Refugees, HIV and AIDS:

Fighting HIV and AIDS together with Refugees

Anti AIDS school club, Nangweshi refugee camp, Zambia

Report on UNHCR's HIV and AIDS Programmes and Activities for 2004

04/AB/VAR/CM/267

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I) Statement of Expenditure		USD
VAR Amount Approved by the ORB (USD)		1,300,000.00
Earmarked funds Received:		
BPRM USG CAF. No 2850		350,000.00
Canada Govt. CAF No 351		304,000.00
Danish Govt. CAF No. 3897		459,876.00
Irish Govt. CAF No. 1299		123,124.00
Plus: Carry over from 2003		63,000.00
	TOTAL	1,300,000.00
FUNDS ALLOCATED:		
	Burundi	24,894.00
	Democratic Republic of Congo	91,373.73
	Republic of Congo	36,834.58
	Ethiopia	23,666.18
	Indonesia	7,500.00
	Kenya	19,022.22
	Kyrgyzstan	5,000.00
	Liberia	38,663.00
	Malawi	8,000.00
	Malaysia	7,500.00
	Namibia	5,000.00
	Rwanda	12,559.00
	Sierra Leone	37,196.00
	Sudan	39,499.00
	Somalia	38,000.00
	Uganda	20,719.00
	Zambia	55,277.00
	Positive Lives	4,734.00
	Training and workshops	66,359.27
	Programmatic research	57,071.00
	Interagency collaboration	23,232.64
	Personnel at HQ	110,000.00
	Personnel in Field	120,975.00
	Consultancy Fees	172,470.25
	Travel	140,547.55
	TOTAL FUNDS DISBURSED IN 2004	1,196,095.00

II) Project Report

1) General Information

Project Symbol	04/AB/VAR/CM/267
Project Title	HIV/AIDS and refugees
Project Duration	1 January – 31 December 2004
Implemented by	Technical Support Section, Division of Operational Support

2) Objective of the Project

This project is a response to the growing challenge of combating HIV and AIDS among refugees and other persons of concern to UNHCR. Programme activities were implemented in line with UNHCR's Strategic Plan for HIV/AIDS and refugees 2002-2004 (Annex 1).

The main objectives are: 1) to reduce HIV transmission; 2) to reduce stigma and discrimination; 3) to improve AIDS support, care and treatment through improved and standardised planning and implementation of HIV and AIDS programmes; and 4) to reinforce surveillance, monitoring and evaluation.

3) Description of Beneficiaries

The primary beneficiaries of the HIV and AIDS project in 2004 are located in refugee camps, settlements and urban areas in Africa. Additional projects have been supported for refugees and asylum seekers in Indonesia, Kyrgyzstan, Malaysia, Thailand and Yemen. Women, children and high risk groups are specifically addressed in the programme interventions.

4) Programme Implementation

A) Country Support

Based on assessment and evaluation missions, twenty countries received funds and technical support for their HIV and AIDS programmes. This support was additional to the existing HIV and AIDS country programmes. Technical support was primarily provided to countries in Africa and Asia. The UNHCR Operational Guideline was updated to stress the importance of including HIV and AIDS in UNHCR's country programme planning and implementation (Annex 2). Data for many of the countries listed below are in section III of the report.

Countries in East Africa (Kenya and Tanzania) and Southern Africa (Angola, Namibia, South Africa and Zambia) received reduced funding compared to the previous year. Tanzania and Kakuma refugee camp in Kenya were able to solicit additional funding from other sources such as UNICEF and Centers of Disease Control and Prevention. Furthermore, Tanzania and country programmes in Southern Africa integrated HIV and AIDS activities in their ongoing health and community service activities.

i) Burundi

In Burundi, support focused on HIV prevention. One hundred and twenty community HIV/AIDS workers were trained in various topics including reproductive health, sexually transmitted infections (STIs), sexual and gender-based-violence and community dialogue on HIV and AIDS. Fifty percent of the participants were from the local surrounding community and 50% were young persons. UNHCR supported the implementing partners (IPs) with the procurement of sterilisation equipment and provided test kits to the antenatal care (ANC) clinics, to test pregnant women for syphilis.

