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Update on HIV/AIDS and refugees

Summary

Significant progress has been made over the past year in ensuring access to HIV prevention, treatment and support for refugees, internally displaced persons and others of concern to UNHCR. This paper provides an update on UNHCR's HIV and AIDS interventions, particularly in sub-Saharan Africa - which is one of the most heavily affected regions in the world and where access to HIV prevention, care and support services remains challenging. This paper also discusses progress made by UNHCR and the World Food Programme, as co-conveners of the UNAIDS Division of Labour area "Addressing HIV in humanitarian emergencies," together with relevant partners, in achieving the following global objectives:

- Zero new HIV infections;
- Zero discrimination; and
- Zero AIDS-related deaths.

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I. Introduction

1. According to UNAIDS, at the beginning of 2012 there were an estimated 34 million people in the world living with HIV. Sub-Saharan Africa, with nearly 1 in 20 adults living with HIV, remains the most heavily affected region, accounting for 69 per cent of all HIV infections worldwide. More than 33 per cent of the 35.8 million persons of concern to UNHCR reside in sub-Saharan African countries, where access to HIV prevention, care and support services remains challenging. Against this backdrop, it is essential to incorporate HIV interventions into the overall humanitarian response from the onset of an emergency. If left unaddressed, the consequences may extend beyond the crisis, influencing the outcome of the response and shaping future prospects for rehabilitation and recovery.

2. The extent to which persons of concern to UNHCR are adversely affected by HIV has been increasingly examined in recent years. There is evidence that, in many situations, HIV prevalence among populations affected by conflict and displacement is similar to or lower than that of the surrounding host population. However, the affected populations may be more vulnerable to transmission due to protection and security risks, and may lack access to prevention programmes and treatment. Due to their situation, they are also more likely to resort to sex-work or occasional sex-for-goods without the use of condoms. In response, UNHCR supports immediate life-saving activities and protection strategies at the onset of an emergency and the development of comprehensive HIV programmes as soon as the situation stabilizes. This paper provides an update on such activities since the last report to the Standing Committee in June 2012, and reviews progress made with respect to UNHCR's co-sponsor role in the Joint United Nations Programme on HIV/AIDS (UNAIDS).

II. Update on UNHCR's HIV and AIDS policies and interventions

3. Access to antiretroviral therapy (ART) in low and middle-income countries has increased significantly. One standardized measure, "life-years gained," shows the survival impact of ART on a population. Using this measurement, it is estimated that since 1995 ART has added a total of 14 million life-years to people living with HIV in low and middle-income countries, including 9 million life-years to those in sub-Saharan Africa. Expanded access to ART also helps minimize the spread of HIV by reducing the number of viruses in the blood stream and making transmission more difficult. In UNHCR's operations, the accelerating use of HIV testing, counselling services and treatment has been aided by a number of factors. These include provider-initiated HIV testing in some health care settings, reduced medication costs and continued advocacy for the inclusion of refugees into national AIDS programmes.

4. By the end of 2012, global access to ART for refugees was sustained at 93 per cent, equivalent to the level of access of surrounding populations. UNHCR provides treatment in countries where refugees and other persons of concern do not have access to ART, while at the same time advocating for their inclusion in national programmes.

5. UNHCR aims to reduce HIV transmission through increased protection interventions, culturally appropriate awareness strategies, improved access to voluntary counselling and testing, initiatives for ending mother-to-child transmission of HIV (EMTCT), the provision of post-exposure prophylaxis (PEP), support for voluntary male medical circumcision, strengthened HIV-sensitive social protection programmes, enhanced quality of health care, and various strategies targeting populations at higher risk of HIV infection and transmission. In 2012, the percentage of women with access to EMTCT programmes continued to rise, contributing to a 5 per cent increase since 2008. Nevertheless, only 35 per cent of operations currently meet UNHCR's objective of 90 per cent coverage. Substantial improvements in women's access to EMTCT programmes were observed in countries such as Burundi (43 per cent in 2008 to 98 per cent in 2012) and Uganda (56 per cent to 93 per cent during the same time period).

6. In West and Central Africa, technical support was provided to establish cross-border coordination mechanisms aimed at ensuring continued access to EMTCT and family

planning services after repatriation. Those enrolled in EMTCT and family planning programmes were identified, their information was shared on a confidential basis between sending and receiving countries, and services continued after repatriation. When EMTCT and family planning services were not available in areas of return, referral mechanisms with district authorities were put into place. To reach the objective of no infant born with HIV in 2013, UNHCR will scale up its activities to prevent infection in women of child-bearing age, identify HIV-positive pregnant women and provide treatment to prevent transmission from mother to child. In addition, increased technical support was provided to countries experiencing new influxes of refugees in 2012 to ensure continuation of treatment and the provision of PEP, including the Democratic Republic of the Congo and Mali. In these operations, the Inter-Agency Standing Committee (IASC) *Guidelines for Addressing HIV in Humanitarian Settings*[1] and the Minimum Initial Service Package for Reproductive Health in Crisis Situations were implemented in new camps in Burkina Faso, Burundi, the Democratic Republic of the Congo (Équateur Province), Niger and Rwanda. All camps have integrated EMTCT services with referrals to district hospitals where necessary.

7. UNHCR promoted voluntary male medical circumcision in many operations, and supported the extension of national programmes to refugees, including in Ethiopia, Kenya and Uganda. By the end of 2012, these three countries had significantly scaled up their voluntary male medical circumcision programmes, and most refugee operations on the continent were effectively implementing such activities or had ensured that refugees could easily access national programmes.

