of IDPs, asylum seekers and refugees as well as to identify any gaps in HIV programming. In all countries there is evidence (often anecdotal) of IDPs and refugees engaging in HIV risk behaviour, although the extent to which this takes place within their own country or during seasonal migration is unknown. **Georgia** is the only country with information on the number of registered people living with HIV who are IDPs.

With additional earmarked HIV funding, UNHCR supported the country programmes to address the most urgent needs in these countries. In South Ossetia, Georgia, UNHCR supported safe blood supplies through the procurement of reagents and facilities for the blood bank in the regional hospital. In Turkey, UNHCR provided support for the development of IEC materials in different languages for the asylum seeker centres throughout the country. The mission reports from Azerbaijan, Armenia, Georgia and Turkey are attached in annexes 41 – 44.

In **Russia** UNHCR continued its close cooperation with the Moscow office of UNAIDS and regularly participated in the UN Them Group meetings. UNHCR and IP staff participated in the Eastern European and Central Asian AIDS Conference organised in Moscow from 15 to 17 May 2006. Besides advocacy, HIV issues continued to be addressed through the preventive health programme in Moscow and St. Petersburg for urban refugees. Prevention education was carried out with adolescents in schools and community centres and with women attending the Sunday school and Women's Club in the form of lectures and seminars. Condoms were distributed together with booklets on HIV-prevention in refugee languages during individual discussion of HIV prevention issues with health care workers. Condoms and booklets were also distributed by social

partners in the community centres. The partners continued showing video clips on HIV-prevention in the waiting area of the Refugee Support Centre in Moscow and the Refugee House in St. Petersburg. The UNHCR office in Moscow followed up on each HIV-positive individual case known to the office in order to try to identify a durable solution. In-kind assistance in the form of winter clothing and footwear as well as special food-kits was provided to all HIV-positive beneficiaries through UNHCR's social partner.

F) Global Activities

With UNHCR's expanding role for IDPs and its designated role as lead technical agency for refugees and IDPs within the UNAIDS division of labour, the HIV Unit expanded technical support and conducted **HIV and IDP** assessment missions in Colombia, Eastern Europe and Nepal. More missions are planned in various countries in 2007. A review of humanitarian reform missions showed that HIV had only been included in one mission to Liberia by late 2006. UNHCR is working closely with UNAIDS, its cosponsors, OCHA and NGOs to discuss issues on global response to HIV and IDPs in emergencies.

UNHCR and UNAIDS led the first interagency assessment mission of HIV in conflict-affected populations in three sites in Nepal. Seven UN agencies participated (UNHCR, UNAIDS, WFP, OCHA, UNFPA, UNDP and UNESCO) in addition to the National STI and AIDS Control Programme as well as international and national NGOs. Crucial gaps in the prevention and response to HIV and key interventions to address these were identified. Funding has been provided to improve coverage and quality of HIV prevention activities in most at-risk populations and to ensure consideration of the post-conflict scenario in national HIV planning. The report can be found in annex 45.

Under the **"UN Cares"** programme, UNHCR rolled out its HIV work place programme and is in the process of adopting the ten minimum standards for HIV/AIDS in the workplace. Since November, a full time person supported by the French Government is working on UNHCR's HIV Work Place programme. In 2006, UNHCR staff participated in orientation sessions on HIV work place programmes and in the UN leaning strategy in Middle East and Central and West Africa. One of the main challenges for UNHCR remains the high number of remote isolated duty stations where few other UN agencies are in situ to work under the joint programme.

A workshop on Health, Nutrition and HIV for all of UNHCR's coordinators in these sectors was held in Nairobi in November 2006. The workshop provided UNHCR's health,

nutrition and HIV coordinators (mainly United Nations Volunteers) with the latest information on avian/human influenza; safe motherhood; nutrition; HIV; UNHCR's health information system; medical criteria for repatriation; systems to effectively and adequately organise medical care and referral services for urban refugees; and medical resettlement. Country action plans were drafted for 2007.

World AIDS Day was widely commemorated in the different UNHCR offices in the field and at headquarters. Refugees, surrounding communities, Governments, community leaders, NGOs, PLWHA and UNHCR staff actively participated. Activities included raising charity funds for refugees living with HIV and AIDS in Geneva, community activities in different refugee locations including concerts and sport competitions for young people.

IV) Interagency collaboration

As a UNAIDS cosponsor, UNHCR has been actively involved in the UNAIDS' Joint Programme. UNAIDS and UNHCR worked on a joint **policy brief on HIV and Refugees** that was published in numerous languages. It focused on actions required to address the spread and effect of HIV on refugees and their surrounding communities (annexes 46, 47 and 48).

In 2006, significant focus was provided on the inclusion of conflict-affected and humanitarian emergencies in several high level meetings. In the **Political Declaration** that was adopted during the 2006 AIDS Review, the UN General Assembly requested all stakeholders to ensure that HIV prevention, treatment and care services for conflict-affected and humanitarian emergencies are included in strategic plans and programmes.

The **UNAIDS Programme Coordination Board,** in Lusaka called on all stakeholders to actively address HIV needs of emergency-affected populations and urged them to develop stronger linkages between humanitarian recovery and national development responses. UNHCR, UNAIDS Secretariat and Cosponsors presented a paper on **AIDS, Security and Humanitarian Response** to the Programme Coordination Board. In a session moderated by UNHCR, the UNHCR Representative in DRC and Government Officials from DRC presented the prevailing situation in the country with regard to displaced populations, ongoing HIV programmes while openly discussing the constraints. The UNAIDS Secretariat and the cosponsors revised the 2006-2007 **Unified Budget**

and Work plan (UBW) to increase its flexibility and to strengthen it as an instrument for UN system coherence as well as to capture country level financing and harmonisation. UNHCR was involved in numerous areas including the review of how different cosponsoring organisations have used the UBW funds to respond to the AIDS epidemic; the development of the UBW for 2008-2009; and the Performance Monitoring Framework for the UBW.

The most important regional initiative on HIV and displaced populations in the West African region is the **Manu River Union** (MRU) project funded by the African Development Bank. The MRU Secretariat, based in Freetown, Sierra Leone, is the executing agency. UNFPA is responsible for the management and the coordination of project activities in four countries: Guinea, Sierra Leone, Liberia and Côte D'Ivoire. The project aims at (1) preventing new STI/HIV infections in refugees, IDPs and their host populations, and (2) ensuring psycho-social and medical care for PLWHAs. UNHCR has been working closely with the MRU Secretariat and UNFPA on this sub-regional initiative.

The **Oubangui Chiari initiative,** funded by the African development Bank, comprises four countries: DRC, ROC, CAR and Chad. It was officially launched in mid 2006. So far there has not been significant progress in terms of field implementation. UNHCR and Oubangui Chari Initiative have agreed to collaborate in those sites with refugees, IDPs and returnee populations in a similar to manner of that of as GLIA.

UNHCR and UNFPA continued to work on the improved provision of **PEP and clinical management of rape.** Two regional training courses were conducted in Southern Africa and Central Africa (report in annex 49). With support from WHO, the 2004 WHO/UNHCR clinical guidelines for rape survivors have been translated in Arabic. In early 2007, UNHCR will fund the printing of those guidelines. UNHCR participated in the peer-review of the WHO/ILO guidelines on PEP for occupational and non-occupational exposure.

UNHCR and UNFPA worked closely to ensure that sufficient **condoms** are made available in major refugee operations. In 2006, UNFPA donated a total of 17,300,100 male condoms and 89,000 female condoms to 22 country operations in Africa and Asia (report in annex 50). Furthermore, USAID donated approximately 5.4 million male condoms to Côte d'Ivoire (~1,450,000), Ghana (~1,010,000), Guinea (~1,800,000) and Sierra Leone (~1,150,000).

ARVs in Emergency Settings

WHO, UNHCR, UNAIDS, MSF and UNICEF co-organised an expert consensus meeting on "providing antiretroviral drugs as part of comprehensive HIV services to populations in emergency settings" in September 2006. During the meeting concerns were raised that populations affected by emergencies have been neglected in the provision of essential HIV/AIDS prevention, treatment and care services, in particularly of life-saving antiretroviral drugs for prevention and treatment of HIV infections. The meeting concluded that emergencies should not affect one's access to HIV services and provision of such services is not only feasible but an inalienable human right and that the delivery of ARV's should be included in national strategic plans.(annex 51includes the consensus statement).

In Southern Africa, UNHCR collaborated with the Southern African HIV Clinicians Society (SAHCS) to develop **Guidelines for Clinicians on ART Management in Displaced Populations.** A drafting committee comprised of SAHCS members, UNHCR, US Centers for Disease Control and Prevention, and Médecins sans Frontières finalised the guidelines with input from a broad range of experts. The guidelines will be published in the March 2007 issue of the Southern African Journal of HIV Medicine that reaches over 2,000 practitioners in the region.