A voluntary counselling and testing (VCT) service with pre- and post-test counselling began at the refugee camps. Blood was screened for HIV and other diseases in the District Hospitals.

ii) Côte d'Ivoire

Following a needs assessment mission to Côte d'Ivoire, recommendations were made and proposals developed. However, due to the unstable situation and the evacuation of UNHCR staff, the funds could not be utilised and were re-directed to support the Liberian programme to cope with the new influx of refugees from Côte d'Ivoire.

iii) Democratic Republic of Congo (DRC)

In line with the recommendations of the 2003 assessment in DRC, the focus was on capacity building of the health staff through a series of three training courses: 1) standardised identification and treatment of STIs; 2) universal precautions; and 3) effective condom promotion and distribution. Participants were the health and community health workers from the refugee communities and surrounding populations in Bas Congo Province (Angolan refugees), Katanga province (Angolan refugees), Oriental Province (Sudanese refugees) and Bandundu Province (Angolan refugees).

Funds from the HIV project permitted continued availability of materials and equipment to ensure that the programmes could adhere to the standards for universal precaution and blood safety in all refugee health facilities in DRC.

Multisectoral HIV/AIDS committees were organised in Bas Congo and Katanga provinces. Various refugee community-based organisations (e.g. young people, religious leaders, and women), IPs and some members from the surrounding populations are part of the multisectoral HIV/AIDS committees. UNHCR purchased bicycles for the community development workers, to strengthen supervisions and outreach activities for awareness-raising and events.

iv) Ethiopia

The programme supported Ethiopia with the establishment of VCT services for refugees and the surrounding host population in Dimma. With support from UNHCR, the African Humanitarian and Development Agency established and started the VCT service in August 2004. It is the first VCT accessible to the refugees in Ethiopia.

The ongoing HIV/AIDS awareness campaign focused on the 'ABCs' – **A**bstinence, **B**e faithful and **C**ondoms as well as VCT in order to encourage people to know their status. There was a gradual increase of clients, particularly from the surrounding communities. Refugees, however, are more reluctant to use the VCT services; less than 20% of those tested were refugees. Males between 20-29 years of age accounted for approximately 60% of all VCT clients. In 2005, the VCT program will address factors that impede access to the utilisation of services of refugees and women.

Explanation of condom distribution in Zambia

v) Indonesia

In line with the recommendations of a joint UNHCR/UNAIDS mission (Annex 3), a HIV prevention strategy was rolled out for refugees and asylum seekers in Indonesia. Information, education and communication (IEC) materials were developed on healthy lifestyles and HIV and STI prevention. Workshops and focus group discussions were organised with the different refugee communities to improve the technical skills and knowledge of refugee volunteers and representatives of asylum seekers; 60% of the attendees in the training courses were female refugees.

vi) Kenya

Dadaab refugee camps were supported to develop more comprehensive HIV and AIDS services. Funds were allocated for increasing refugee awareness on STIs, HIV and AIDS, developing VCT services, and conducting sentinel surveillance. To enhance HIV/AIDS awareness, videos and tapes were procured and shown in the newly opened VCT clinic as well in community centres. The refugee community holds strong beliefs and perception about HIV/AIDS. Condom promotion and distribution is openly challenged and the community perceives HIV as a foreign problem that does not affect Somali people. Open exchanges were initiated with the refugees to discuss these and other important prevention issues, such as abstinence and being faithful to one partner (or partners if polygamous marriages occur in that community).

The first VCT in Dadaab opened in Ifo in September 2004. By the end of December 2004, a total of 98 people had been enrolled and tested for HIV. Almost 70% of attendees were young men, which indicate problems regarding the accessibility or acceptability of such services for women.

vii) Kyrgyzstan

UNHCR contributed funds with other UN agencies to recruit a national United Nations Volunteer (UNV) to work at UNAIDS in the capital. The UNV focused on the inclusion of refugees and asylum seekers in the National AIDS Plan as well as the implementation of the approved activities for the expansion of HIV/AIDS activities in the country, also covering refugees and asylum

seekers, through funds from the Global Fund to Fight AIDS, Tuberculosis and Malaria.

viii) Liberia

The HIV programme in Liberia focused on capacity building and the provision of equipment to facilities in order to strengthen prevention programmes in the seven counties where UNHCR is working. In this context, a trainer programme on HIV and STI awareness was developed. Furthermore, IEC materials developed by the National AIDS Control Programme were reproduced and distributed widely in the seven counties.