8. In East Africa, a regional initiative to address the special protection and health needs of sex-workers as well as sexually-exploited and abused adolescents in humanitarian settings continues to be implemented by UNHCR and its partners. Multi-functional teams worked to develop or strengthen programmes in the refugee-hosting countries of Ethiopia, Kenya, Uganda and Zambia, with targeted training and support; HIV and reproductive health services for sex workers; community sensitization campaigns; and the development of peer-led networks. In addition, in 2012 Ecuador implemented a project in Sucumbíos Province, along the northern border with Colombia, to prevent HIV and sexually-transmitted infections. This project, which also aimed to raise awareness about sexual and gender-based violence and reproductive health, was geared towards sex workers. It corresponds to an HIV/AIDS regional strategy for Latin America in which UNHCR is involved in designing and implementing projects to reduce the risks for persons of concern engaged in sex work along border areas.

9. UNHCR has made efforts to increase the provision of post-exposure prophylaxis in its operations. For the past four years, most countries showed sustained improvement in coverage (e.g. the United Republic of Tanzania from 49 per cent in 2009 to 80 per cent in 2012; and Kenya from 54 per cent in 2010 to 98 per cent in 2012). However, some countries are still struggling to reach the standard of 100 per cent of rape survivors receiving post-exposure prophylaxis within 72 hours following potential exposure. UNHCR will work to identify the bottlenecks to ensure timely and adequate care for rape survivors.

10. UNHCR continues to advocate for the right of persons of concern to have access to HIV prevention, treatment and support programmes. A key strategy is to ensure that the HIV status of an asylum-seeker does not constitute a bar to accessing asylum nor constitute grounds for *refoulement*. As discussed in the publication *Mapping of restrictions on the entry, stay and residence of people living with HIV* (UNAIDS, May 2009), and taking into consideration developments up to January 2013, 44 countries, territories and administrative areas impose some form of restriction on the entry, stay and residence of people living with HIV based on this status; nineteen countries have legislation which calls for the deportation of individuals once their HIV-positive status is discovered. UNHCR fully supports and participates in UNAIDS-led efforts to remove such restrictions due to HIV status.

[1] See http://www.unaids.org/en/media/unaids/contentassets/documents/unaidspublication/2010/jc1767_iasc_doc_en.pdf

III. UNHCR and UNAIDS

11. As the co-conveners of the UNAIDS Division of Labour area "Addressing HIV in humanitarian emergencies," UNHCR and WFP have increased coordination and, together with relevant partners, achieved collective results towards the global objectives of "zero new HIV infections; zero discrimination; and zero AIDS-related deaths." These efforts are discussed below.

12. The Inter-Agency Task Team (IATT) "Addressing HIV in Emergencies" increased global visibility of the issue through participation in the International AIDS Conference in July 2012, which took place in Washington, D.C. At this event, a presentation and discussion was held on the topic "ensuring universal access to HIV services for populations affected by humanitarian crises," which aimed to advance the mainstreaming of HIV prevention and support in humanitarian emergencies. The Team representatives also met with civil society actors, including potential future members of the IATT. Posters and a display booth were used as advocacy tools.

13. The IATT strengthened information-sharing by developing a website[2] dedicated to addressing HIV in emergencies. It serves as a resource for stakeholders working in the field, contains information on regional initiatives and provides links to relevant information in different languages. It also showcases regional websites, country profiles, country assessments, evaluations and reports, online training tools, a calendar of events and links to related external websites.

14. In partnership with the IATT on HIV and Gender-Based Violence in Emergencies in Eastern and Central Africa, a regional advocacy and capacity-building workshop held in August 2012 in Nairobi focused on lessons learned, capacity building and planning. In line with the 31+ UNAIDS high-impact focus countries, the workshop focused on Djibouti, Ethiopia and Kenya and also incorporated experiences from Somalia and South Sudan. Participants came from those countries as well as from UNHCR regional offices and headquarters.

15. Training to build the capacity of UN country teams was organized using the IASC *Guidelines for Addressing HIV in Humanitarian Settings* as a basis for the discussion and was held in Bangladesh, India, Myanmar, Malaysia and Nepal. Sensitization sessions for immigration services were also organized in a number of locations including Latin America and the Caribbean.

16. In an effort to strengthen the HIV response at the onset of emergencies, inter-agency assessments were organized in response to new crises. These assessments were followed by development of a work plan, coordination meetings and close follow-up using activity matrices. Key activities in line with the IASC *Guidelines for Addressing HIV in Humanitarian Settings* included coordination, the provision of supplies, and the identification of people living with HIV including those on ART. In 2012, UNHCR provided support to country operations to improve the HIV response for populations displaced from the Democratic Republic of Congo, Mali, South Sudan, Sudan and Yemen.

17. UNHCR strengthened its partnerships with HIV networks and experts connected with national AIDS programmes in countries affected by humanitarian crises as well as in countries working on preparedness plans. A regional strategy development workshop was organized with the Asia Pacific network of people living with HIV to examine a more inclusive response for people living with HIV and AIDS in emergencies. Recommendations from this workshop will be implemented in Indonesia and Myanmar in 2013.

IV. Conclusion

18. Significant progress has been made in ensuring access to HIV protection, prevention, treatment and support for refugees, IDPs and other persons of concern to UNHCR. Coverage and the quality of HIV interventions are steadily increasing in emergencies as well as in protracted situations. UNHCR and its partners will continue to

2 See http://his.unhcr.org/aae/

advocate for the inclusion of refugees and IDPs into national HIV strategic plans and programmes. As co-convener in the UNAIDS Division of Labour area on Addressing HIV in Emergencies, UNHCR and its partners will continue to advocate for governments, donors and humanitarian partners to mitigate the impact of HIV and reduce discrimination against affected populations.