In 2006, UNHCR, UNICEF and WFP, in collaboration with the Governments of Uganda and of Zambia and NGOs, implemented specific programme strategies in refugee settings in Uganda (Kayak II refugee settlement) and in Zambia (Kala and Mwange camps) to **integrate HIV activities with food and nutrition support**. Project evaluation and reports indicated good achievements in terms of community mobilisation; capacity building and training; and production and dissemination of IEC materials; HIV prevention, care and support for PLWHAs; nutrition education; integration of some of the strategies into ongoing health centre programmes; monitoring; interagency collaboration; referral system; and increased uptake and demand for services. However, given the short time span of the project, a long term impact could not be assessed as of yet. The lessons from these field experiences demonstrated the feasibility and relevance of integrating HIV and AIDS programmes with food and nutrition activities (annex 52).

UNHCR and UNICEF organised an affiliate event on HIV, conflict and displacement, before the **XVI International AIDS Conference in Toronto, Canada**. The one day event

was specifically dedicated to HIV and AIDS programming in conflict settings. A wide range of topics were discussed; including the epidemiology of HIV in conflict and emergency settings, multi-sectoral programming, protection and SGBV, funding and implementation of ARV-based programmes. The event brought together a diverse group of people including the humanitarian community, academia, human rights advocates, policy makers, implementing agencies, donors, the civil society, and PLWHAs. Participants took stock of their experiences; discussed lessons learnt and debated the way forward (annexes 53 and 54).

UNHCR assisted in the facilitation of a numerous workshops on the **Guidelines on HIV Interventions in Emergency Settings** that were released by the Interagency Standing Committee. The meeting organised by UNAIDS in Bangkok focused on participants from Nepal, Myanmar, Sri Lanka, Indonesia and Pakistan. UNHCR facilitated a Training of Trainers meeting on the guidelines in Senegal. This meeting targeted a long existing gap in making the guidelines accessible to Francophone Africa. Participants from NGOs, UN agencies and Governments were introduced to the guidelines and were provided tools to repeat the exercise in their respective countries. In Nairobi, over 15 UNHCR and IPs from East Africa were trained on the HIV and SGBV IASC guidelines.

V) Publications

UNHCR, WFP and UNAIDS published a **Best Practice "The Development of Programme Strategies for Integration of HIV, Food and Nutrition Activities in Refugee Settings".** The best practice recommends a set of strategies for using food and nutrition-based interventions to support HIV prevention, care, treatment and support for PLWHAs (annex 55).

Together with UNESCO, UNHCR published a discussion paper on **"Educational Responses to HIV/AIDS for refugees and IDPs"** (annex 56). The document is published in English, French and Arabic and aims to examine the current situation with regard to conflict, displacement and HIV. It notes the protection risks faced by refugees and Internally Displaced Persons (IDPs) and recognises the importance of education for affected populations. The document refers to the existing and significant work undertaken to develop minimum standards for education in emergency situations. The paper concludes with a number of recommendations, including a call to Ministries of Education, civil society organisations, and their development partners to:

- Coordinate HIV/AIDS education for refugees and IDPs with other educational initiatives at country, district and organisational levels to avoid duplication of efforts and to maximise effective use of human, financial and material resources
- Promote principles put forward in the Dakar Framework for Action including achievement of the six 'Education for All' goals by 2015
- Meaningfully involve communities in programme development and implementation
- Scale up and make programmes more comprehensive across displacement phases
- Customise the message in consultation with community
- M&E to guide future actions and take corrective measures if needed

Academic articles by UNHCR colleagues on HIV and AIDS included the following:

- Burton A, Displaced and infected. The Human Rights bimonthly 2006. Volume 5 (2): 54-55 (annex 57)
- Kaiser R, Kedamo T, Lane J, et al. HIV, syphilis, herpes simplex virus 2, and behavioral surveillance among conflict-affected populations in Yei and Rumbek, southern Sudan. Aids 2006;20(6):942-944 (annex 58).

VI) Financial Statement

1 January - 31 December 2006[1]

I. GRANTS RECEIVED 2006	**Amount in US$**
Annual Budget Contributions 06/AB/VAR/CM/267	
Australia	158,361.00
Canada	363,636.00
Denmark	376,000.00
United States of America	280,000.00
UNAIDS	1,700,000.00
	2,877,997.00
Additional Contributions 07/AB/VAR/CM/267	
UNICEF	10,000.00
UNAIDS	14,580.00
UNAIDS	386,250.00
UNAIDS	15,000.00
MERCK foundation	50,000.00
	475,830.00
Direct additional Country Contributions	
OFID	500,000.00
MAP DRC	716,900.00
PAF UNAIDS Gabon	15,822.70
	1,232,722.70
Contributions in Kind	
PRM - Snr. HIV/AIDS Coordinator 8 months	170,000.00
USAID condoms West Africa	318,500.65
UNFPA male and female condoms	800,000.00
UNFPA clinical management of rape training	70,000.00
UNFPA kits	2,350.00
	1,360,850.65
Total Funds received (including in kind)	**5,947,400.35**

[1] Note that the NAM contributions are additional to UNHCR Core Programmes that constitute the basis of UNHCR's HIV and AIDS programmes

1 January - 31 December 2006 06/AB/VAR/CM/267

II. Expenditure projects by (sub)region 06/AB/VAR/CM/267	Amount in US$
Central Africa	130,000.00
East Africa	225,000.00
Southern Africa	135,000.00
West Africa	180,000.00
Asia	180,000.00
Eastern Europe	40,000.00
Regional and Global Activities	971,865.10
ABOD Staffing	1,137,963.00
HIV and Workplace UNHCR Cares	100,000.00
Total Expenditures 06/AB/VAR/CM/267	**3,099,828.10**

VII) HIV Information System

Central Africa: 5 countries, 29 sites/ groups and 4 areas of return	Pop. Estimate	CMR	U5MR	No of condoms	Male Urethral Discharge	Genital Ulcer Discharge	PMTCT	ART received
Mean	11427	0.55	0.99	0.5	2.45	2.22	3.9	10.66
Median	13940	0.3	0.8	0.16	2.3	1.36	3.7	10
Minimum	411	0.08	0.1	0.002	0	0	1.5	0
Maximum	28880	4	3	3	5	8.33	6.5	39
Sum	377113	14.41	25.99	13.57	27	26.64	11.7	96
Count	33	26	26	27	11	12	3	9
NR or RI	0	7	7	6	22	21	5	1
SNP	0	0	0	0	0	0	25	23
Total count	33	33	33	33	33	33	33	33

	Yes	%	N	%	NR	%	Total
Universal Precautions							
Sufficient needles / syringes	28	85%	2	6%	3	9%	33
Sufficient gloves	28	85%	2	6%	3	9%	33
Is blood before transfusion screened for HIV	27	82%	0	0%	6	18%	33
STI data				9%			
Sufficient condoms	28	85%	4	12%	1	3%	33
Sufficient STI drugs	27	82%	3	9%	3	9%	33
STI syndromic approach	29	88%	1	3%	3	9%	33
VCT							
Access to VCT	10	30%	23	70%	0	0%	33
PMTCT							
Access to PMTCT	8	24%	25	76%	0	0%	33
Antiretroviral Therapy							
Local population access to ART	11	33%	22	67%	0	0%	33
Refugees access to ART	10	30%	23	70%	0	0%	33
PEP available Post rape							
PEP available Post rape	21	64%	12	36%	0	0%	33

Interpretation
CMR and U5MR-Acceptable
Condom distribution-Insufficient; not even reaching ER level
Universal precautions-OK at 85%; want 100% for all
STI supplies-OK at 82% want 100% for all
VCT-Insufficient at30% access
PMTCT-Insufficient at 24% access
ART- Insufficient at 30% access local and refs
PEP- Reasonable at 64%

1 CMR baseline in Sub-Saharan Africa for non emergency is 0.5 deaths/10,000/day
2 U5MR baseline for Sub-Saharan Africa is 1.0 deaths/10,000/day
3 Sufficient supply defined as no stock out of >1 week at anytime during the past year
4 Goal for emergency phase is 0.5 condoms/person/month and for non-emergency phase is 1.0 condoms/person/month
5 # women who counselled on MTCT an offered voluntary test/# women who had 1st ANC visit =%
6 # women who counselled on MTCT, offered voluntary test during 1st ANC visit and accepted test / # women who had 1st ANC visit, were counselled on MTCT and offered voluntary test =%
SNP=service not provided; NR = not reported; RI = reported incorrectly; Y=yes; N=no