The additional funding for the influx of refugees from Cote D' Ivoire was used to strengthen universal precautions and to improve STI services in the health centres, in accordance with the guidelines for HIV/AIDS interventions in emergencies from the Inter Agency Standing Committee (IASC) (Annexes 4 – English and 5- French).

ix) Malawi

The two refugee camps in Malawi, Dzaleka and Luwani, received support from UNHCR to strengthen community-based HIV/AIDS awareness activities including IEC development, training and mobilisation of peer educators, and the development of a mobile educational video programme. In addition, support was provided to ensure supplementary nutrition for refugees living with AIDS, in a confidential manner. The small amount of additional funding provided through this HIV project at headquarters had an important add-on effect, leading to the establishment of strategic linkages with local programmes including a Family Health International community-based care programme for orphans and vulnerable children. Family Health International also provided one of UNHCR's IP, the Malawi Red Cross Society, with funding to strengthen the refugee home-based care programme in Dzaleka camp. Access to prevention of mother-to-child transmission (PMTCT) programmes at local health facilities also improved with the assistance of UNICEF and district level health authorities.

x) Malaysia

In Malaysia, funding was provided to ACST, UNHCR's IP that provides health services for men living in remote areas near construction worksites and in detention centres. The IP has already developed good relations with several key refugee leaders and community groups. A rapid analysis was conducted with the assistance of refugee community groups to identify levels of awareness and understanding of HIV/AIDS among Myanmar's men (85% of the population), women (12% of the population) and children under 18 years of age (3%) and determine appropriate intervention points within community structures for appropriate dissemination of HIV information. The needs of various ethnic groups including Chin, Rohingyas, Karens, Kachins, Myanmar Muslims and ethnic Burmese were also assessed. Based on the assessment, training materials on HIV prevention and care for people living with HIV and AIDS (PLWH/As) were developed and training of peer educators was carried out.

xi) Mozambique

A trainer from a South African IP, Planned Parenthood Association of South Africa (PPASA), was supported to provide training, technical assistance and guidance to the refugee programme in Mozambique. In the absence of any specific comprehensive HIV/AIDS programme in Marratane refugee camp, this exchange of skills filled a critical gap while a suitable IP was being identified in Mozambique for the 2005 programme. The training, provided to refugee community groups in their local language, included basic information on HIV transmission, risk factors, stigma and discrimination, living with HIV/AIDS, children made vulnerable by HIV/AIDS, and gender considerations. The trainer used modules adapted from PPASA's local programmes such as Women's Wellness, Adolescent Reproductive Health and Life Skills, and Men as Partners.

xii) Namibia

The HIV/AIDS programme in Namibia continued to focus on building skills and awareness among Angolan refugees prior to their return. As Angolan refugees in Namibia originate from many different parts of Angola, which have varying levels of health and social infrastructure, it was critical to educate and equip returnees with knowledge about HIV and AIDS so they could contribute to the fight against the pandemic once back in their home communities. Activities in Osire refugee camp in Namibia were implemented by Africa Humanitarian Action (AHA). Through the UNHCR programme, AHA provided refugees living with AIDS with nutritional support to assist with recovery from opportunistic infections, weight loss and other AIDS-related conditions. AHA also provided refresher training on basic HIV/AIDS information to refugee leaders, youth and women's groups in order to enable them to pass on accurate information as peer educators in their community. Issues around stigma and discrimination against people living with HIV/AIDS (PLWH/As) were also addressed through this training, and through bringing local Namibians living with HIV and AIDS to speak in the camp. New IEC materials were developed by the refugees themselves for use in the camp, in local languages and using culturally appropriate messaging. These materials also formed part of the information package distributed to all returnees prior to departure for Angola.

Women's group In Osiri, Namibia, with HIV awareness materials

xiii) Republic of Congo (RoC)

During the first assessment mission, HIV and AIDS interventions in RoC were found to be minimal. As a result of the remote locations and inaccessibility of refugee settings alongside the Oubangui River, refugee communities were hardly aware of HIV and AIDS. The additional VAR funds were used to develop a community based approach and to strengthen the implementation of universal precautions and support the provision of essential supplies.

Around 80 community members from both the refugee and surrounding populations in the three main refugee locations (Betou, Impfondo, and Loukolela) were trained in "Community Dialogue on HIV". The training aimed at empowering community members to organise a community based HIV and AIDS response with limited resources. Women and young people were actively involved in this initiative. To support the initiative, awareness materials were developed and supporting equipment such as videos and TVs were procured.