Indicators Central Africa (1/3)	Burundi	Burundi	CAR	CAR	CAR	Rwanda	Rwanda	Rwanda	DRC Urban refugees	
	Gasorwe	Gihinga	CNR	MOLANGUE	MBOKI	KIZIBA	GIHEMBE	NYABIHEKE	KINSHASA	LUBUMBASHI
Total Population	6970	2617	5497	845	13949	17971	17699	4771	2969	411
Crude MR (deaths/10,000/day)	4	1.15	NR	NR	NR	0.3	0.2	0.5	0.4	0.5
<5 years MR (deaths/10,000/day)	1.9	1.2	3	NR	NR	0.46	0.5	1.3	2.8	NR
Universal precautions										
Sufficient needles / syringes	Yes	Yes	No	No	Yes	Yes	Yes	Yes	Yes	Yes
Sufficient gloves	Yes	Yes	No	No	Yes	Yes	Yes	Yes	Yes	Yes
Is blood before transfusion screened for HIV	Yes	Yes	Yes	NR	Yes	NR	NR	NR	Yes	Yes
Information-Education-Communication (IEC) Materials										
Do appropriate IEC exist for refugees in camp	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
If Yes is there a sufficient supply	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Sexually transmitted infection (STI) data										
No of condoms distributed (1)	0.02	0.08	NR	NR	NR	1	0.34	0.1	0.5	0.6
Sufficient condoms	Yes	Yes	No	Yes	No	Yes	No	Yes	Yes	Yes
Sufficient STI drugs	Yes	Yes	No	No	Yes	Yes	Yes	Yes	Yes	Yes
STI syndromic approach used	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Incidence male urethral discharge among male population	RI	RI	4	NR	NR	1.5	4.8	RI	5.0	0
Incidence genital ulcer disease among total population	2	1	NR	NR	NR	NR	0.45	5.23	1.7	RI
Voluntary counseling and testing (VCT)										
Access to VCT	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
If Yes, in refugee site or outside	site	outside	outside	outside	site	Site	site	site	outside	outside
Proportion of clients, who received pre-test, counseling, testing, post test and results	100%	100%	NR	NR	NR	99%	100%	100%	71.4	NR
Prevention of mother-to-child transmission (PMTCT)										
Access to PMTCT	No	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
If Yes, in refugee site or outside			Outside	Outside	site	site	site	site	outside	outside
Proportion of first time ANC visits, received pre-test, counseling, testing, results and post counseling			NR	NR	NR	96%	100%	100%	NR	100
% HIV prevalence of PMTCT clients			NR	NR	NR	1.5	3.7	6.5	NR	NR
People living with HIV / AIDS										
Trimthoprim/Sulfamethoxazole Prophylaxis for PLWA provided (adults)	Yes	NR	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Trimthoprim/Sulfamethoxazole Prophylaxis for PLWA provided (children)	NR	NR	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Antiretroviral Therapy (ART)										
Do local population have access to ART	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes
Do refugees have access to ART	Yes	No	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes
If Yes, how many refugees are receiving ART Now	13		NR	10		17	39	12	2	0
Post Exposure Prophylaxis (PEP) rape survivors										
PEP available Post Rape	Yes	Yes	No	No	Yes	Yes	Yes	Yes	No	No
Surveillance/Surveys										
Sentinel surveillance among pregnant women	NR	SNP	SNP	SNP	SNP	NR	NR	NR	SNP	SNP
HIV prevalence:	5.4%					3%	4.7	4.1		
Latest HIV or Repro Health BSS/KAPB (2)	SNP	SNP	SNP	SNP	SNP	May-04	SNP	SNP	SNP	SNP

Indicators Central Africa (2/3)	Eastern DRC			Returnees	ARU / REFUGIES SOUDANRIS				EASTERN CHAD (SUDANESE REFUGEES)			
	FIZi / Bara//VIRA	DONGO	MBANDAKA	KINSHASA	DUNGU	ABA	DORUMA	BIRINGI	Gaga	Farchana	Bredging	Treguine
Total Population	16502	8697	3330	2437	1027	5060	1496	421	13940	18406	28880	14797
Crude MR (deaths/10,000/day)	NR	NR	NR	NR	0.6	0.3	0.3	1.6	0.6	0.2	0.2	0.6
<5 years MR (deaths/10,000/day)	NR	NR	NR	NR	1.8	0.7	0.4	1.7	1.4	0.5	0.4	1.9
Universal precautions												
Sufficient needles / syringes	NR	NR	Yes	NR	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Sufficient gloves	NR	NR	Yes	NR	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Is blood before transfusion screened for HIV	NR	NR	Yes	NR	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Information-Education-Communication (IEC) Materials												
Do appropriate IEC exist for refugees in camp	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No*	No*	No*	No*
If Yes is there a sufficient supply	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	NA	NA	NA	NA
Sexually transmitted infection (STI) data												
No of condoms distributed (1)	0.5	0.4	3.1	1.9	0.3	0.2	0.3	1.6	0,002	NR	0.007	0,014
Sufficient condoms	Yes	Yes	Yes	NR	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Sufficient STI drugs	NR	NR	Yes	NR	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes
STI syndromic approach used	NR	NR	No	NR	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Incidence male urethral discharge among male population	NR	NR	IR	NR	RI	RI	RI	0	0	2,3	RI	4
Incidence genital ulcer disease among total population	NR	NR	IR	NR	RI	1.0	RI	0	3	3.4	0	1
Voluntary counseling and testing (VCT)												
Access to VCT	No	No	No	No	No	No	No	No	No*	No*	No*	No*
If Yes, in refugee site or outside									NA	NA	NA	NA
Proportion of clients, who received pre-test, counseling, testing, post test and results									SNP	SNP	SNP	SNP
Prevention of mother-to-child transmission (PMTCT)												
Access to PMTCT	No	No	No	No	No	No	No	No	No	No	No	No
If Yes, in refugee site or outside												
Proportion of first time ANC visits, received pre-test, counseling, testing, results and post counseling												
% HIV prevalence of PMTCT clients												
People living with HIV / AIDS												
Trimthoprim/Sulfamethoxazole Prophylaxis for PLWA provided (adults)	Yes	No	Yes	No	NR	NR	NR	NR	No	No	No	No
Trimthoprim/Sulfamethoxazole Prophylaxis for PLWA provided (children)	Yes	No	Yes	No	NR	NR	NR	NR	No	No	No	No
Antiretroviral Therapy (ART)												
Do local population have access to ART	Yes	No	Yes	No	Yes	No	No	No	No	No	No	No
Do refugees have access to ART	Yes	No	No	No	Yes	No	No	No	No	No	No	No
If Yes, how many refugees are receiving ART Now	2				1							
Post Exposure Prophylaxis (PEP) rape survivors												
PEP available Post Rape	No	No	No	No	No	No	No	No	Yes	Yes	Yes	Yes
Surveillance/Surveys												
Sentinel surveillance among pregnant women	SNP	SNP	SNP	SNP	SNP	SNP	SNP	SNP	SNP	SNP	SNP	SNP
HIV prevalence:												
Latest HIV or Repro Health BSS/KAPB (2)	SNP	SNP	SNP	SNP	SNP	SNP	SNP	SNP	SNP	SNP	SNP	KAPB(Feb.06)

Indicators Central Africa (3/3)	SOUTHERN CHAD (CENTRAL AFRICAN REFUGEES)						EASTERN CHAD (SUDANESE REFUGEES)				
	Djabal	Goz-amer	Amboko	Gondje	Yaroungou	Oure Cassoni	Iridimi	Touloum	Amnabak	Mile	Kounoungou
Total Population	15103	18256	12005	17815	15171	26293	17237	22075	16504	15399	12646
Crude MR (deaths/10,000/day)	0.4	0.36	0.3	0.7	0.2	0.3	0.1	0.08	0.19	0.14	0.19
<5 years MR (deaths/10,000/day)	1.2	1	0.7	0.9	0.1	0.9	0.1	0.28	0.25	0.28	0.32
Universal precautions											
Sufficient needles / syringes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Sufficient gloves	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Is blood before transfusion screened for HIV	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Information-Education-Communication (IEC) Materials											
Do appropriate IEC exist for refugees in camp	No*	No*	Yes		Yes	No*	No*	No*	No*	No*	No*
If Yes is there a sufficient supply	NA	NA	No		No	NA	NA	NA	NA	NA	NA
Sexually transmitted infection (STI) data											
No of condoms distributed (1)	0.053	0.065	0.6	NR	1.7	0,054	0.002	N/R	0,08	0,05	0,08
Sufficient condoms	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Sufficient STI drugs	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
STI syndromic approach used	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Incidence male urethral discharge among male population	RI	RI	RI	NR	RI	NR	RI	RI	RI	4	1,4
Incidence genital ulcer disease among total population	NR	NR	8.33	NR	RI	NR	NR	NR	RI	RI	RI
Voluntary counseling and testing (VCT)											
Access to VCT	No*	No*	No*	No*	No*	No*	No*	No*	No*	No*	No*
If Yes, in refugee site or outside	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Proportion of clients, who received pre-test, counseling, testing, post test and results	SNP	SNP	SNP	SNP	SNP	SNP	SNP	SNP	SNP	SNP	SNP
Prevention of mother-to-child transmission (PMTCT)											
Access to PMTCT	No	No	No	No	No	No	No	No	No	No	No
If Yes, in refugee site or outside											
Proportion of first time ANC visits, received pre-test, counseling, testing, results and post counseling											
% HIV prevalence of PMTCT clients											
People living with HIV / AIDS											
Trimthoprim/Sulfamethoxazole Prophylaxis for PLWA provided (adults)	No	No	No	No	No	No	No	No	No	No	No
Trimthoprim/Sulfamethoxazole Prophylaxis for PLWA provided (children)	No	No	No	No	No	No	No	No	No	No	No
Antiretroviral Therapy (ART)											
Do local population have access to ART	No	No	No	No	No	No	No	No	No	No	No
Do refugees have access to ART	No	No	No	No	No	No	No	No	No	No	No
If Yes, how many refugees are receiving ART Now											
Post Exposure Prophylaxis (PEP) rape survivors											
PEP available Post Rape	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Surveillance/Surveys											
Sentinel surveillance among pregnant women	SNP	SNP	SNP	SNP	SNP	SNP	SNP	SNP	SNP	SNP	SNP
HIV prevalence:											
Latest HIV or Repro Health BSS/KAPB (2)	SNP	SNP	SNP	SNP	SNP	SNP	SNP	SNP	SNP	SNP	SNP

East and Horn of Africa; 5 countries, 35 refugee camps/sites	Pop. Estimate	CMR	U5MR	No of condoms	Male Urethral DC	Genital Ulcer DC	PMTCT	ART received
Mean	27447	0.42	0.69	0.66	0.18	0.02	1.41	4.38
Median	18403	0.3	0.63	0.4	0.01	0.001	0.028	0.5
Minimum	1518	0.1	0	0	0	0	0.007	0
Maximum	87593	2.8	1.8	3	0.86	0.17	6.4	49
Sum		13.49	22.28	22.28	4.51	0.464	15.491	70
Count	35	32	32	34	25	24	11	16
NR or RI	0	3	3	1	10	11	17	13
SNP	0	0	0	0	0	0	7	6
Total count	35	35	35	35	35	35	35	35

	Yes	%	N	%	NR	%	Total
Universal Precautions							
Sufficient needles / syringes	35	100%	0	0%	0	0%	35
Sufficient gloves	35	100%	0	0%	0	0%	35
Is blood before transfusion screened for HIV	20	100%	0	0%	0	0%	20
STI data				9%			
Sufficient condoms	34	97%	1	3%	0	0%	35
Sufficient STI drugs	35	100%	0	0%	0	0%	35
STI syndromic approach	35	100%	0	0%	0	0%	35
VCT							
Access to VCT	25	71%	10	29%	0	0%	35
PMTCT							
Access to PMTCT	18	51%	17	49%	0	0%	35
Antiretroviral Therapy							
Local population access to ART	26	74%	2	6%	7	20%	35
Refugees access to ART	20	57%	7	20%	8	23%	35
PEP available Post rape							
PEP available Post rape	20	57%	15	43%	0	0%	35

Interpretation:
CMR and U5MR-Acceptable
Condom distribution-Insufficient; not even reaching ER level
Universal precautions- Excellent at 100%
STI supplies- Excellent at 100%
VCT- Good at 71% access
PMTCT-Reasonable at 51% access
ART- Reasonable at 57% access local and refs
PEP- Reasonable at 57%

1 CMR baseline in Sub-Saharan Africa for non emergency is 0.5 deaths/10,000/day
2 U5MR baseline for Sub-Saharan Africa is 1.0 deaths/10,000/day
3 Sufficient supply defined as no stock out of >1 week at anytime during the past year
4 Goal for emergency phase is 0.5 condoms/person/month and for non-emergency phase is 1.0 condoms/person/month
5 # women who counselled on MTCT an offered voluntary test/# women who had 1st ANC visit =%
6 # women who counselled on MTCT, offered voluntary test during 1st ANC visit and accepted test / # women who had 1st ANC visit, were counselled on MTCT and offered voluntary test =%
SNP=service not provided; NR = not reported; RI = reported incorrectly; Y=yes; N=no

Indicators East and Horn of Africa (1/3)	Bonga	Dimma	Fugnido	Sherkole	Yarenja	Shimelba	Kebribeyah	kakuma	Dagahaley	Hagadera	Ifo
	Ethiopia	Ethiopia	Ethiopia	Ethiopia	Ethiopia	Ethiopia	Ethiopia	Kenya	Kenya	Kenya	Kenya
Total Population	15367	8625	27175	14035	2033	13217	16422	87593	34703	50892	51201
Crude MR (deaths/10,000/day)	NR	0.44	0.2	0.12	0.16	0.16	0.11	0.8	0.4	0.4	0.3
<5 years MR (deaths/10,000/day)	NR	0.65	0.36	0.17	0.19	0.49	0.12	0.3	1.3	1.3	0.9
Universal precautions											
Sufficient needles / syringes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Sufficient gloves	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Is blood before transfusion screened for HIV	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Information-Education-Communication (IEC) Materials											
Do appropriate IEC exist for refugees in camp	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes
If yes is there a sufficient supply	No	No	No	No	No	No	No	No	No	No	No
Sexually transmitted infection (STI) data											
No of condoms distributed (1)	0.2	0.4	0.2	NR	0.2	0.4	0.1	0.2	1.8	2.9	0.8
Sufficient condoms	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes
Sufficient STI drugs	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
STI syndromic approach used	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Incidence male urethral discharge among male population	0.64	0.63	0.48	0.20	0.48	0.86	0.45	0.01	0.03	0.01	0.01
Incidence genital ulcer disease among total population	0.02	0.01	0.11	0.00	0.07	0.07	0.17	0.00	0.00	0.00	0.00
Voluntary counseling and testing (VCT)											
Access to VCT	No	Yes	Yes	Yes	No	No	No	Yes	Yes	Yes	Yes
If yes, in refugee site or outside	NR	Site	Site	Site	No	No	No	site	site	site	site
Proportion of clients, who received pre-test, counseling, testing, post test and results	SNP	100%	70%	100%	SNP	SNP	SNP	99%	100%	100%	100%
Prevention of mother-to-child transmission (PMTCT)											
Access to PMTCT	No	No	No	No	No	No	No	Yes	Yes	Yes	Yes
If yes, in refugee site or outside								site	site	site	site
Proportion of first time ANC visits, received pre-test, counseling, testing, results and post counseling								0.76	RI	RI	RI
% HIV prevalence of PMTCT clients								0.01	RI	RI	RI
People living with HIV / AIDS											
Trimthoprim/Sulfamethoxazole Prophylaxis for PLWA provided (adults)	No	No	No	Yes	No	No	No	Yes	Yes	Yes	Yes
Trimthoprim/Sulfamethoxazole Prophylaxis for PLWA provided (children)	No	No	No	Yes	No	No	No	Yes	Yes	Yes	Yes
Antiretroviral Therapy (ART)											
Do local population have access to ART	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Do refugees have access to ART	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
If yes, how many refugees are receiving ART Now	NR	1	NR	2	NR	NR	NR	49	0	3	5
Post Exposure Prophylaxis (PEP) rape survivors											
PEP available Post Rape	No	No	No	No	No	No	No	Yes	Yes	Yes	Yes
Surveillance/Surveys											
Sentinel surveillance among pregnant women	No	No	No	No	No	No	No	2002	2005	2005	2005
HIV prevalence:								0.05	NR	1.40	1.40
Latest HIV or Repro Health BSS/KAPB (2)	No	2003	No	2004	2004	2004	No	2004	SNP	SNP	SNP

Indicators East and Horn of Africa (2/3)	Lukole	Kibondo	Nyaragusu	Kasulu	Lugufu	Sherifey	Shagaraba	Kilo26	Girba	UmGargour	Suki
	Tanzania	Tanzania	Tanzania	Tanzania	Tanzania	Sudan	Sudan	Sudan	Sudan	Sudan	Sudan
Total Population	45305	63896	58237	75501	81636	32919	21063	10566	9279	9644	3234
Crude MR (deaths/10,000/day)	0.3	0.3	0.3	0.2	0.2	0.8	0.3	0.3	0.1	0.3	0.1
<5 years MR (deaths/10,000/day)	0.9	0.7	0.6	0.5	0.7	0.2	0.8	1.2	0.4	1.0	0.5
Universal precautions											
Sufficient needles / syringes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Sufficient gloves	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Is blood before transfusion screened for HIV	Yes	Yes	Yes	Yes	Yes	SNP	SNP	SNP	SNP	SNP	SNP
Information-Education-Communication (IEC) Materials											
Do appropriate IEC exist for refugees in camp	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
If yes is there a sufficient supply	Yes	Yes	Yes	Yes	Yes	No	No	No	No	No	No
Sexually transmitted infection (STI) data											
No of condoms distributed (1)	0.7	0.3	0.3	0.4	0.4	0.5	0.1	0.8	0.0	3.0	0.0
Sufficient condoms	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Sufficient STI drugs	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
STI syndromic approach used	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Incidence male urethral discharge among male population	0.00	0.20	0.00	0.00	0.00	0.41	0.00	0.00	0.00	0.00	0.00
Incidence genital ulcer disease among total population	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Voluntary counseling and testing (VCT)											
Access to VCT	Yes	Yes	Yes	Yes	Yes	No	No	No	No	No	No
If yes, in refugee site or outside	site	site	site	site	site	No	No	No	No	No	No
Proportion of clients, who received pre-test, counseling, testing, post test and results	97%	99%	100%	100%	100%	SNP	SNP	SNP	SNP	SNP	SNP
Prevention of mother-to-child transmission (PMTCT)											
Access to PMTCT	Yes	Yes	Yes	Yes	Yes	No	No	No	No	No	No
If yes, in refugee site or outside	site	site	site	site	site						
Proportion of first time ANC visits, received pre-test, counseling, testing, results and post counseling	1.00	1.00	1.00	1.00	0.99						
% HIV prevalence of PMTCT clients	0.02	0.02	0.01	0.03	0.01						
People living with HIV / AIDS											
Trimthoprim/Sulfamethoxazole Prophylaxis for PLWA provided (adults)	Yes	Yes	Yes	Yes	Yes	No	No	No	No	No	No
Trimthoprim/Sulfamethoxazole Prophylaxis for PLWA provided (children)	Yes	Yes	Yes	Yes	Yes	No	No	No	No	No	No
Antiretroviral Therapy (ART)											
Do local population have access to ART	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Do refugees have access to ART	No	No	No	No	No	Yes	Yes	Yes	Yes	Yes	Yes
If yes, how many refugees are receiving ART Now		2				0	0	0	0	2	0
Post Exposure Prophylaxis (PEP) rape survivors											
PEP available Post Rape	Yes	Yes	Yes	Yes	Yes	No	No	No	No	No	No
Surveillance/Surveys											
Sentinel surveillance among pregnant women	2003	2003	2003	2003	2003	No	No	No	No	No	No
HIV prevalence:	1.40	0.03	0.03	0.03	0.03						
Latest HIV or Repro Health BSS/KAPB (2)	2005	No	No	No	2005	No	No	No	No	No	No

Indicators East and Horn of Africa (3/3)	Fau 5	Abuda	Ikafe	Kiryandongo	Okollo	Rhino	Imvepi	Kyakall	Oruchinga	NRkivale	Palorinya	Adjumani	Kyangwali
	Sudan	Sudan	Uganda	Uganda	Uganda	Uganda	Uganda	Uganda	Uganda	Uganda	Uganda	Uganda	Uganda
Total Population													
Crude MR (deaths/10,000/day)	0.3	2.8	0.1	0.3	0.8	RI	RI	0.7	0.5	0.9	0.1	0.3	0.4
<5 years MR (deaths/10,000/day)	0.0	1.1	0.2	0.5	0.6	RI	RI	1.8	1.1	1.6	0.2	0.9	1
Universal precautions													
Sufficient needles / syringes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Sufficient gloves	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Is blood before transfusion screened for HIV	SNP	SNP	SNP	SNP	SNP	Yes	Yes	SNP	SNP	SNP	Yes	Yes	SNP
Information-Education-Communication (IEC) Materials													
Do appropriate IEC exist for refugees in camp	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
If yes is there a sufficient supply	No	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Sexually transmitted infection (STI) data													
No of condoms distributed (1)	0.0	0.3	1.0	1.0	1.0	0.4	0.5	1.0	1.0	1.0	0.0	0.3	1.0
Sufficient condoms	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Sufficient STI drugs	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
STI syndromic approach used	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Incidence male urethral discharge among male population	0.00	0.00	0.08	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
Incidence genital ulcer disease among total population	0.00	0.00	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
Voluntary counseling and testing (VCT)													
Access to VCT	No	No	Yes	Yes	Yes	Yes	Yes	Yes	No	No	Yes	Yes	Yes
If yes, in refugee site or outside	No	No	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
Proportion of clients, who received pre-test, counseling, testing, post test and results	SNP	SNP	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
Prevention of mother-to-child transmission (PMTCT)													
Access to PMTCT	No	No	Yes	Yes	Yes	Yes	Yes	Yes	No	No	Yes	Yes	Yes
If yes, in refugee site or outside			NR	NR	NR	NR	NR	NR			NR	NR	NR
Proportion of first time ANC visits, received pre-test, counseling, testing, results and post counseling			NR	NR	NR	NR	NR	NR			NR	NR	NR
% HIV prevalence of PMTCT clients			1.2	6.4	NR	NR	NR	4			1.5	NR	2.3
People living with HIV / AIDS													
Trimthoprim/Sulfamethoxazole Prophylaxis for PLWA provided (adults)	No	No	NR	Yes	Yes	NR	NR	NR	NR	NR	NR	NR	Yes
Trimthoprim/Sulfamethoxazole Prophylaxis for PLWA provided (children)	No	No	NR	Yes	No	NR	NR	NR	NR	NR	NR	NR	Yes
Antiretroviral Therapy (ART)													
Do local population have access to ART	Yes	Yes	NR	No	Yes	NR	NR	NR	NR	NR	NR	NR	No
Do refugees have access to ART	Yes	Yes	NR	No	Yes	NR	NR	NR	NR	NR	NR	NR	No
If yes, how many refugees are receiving ART Now	0	0			6								
Post Exposure Prophylaxis (PEP) rape survivors													
PEP available Post Rape	No	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Surveillance/Surveys													
Sentinel surveillance among pregnant women	No	No	NR	No	No	NR	NR	NR	NR	NR	NR	NR	2004
HIV prevalence:													2.20%
Latest HIV or Repro Health BSS/KAPB (2)	No	No	2006	2006	No	2006	NR	NR	NR	NR	NR	2004	2006

South Africa: 4 Countries, 9 refugee sites	Pop. Estimate	CMR	U5MR	No of condoms	Male Urethral DC	Genital Ulcer DC	PMTCT	ART received
Mean	10468	0.33	0.47	1.42	7.11	2.27	2.09	14.13
Median	6486	0.11	0.35	1	6.25	2.5	2.1	15
Minimum	2700	0.07	0.03	1	0.17	0.03	0.43	3
Maximum	21179	1.1	1.5	4	18	5	3.2	23
Sum	94213	1.987	2.83	12.75	42.67	11.32	10.43	113
Count	9	6	6	9	6	5	5	8
NR or RI	0	3	3	0	3	4	3	1
SNP	0	0	0	0	0	0	1	0
Total count	9	9	9	9	9	9	9	9

	Yes	%	N	%	NR	%	Total
Universal Precautions							
Sufficient needles / syringes	9	100%	0	0%	0	0%	9
Sufficient gloves	9	100%	0	0%	0	0%	9
Is blood before transfusion screened for HIV	8	89%	0	0%	1	11%	9
STI data				9%			
Sufficient condoms	9	100%	0	0%	0	0%	9
Sufficient STI drugs	7	78%	2	22%	0	0%	9
STI syndromic approach	9	100%	0	0%	0	0%	9
VCT							
Access to VCT	9	100%	0	0%	0	0%	9
PMTCT							
Access to PMTCT	8	89%	1	11%	0	0%	9
Antiretroviral Therapy							
Local population access to ART	9	100%	0	0%	0	0%	9
Refugees access to ART	9	100%	0	0%	0	0%	9
PEP available Post rape							
PEP available Post rape	3	33%	6	67%	0	0%	9

Interpretation
CMR and U5MR- Acceptable
Condom distribution- Good at 1.42
Universal precautions-Good at 89%- 100%
STI supplies-Good at 78%-100%
VCT- Excellent at 100% access
PMTCT-Good at 89% access
ART- Excellent at 100% access local and refs
PEP- Insufficient at 33%

1 CMR baseline in Sub-Saharan Africa for non emergency is 0.5 deaths/10,000/day
2 U5MR baseline for Sub-Saharan Africa is 1.0 deaths/10,000/day
3 Sufficient supply defined as no stock out of >1 week at anytime during the past year
4 Goal for emergency phase is 0.5 condoms/person/month and for non-emergency phase is 1.0 condoms/person/month
5 # women who counselled on MTCT an offered voluntary test/# women who had 1st ANC visit =%
6 # women who counselled on MTCT, offered voluntary test during 1st ANC visit and accepted test / # women who had 1st ANC visit, were counselled on MTCT and offered voluntary test =%
SNP=service not provided; NR = not reported; RI = reported incorrectly; Y=yes; N=no

Indicators South Africa (1/1)	DZALEKA	Luwani	Maratane	Osiri	Kala	Mwange	Mayukwayukwa	Maheba	Nrngweshi
	Malawi	Malawi	Mozambique	Namibia	Zambia	Zambia	Zambia	Zambia	Zambia
Total Population	5073	2700	5000	6486	19143	21179	5600	13732	15300
Crude MR (deaths/10,000/day)	NR	NR	NR	0.067	0.5	0.1	1.1	0.12	0.1
<5 years MR (deaths/10,000/day)	NR	NR	NR	0.027	1.5	0.2	0.4	0.4	0.3
Universal precautions									
Sufficient needles / syringes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Sufficient gloves	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Is blood before transfusion screened for HIV	Yes	Yes	Yes	N/A	Yes	Yes	Yes	Yes	Yes
Information-Education-Communication (IEC) Materials									
Do appropriate IEC exist for refugees in camp	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes
If yes is there a sufficient supply	No	No	No	Yes	Yes	Yes	No	No	No
Sexually transmitted infection (STI) data									
No of condoms distributed (1)	1.0	1.3	1.5	4.0	1.0	1.0	1.0	1.0	1.0
Sufficient condoms	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Sufficient STI drugs	No	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes
STI syndromic approach used	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Incidence male urethral discharge among male population	4	6.9	RI	17.40%	5.6	NR	8	18	NR
Incidence genital ulcer disease among total population	2.5	NR	RI	2.70%	3.3	NR	0.5	5	NR
Voluntary counseling and testing (VCT)									
Access to VCT	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
If yes, in refugee site or outside	Site	Outside	Outside	site	site	site	site	site	site
Proportion of clients, who received pre-test, counselling, testing, post test and results	100%	NR	RI	100%	100%	100%	100%	100%	NR
Prevention of mother-to-child transmission (PMTCT)									
Access to PMTCT	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes
If yes, in refugee site or outside	Site	Outside		site	sites	No	sites	Outside	sites
Proportion of first time ANC visits, received pre-test, counselling, testing, results and post counselling	NR	NR		100.00%	100%	SNP	100.00%	NR	100%
% HIV prevalence of PMTCT clients	1.80	NR		0.43	2.10	NR	2.90	NR	3.20
People living with HIV / AIDS									
Trimethoprim/sulfamethoxazole prophylaxis for PLWA provided (adults)	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes
Trimethoprim/sulfamethoxazole prophylaxis for PLWA provided (children)	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes
Antiretroviral Therapy (ART)									
Do local population have access to ART	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Do refugees have access to ART	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
If yes, how many refugees are receiving ART now	20	18	12	23	10	4	3	23	Camp closed
Post Exposure Prophylaxis (PEP) rape survivors									
PEP available Post Rape	Yes	Yes	No	Yes	No	No	No	No	No
Surveillance/Surveys									
Sentinel surveillance among pregnant women	No	No	None	N/A	2005	2005	SNP	SNP	SNP
HIV prevalence:	NR	NR	NR	0.85%	3.40%	1.22%	NR	NR	NR
Latest HIV or Repro Health BSS/KAPB (2)	2003	2003	2005	N/A	Nov-06	Nov-06	SNP	SNP	SNP

West Africa 4 countries, 2 camps, 8 areas of return and 1 urban site	Pop. Estimate	CMR	U5MR	No of condoms	Male Urethral DC	Genital Ulcer DC	PMTCT	ART received
Mean	63277	0.95	1.37	0.91			4	4.5
Median	38013	0.58	1.05	1			4	4.5
Minimum	5980	0.4	0.97	0.03			4	4
Maximum	175372	2.36	2.89	1.4			4	5
Sum	696053	5.72	8.26	10.04			4	9
Count	11	6	6	11			1	2
NR or RI	0	5	5	0	11	11	10	2
SNP	0	0	0	0			0	7
Total count	11	11	11	11	11	11	11	11

	Yes	%	N	%	NR	%	Total
Universal Precautions							
Sufficient needles / syringes	11	100%		0%	0	0%	11
Sufficient gloves	11	100%		0%	0	0%	11
Is blood before transfusion screened for HIV	11	100%		0%	0	0%	11
STI data				9%			
Sufficient condoms	11	100%		0%	0	0%	11
Sufficient STI drugs	11	100%		0%	0	0%	11
STI syndromic approach	10	91%	1	9%	0	0%	11
VCT							
Access to VCT	5	45%	6	55%	0	0%	11
PMTCT							
Access to PMTCT	3	27%	8	73%	0	0%	11
Antiretroviral Therapy							
Local population access to ART	4	36%	7	64%	0	0%	11
Refugees access to ART	4	36%	7	64%	0	0%	11
PEP available Post rape							
PEP available Post rape	2	18%	9	82%	0	0%	11

Interpretation
CMR and U5MR- UMR high
Condom distribution- Reasonable at 0.91 target is 1
Universal precautions-Good at 100%
STI supplies-Good at 100%
VCT- Insufficient at 45% access
PMTCT- Low at 27% access
ART- Insufficient at 36% access local and refs
PEP- Insufficient at 18% access

1 CMR baseline in Sub-Saharan Africa for non emergency is 0.5 deaths/10,000/day
2 U5MR baseline for Sub-Saharan Africa is 1.0 deaths/10,000/day
3 Sufficient supply defined as no stock out of >1 week at anytime during the past year
4 Goal for emergency phase is 0.5 condoms/person/month and for non-emergency phase is 1.0 condoms/person/month
5 # women who counselled on MTCT an offered voluntary test/# women who had 1st ANC visit =%
6 # women who counselled on MTCT, offered voluntary test during 1st ANC visit and accepted test / # women who had 1st ANC visit, were counselled on MTCT and offered voluntary test =%
SNP=service not provided; NR = not reported; RI = reported incorrectly; Y=yes; N=no

Indicators West Africa (1/1)	Nicla	Budbuburam	Lofa	Bong	Montserrado	Nimba	Maryland	Bomi	Gbarpolu	Grand Cape Mnt	Oru
	Côte d Ivoire	Ghana	LIBERIA	LIBERIA	LIBERIA	LIBERIA	LIBERIA	LIBERIA	LIBERIA	LIBERIA	Nigeria
	5980	38013	175372	12948	7500	126635	59567	26058	110000	12800	5980
Crude MR (deaths/10,000/day)	0.56	2.36	NR	NR	0.5	0.4	1.3	NR	NR	NR	0.6
<5 years MR (deaths/10,000/day)	0.97	2.89	NR	NR	1.3	1	1.1	NR	NR	NR	1
Universal precautions											
Sufficient needles / syringes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Sufficient gloves	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Is blood before transfusion screened for HIV	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Information-Education-Communication (IEC) Materials											
Do appropriate IEC exist for refugees in camp	Yes	Yes	No	No	No	No	No	No	No	No	Yes
If Yes is there a sufficient supply	No	Yes	No	No	No	No	No	No	No	No	Yes
Sexually transmitted infection (STI) data											
No of condoms distributed (1)	1.4	0.6	1	1	1	1	1	1	1	1	0.03
Sufficient condoms	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Sufficient STI drugs	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
STI syndromic approach used	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No
Incidence male urethral discharge among male population	RI	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
Incidence genital ulcer disease among total population	RI	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
Voluntary counseling and testing (VCT)											
Access to VCT	Yes	Yes	No	No	Yes	Yes	No	No	No	No	Yes
If Yes, in refugee site or outside	Yes	site	NR	NR	Outside	site	NR	NR	NR	NR	outside
Proportion of clients, who received pre-test, counseling, testing, post test and results	NR	RI	NR	NR	NR	NR	NR	NR	NR	NR	NR
Prevention of mother-to-child transmission (PMTCT)											
Access to PMTCT	Yes	Yes	No	No	No	No	No	No	No	No	Yes
If Yes, in refugee site or outside	outside	site									outside
Proportion of first time ANC visits, received pre-test, counseling, testing, results and post counseling	RI	95.79	NR	NR	NR	NR	NR	NR	NR	NR	NR
% HIV prevalence of PMTCT clients	RI	4	NR	NR	NR	NR	NR	NR	NR	NR	NR
People living with HIV / AIDS											
Trimthoprim/Sulfamethoxazole Prophylaxis for PLWA provided (adults)	Yes	Yes	No	No	No	No	No	No	No	No	No
Trimthoprim/Sulfamethoxazole Prophylaxis for PLWA provided (children)	Yes	Yes	No	No	No	No	No	No	No	No	No
Antiretroviral Therapy (ART)											
Do local population have access to ART	Yes	Yes	No	No	Yes	No	No	No	No	No	Yes
Do refugees have access to ART	Yes	Yes	No	No	Yes	No	No	No	No	No	Yes
If Yes, how many refugees are receiving ART Now	NR	4			NR						5
Post Exposure Prophylaxis (PEP) rape survivors											
PEP available Post Rape	Yes	Yes	No	No	No	No	No	No	No	No	No
Surveillance/Surveys											
Sentinel surveillance among pregnant women	2004	No	2006-07	2006-07	2006-07	2006-07	2006-07	2006-07	2006-07	2006-07	Yes
HIV prevalence:	4.70%		5.8	5.8	5.8	5.8	5.8	5.8	5.8	5.8	NR
Latest HIV or Repro Health BSS/KAPB (2)	2005	No	2006	No	No	No	No	No	No	No	No

Asia[1]; 7 Countries, 31 refugee sites and 3 urban areas	Pop. Estimate	CMR	U5MR	No of condoms	Male Urethral DC	Genital Ulcer DC	PMTCT	ART received
Mean	38173	0.56	0.61	0.06	0.21	0.41	0.0005	6.56
Median	19252	0.2	0.4	0.06	0	0	0	0
Minimum	1170	0.1	0	0.005	0	0	0	0
Maximum	191888	2.9	2.8	0.16	0.96	2.56	0.0015	45
Sum	1297899	7.8	8.6	0.79	2.28	5	0.0015	105
Count	34	14	14	13	11	12	4	14
NR or RI	0	20	20	21	23	22	13	2
SNP	0	0	0	0	0	0	17	18
Total count	34	34	34	34	34	34	34	34

	Yes	%	N	%	NR	%	Total
Universal Precautions							
Sufficient needles / syringes	33	97%	0	0%	1	3%	34
Sufficient gloves	33	97%	0	0%	1	3%	34
Is blood before transfusion screened for HIV	32	94%	2	6%	0	0%	34
STI data							
Sufficient condoms	25	74%	8	24%	1	3%	34
Sufficient STI drugs	30	88%	2	6%	2	6%	34
STI syndromic approach	30	88%	2	6%	2	6%	34
VCT							
Access to VCT	18	53%	16	47%	0	0%	34
PMTCT							
Access to PMTCT	10	29%	17	50%	7	21%	34
Antiretroviral Therapy							
Local population access to ART	19	56%	15	44%	0	0%	34
Refugees access to ART	16	47%	18	53%	0	0%	34
PEP available Post rape							
PEP available Post rape	16	47%	18	53%	0	0%	34

Interpretation

CMR and U5MR-Acceptable
Condom distribution-Insufficient; not even reaching ER level
Universal precautions-OK at 94-97%; want 100% for all
STI supplies-OK at 88 want 100% for all
VCT-Insufficient at 53% access
PMTCT-Insufficient at 50 access
ART- Insufficient at 47% access local and refs
PEP- Still Insufficient at 47%
Good improvement in data collection in the region

1 CMR baseline in South Asia for non-emergency is 0.25 deaths/10,000/day
2 U5MR baseline for South Asia is 0.5 deaths/10,000/day
3 Sufficient supply defined as no stock out of >1 week at anytime during the past year
4 Goal for emergency phase is 0.5 condoms/person/month and for non-emergency phase is 1.0 condoms/person/month
5 # women who counselled on MTCT an offered voluntary test/# women who had 1st ANC visit =%
6 # women who counselled on MTCT, offered voluntary test during 1st ANC visit and accepted test / # women who had 1st ANC visit, were counselled on MTCT and offered voluntary test =%
SNP=service not provided; NR = not reported; RI = reported incorrectly; Y=yes; N=no

[1] Data for South Asia includes Iran and Pakistan, reflecting the new structure of the Asia Bureaux as per 1 january 2007

Indicators Asia (1/3)	Nryapara	Kutupalong	Urban	camps	Urban	Beldangil	BeldangII	BeldanExt	Sanischre	Timai	Goldhap
	Bangladesh	Bangladesh	India	Iran	Malaysia	Nepal	Nepal	Nepal	Nepal	Nepal	Nepal
Total Population	16054	10177	11560	31502	46356	18502	22748	11646	20992	10382	9493
Crude MR (deaths/10,000/day)	2.5	2.9	NR	NR	NR	RI	RI	RI	RI	RI	RI
<5 years MR (deaths/10,000/day)	2.8	1.1	NR	NR	NR	RI	RI	RI	RI	RI	RI
Universal precautions											
Sufficient needles / syringes	Yes	Yes	NR	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Sufficient gloves	Yes	Yes	NR	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Is blood before transfusion screened for HIV	No	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Information-Education-Communication (IEC) Materials											
Do appropriate IEC exist for refugees in camp	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
If Yes is there a sufficient supply	Yes	Yes	No	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Sexually transmitted infection (STI) data											
No of condoms distributed (1)	0.05	0.08	0.005	NR	NR	0.06	0.06	0.06	0.06	0.06	0.06
Sufficient condoms	Yes	Yes	Yes	Yes	NR	No	No	No	No	No	No
Sufficient STI drugs	Yes	Yes	NR	No	NR	Yes	Yes	Yes	Yes	Yes	Yes
STI syndromic approach used	Yes	Yes	NR	Yes	NR	Yes	Yes	Yes	Yes	Yes	Yes
Incidence male urethral discharge among male population	0.24	0.96	NR	NR		0	0	0	0.38	0	0
Incidence genital ulcer disease among total population	0.04	0.09	NR	NR	NR	0.32	0	0	0	0	0
Voluntary counseling and testing (VCT)											
Access to VCT	No	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
If Yes, in refugee site or outside			Outside	Outside	outside	site	site	site	site	site	site
Proportion of clients, who received pre-test, counseling, testing, post test and results			NR	NR	NR	83%	83%	83%	83%	83%	83%
Prevention of mother-to-child transmission (PMTCT)											
Access to PMTCT	No	No	Yes	No	Yes	NR	NR	NR	NR	NR	NR
If Yes, in refugee site or outside			Outside		outside	NR	NR	NR	NR	NR	NR
Proportion of first time ANC visits, received pre-test, counseling, testing, results and post counseling			NR		NR	NR	NR	NR	NR	NR	NR
% HIV prevalence of PMTCT clients			NR		NR	NR	NR	NR	NR	NR	NR
People living with HIV / AIDS											
Trimthoprim/Sulfamethoxazole Prophylaxis for PLWA provided (adults)	No	No	NR	Yes	Yes	No	No	No	No	No	No
Trimthoprim/Sulfamethoxazole Prophylaxis for PLWA provided (children)	No	No	NR	Yes	Yes	No	No	No	No	No	No
Antiretroviral Therapy (ART)											
Do local population have access to ART	No	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Do refugees have access to ART	No	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
If Yes, how many refugees are receiving ART Now			NR	NR	32	0	0	0	0	0	0
Post Exposure Prophylaxis (PEP) rape survivors											
PEP available Post Rape	No	No	No	No	No	Yes	Yes	Yes	Yes	Yes	Yes
Surveillance/Surveys											
Sentinel surveillance among pregnant women	No	No	No	No	No	No	No	No	No	No	No
HIV prevalence:											
Latest HIV or Repro Health BSS/KAPB (2)						2005	2005	2005	2005	2005	2005

Indicators Asia (2/3)	AMWA	AHTP	CWS	Darus	FPHC	HMRB	IMC	IRC	KJRC	PDH	SCF	UAAR
	Pakistan	Pakistan	Pakistan	Pakistan	Pakistan	Pakistan	Pakistan	Pakistan	Pakistan	Pakistan	Pakistan	Pakistan
Total Population												
Crude MR (deaths/10,000/day)	0.1	0.2	0.2	0.2	0.3	0.2	0.2	0.2	0.2	0.2	0.2	0.2
<5 years MR (deaths/10,000/day)	0.2	0.4	0.4	0.4	0.8	0.3	0.4	0.6	0.2	0.3	0.5	0.2
Universal precautions												
Sufficient needles / syringes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Sufficient gloves	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Is blood before transfusion screened for HIV	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Information-Education-Communication (IEC) Materials												
Do appropriate IEC exist for refugees in camp	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
If Yes is there a sufficient supply	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Sexually transmitted infection (STI) data												
No of condoms distributed (1)	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
Sufficient condoms	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Sufficient STI drugs	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
STI syndromic approach used	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Incidence male urethral discharge among male population	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
Incidence genital ulcer disease among total population	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
Voluntary counseling and testing (VCT)												
Access to VCT	No	No	No	No	No	No	No	No	No	No	No	No
If Yes, in refugee site or outside	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
Proportion of clients, who received pre-test, counseling, testing, post test and results	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
Prevention of mother-to-child transmission (PMTCT)												
Access to PMTCT	No	No	No	No	No	No	No	No	No	No	No	No
If Yes, in refugee site or outside	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
Proportion of first time ANC visits, received pre-test, counseling, testing, results and post counseling	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
% HIV prevalence of PMTCT clients	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
People living with HIV / AIDS												
Trimthoprim/Sulfamethoxazole Prophylaxis for PLWA provided (adults)	No	No	No	No	No	No	No	No	No	No	No	No
Trimthoprim/Sulfamethoxazole Prophylaxis for PLWA provided (children)	No	No	No	No	No	No	No	No	No	No	No	No
Antiretroviral Therapy (ART)												
Do local population have access to ART	No	No	No	No	No	No	No	No	No	No	No	No
Do refugees have access to ART	No	No	No	No	No	No	No	No	No	No	No	No
If Yes, how many refugees are receiving ART Now												
Post Exposure Prophylaxis (PEP) rape survivors												
PEP available Post Rape	No	No	No	No	No	No	No	No	No	No	No	No
Surveillance/Surveys												
Sentinel surveillance among pregnant women	No	No	No	No	No	No	No	No	No	No	No	No
HIV prevalence:												
Latest HIV or Repro Health BSS/KAPB (2)												

Indicators Asia (3/3)	NUPOE	UMPIEM	MAELA	Mae La Oon	Mae Ra	BaDonYang	Ban Mai NRi	Ban Mae S	Tham Hin	Urban
	Thailand	Thailand	Thailand	Thailand	Thailand	Thailand	Thailand	Thailand	Thailand	Thailand
Total Population	11862	19160	47126	14455	11900	3402	19344	3603	9565	1170
Crude MR (deaths/10,000/day)	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
<5 years MR (deaths/10,000/day)	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
Universal precautions										
Sufficient needles / syringes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Sufficient gloves	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Is blood before transfusion screened for HIV	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Information-Education-Communication (IEC) Materials										
Do appropriate IEC exist for refugees in camp	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
If Yes is there a sufficient supply	Yes	Yes	Yes	No	No	No	Yes	Yes	Yes	No
Sexually transmitted infection (STI) data										
No of condoms distributed (1)	NR	NR	NR	NR	NR	RI	0.02	0.06	0.16	NR
Sufficient condoms	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes
Sufficient STI drugs	Yes	Yes	Yes	Yes	Yes	Yes	No	No	Yes	Yes
STI syndromic approach used	Mixed	Mixed	Mixed	Yes	Yes	Yes	No	No	Yes	Yes
Incidence male urethral discharge among male population	NR	NR	NR	NR	NR	RI	0.1	0.6	NR	RI
Incidence genital ulcer disease among total population	NR	NR	NR	NR	NR	RI	0	0	NR	2.6
Voluntary counseling and testing (VCT)										
Access to VCT	Yes	Yes	Yes	Yes	Yes	Yes	No	No	Yes	Yes
If Yes, in refugee site or outside	site	site	site	site	site	site	Outside	outside	site	Outside
Proportion of clients, who received pre-test, counseling, testing, post test and results	100%	96.00%	100%	94.70%	88.80%	RI	RI	0	100%	NR
Prevention of mother-to-child transmission (PMTCT)										
Access to PMTCT	Yes	Yes	Yes	Yes	Yes	Yes	No	No	Yes	Yes
If Yes, in refugee site or outside	site	site	site	Both	Both	site	Outside		site	Outside
Proportion of first time ANC visits, received pre-test, counseling, testing, results and post counseling	NR	25%	97%	4.30%	4.40%	RI	SNP	SNP	100%	NR
% HIV prevalence of PMTCT clients	NR	0	0.15%	NR	NR	RI	SNP	SNP	0%	NR
People living with HIV / AIDS										
Trimthoprim/Sulfamethoxazole Prophylaxis for PLWA provided (adults)	No	No	Yes	Yes	Yes	Yes	Yes	NR	Yes	Yes
Trimthoprim/Sulfamethoxazole Prophylaxis for PLWA provided (children)	No	No	Yes	Yes	Yes	Yes	Yes	NR	Yes	NR
Antiretroviral Therapy (ART)										
Do local population have access to ART	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes
Do refugees have access to ART	Yes	Yes	Yes	No	No	Yes	No	No	Yes	Yes
If Yes, how many refugees are receiving ART Now	1	12	45			1	0	0	11	3
Post Exposure Prophylaxis (PEP) rape survivors										
PEP available Post Rape	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes
Surveillance/Surveys										
Sentinel surveillance among pregnant women	No	No	No	No	No	No	2003/04	2003/04	No	No
HIV prevalence:							0.26%	0.26%		
Latest HIV or Repro Health BSS/KAPB (2)				2004	2004	NR	2006	2006	Nov-06	

VIII) Annexes on CD Rom

1. UNHCR Strategic Plan for Refugees, HIV and AIDS – 2005 - 2007
2. UNHCR Strategic Plan for Refugees, HIV and AIDS – 2005 – 2007 (French)
3. Note on HIV/AIDS and the protection of Refugees, IDPs and other persons of concern, 2006
4. ibid (Arabic), 2006
5. ibid (French),2006
6. ibid (Russian), 2006
7. Information Poster on Note on HIV/AIDS and protection, 2006
8. Information Leaflet on Note on HIV/AIDS and protection (Arabic), 2006
9. Information Poster on Note on HIV/AIDS and protection (French), 2006
10. Review of NSP, GFTAM and MAP, 2006
11. Brazzaville Commitment on scaling up towards universal access, 2006
12. Behavioural Surveillance Survey Tanzania, 2006
13. Behavioural Surveillance Survey Uganda, 2006
14. Substance Use and HIV Assessment Kenya, 2006
15. Substance Use and HIV Assessment Liberia, 2006
16. Substance Use and HIV Assessment Thailand, 2006
17. Regional VCT Training Report Southern Africa, 2006
18. Behavioural Surveillance Survey Zambia, 2006
19. Stigma and Discrimination Training Package Southern Africa, 2006
20. Mission Report Angola 2006
21. Mission Report Botswana 2006
22. Mission Report Malawi 2006
23. Mission Report Mozambique 2006
24. Mission Report Namibia 2006
25. Mission Report Zambia 2006
26. Mission Report Côte d'Ivoire 2006
27. Mission Report Ghana 2006
28. Mission Report Ghana II 2006
29. Mission Report Guinea 2006
30. Mission Report Liberia 2006
31. Mission report Sierra Leone 2006
32. Mission Report Columbia 2006
33. Behavioural Surveillance Survey Nepal, 2006
34. Mission Report Bangladesh 2006
35. Mission Report Malaysia 2006
36. Mission Report Myanmar 2006
37. Mission Report Thailand 2006
38. Training Report HIV and Protection Workshop Tunis, June 2006
39. Training Report Annexes HIV and Protection Workshop, Tunis, June 2006
40. Mission Report Yemen 2006
41. Mission Report Azerbaijan 2006
42. Mission Report Armenia 2006
43. Mission Report Georgia 2006
44. Mission Report Turkey 2006
45. Interagency Mission Report on HIV among Conflict-Affected Persons in Nepal, 2006
46. UNAIDS – UNHCR Policy Brief, 2006
47. ibid (French), 2006
48. ibid (Portuguese), 2006
49. Clinical Management of Rape Training, Johannesburg, July 2006
50. Annual Condom Distribution Report to UNFPA, 2006
51. Delivering ARV Drugs in Emergencies: Neglected but Feasible. Consensus Statement, 2006
52. HIV and Food interventions in Uganda and Zambia, 2006
53. Toronto Conference UNICEF UNHCR pre –event, August 2006
54. Toronto Conference Presentation Annexes, August 2006
55. Best Practice: Development of Programme Interventions for Integration of Food and Nutrition Activities in Refugee Settings, UNAIDS, UNHCR, WFP, 2006
56. Educational Responses to HIV/AIDS for Refugees and IDPs. UNESCO, UNHCR, 2006
57. Burton A, Displaced and infected. The Human Rights bimonthly 2006. Volume 5 (2): 54-55
58. Kaiser R, Kedamo T, Lane J, et al. HIV, syphilis, herpes simplex virus 2, and behavioral surveillance among conflict-affected populations in Yei and Rumbek, southern Sudan. Aids 2006; 20(6):942-944