Health workers received training on universal precautions and the syndromic management of STI. Safe waste disposal sites were developed and sterilisation equipment, safe blood supplies and drugs were purchased.

xiv) Rwanda

HIV and AIDS activities in the refugee camps in Rwanda were strengthened through increased HIV and AIDS awareness sessions in the community using audio visual materiel. The VCT centre in Kiziba camp was rehabilitated to allow refugees to start using these services again.

xv) Sierra Leone

UNHCR supported the health NGO in Largo camp with the institution of universal precautions such as the construction of incinerator and waste management pit. In addition, sterilisers, safe needle boxes, syringes and protective equipment were procured to reduce the risk of occupational transmission. To prevent HIV and reduce the stigma and discrimination, animators started working in community outreach programmes.

xvi) Somalia

The HIV and AIDS programmes in Somalia are coordinated and implemented under the auspices of Somalia Aid Coordination Body (SACB). Under this project, UNHCR funded HIV/AIDS awareness, cultural evenings and advocacy campaigns that brought together religious leaders, local administration, the media and young people. Thousands of Somalis attended the sessions in Somaliland and Puntland. The sessions concentrated on six key messages, namely:

- People who are HIV positive or are living with AIDS should not be isolated from their communities.
- AIDS is not an immediate death sentence
- A couple must talk about STIs and HIV and AIDS
- Counselling and testing is the best way to learn about HIV
- Abstain, be faithful to one partner, or use a condom.
- Female Genital Mutilation increases the risk of contracting HIV

In addition, a palliative care component was funded targeting urban refugees living with AIDS. The objective was to improve their well-being by providing counselling sessions, supplementary food, hygiene packages and access to clinical care. Stigma and discrimination associated with HIV and AIDS in Somalia hinders enrolment of all eligible clients.

To enhance the overall medical care of PLWH/As and their relatives, UNHCR together with the other UN agencies, UNHCR financially supported the African Medical and Research Foundation to train 12 public health workers, including doctors, nurses and a laboratory technician. The training skills and knowledge will enable the introduction of home-based care and a care and treatment programme for persons living with AIDS.

xvii) South Africa

IPs from South Africa were supported to make presentations at regional conferences and to participate in HIV/AIDS technical training courses. Conference presentations served to raise the profile and awareness of refugee issues in the context of HIV and AIDS, and to establish new

partnerships with local HIV/AIDS organisations. One important partnership was developed between the Treatment Action Campaign (TAC), UNHCR and PPASA, which resulted in the translation of TAC information materials into refugee languages and the mobilisation of the extensive TAC volunteer network to advocate on behalf of refugees living with HIV and AIDS. As South African NGOs and IP staff have significant experience and expertise in HIV/AIDS programming, they were also supported to travel to other programmes in the region, providing training and technical advice in refugee camps.

The Refugee Life Skills Programme Manager from PPASA in South Africa was sponsored to attend an intensive course on “Programme Planning for Reproductive Health and HIV/AIDS in Southern Africa”. The four week course, attended by Programme Managers from governments, NGOs and CBOs in the Southern African region, provided practical resources and tools for programme design, monitoring and evaluation. In addition, a staff member of an IP was supported to make a presentation at the 3rd Social Aspects of HIV/AIDS Research Alliance Resource (SAHARA) conference, attended by 350 delegates from 33 countries. The presentation was on the vulnerability of refugee women and children to HIV and AIDS, and the difficulties refugees experience accessing local HIV/AIDS programmes.

The HIV/AIDS Task force in Mwange, Zambia

xviii) Sudan

The additional support in the Sudan Programme focused on strengthening HIV and AIDS awareness, specifically addressing women. In addition, the project supported the construction of two youth centres and the training of peer educators and psycho-social counsellors.

Three training workshops were conducted with technical support from the Ministry of Health. A total of 45 health care workers received training on the syndromic management of STIs, the importance and adherence to universal precautions and the importance of the introduction and interpretation of a health information system.

The assessment of the community based programmes in Showak, by the Sudanese Afhad University for Women, identified lack of psycho-social counselling as a major programmatic weakness. A community-based counselling programme will be established for people with chronic diseases, including PLWH/As and survivors of sexual assaults. An orientation workshop for 15 community health workers was conducted and further training will continue in 2005.

To enhance awareness among adolescents and youth, Plan Parenthood Federation of America – International identified and trained 15 refugee youths and 20 opinion leaders as peer educators, with an equal balance of male and female trainees. Two youth centres are under construction in Um Gargur and Shagarab camps and will be completed in February 2005. The centres will provide recreational activities, health education and vocational training. These are the first youth centres in refugee camps of Eastern Sudan. Pupils from 23 primary schools were invited to participate in essay and drawing competitions on the themes of HIV/AIDS and violence against women. From each school, two students were selected and asked to participate in a poster drawing competition. The three best drawings (one on each theme) will be printed as posters and the awarded essays will be printed and compiled in a booklet and disseminated in the camps in 2005.

During the last quarter of year, the 16 days of activism against violence were launched and the open forum discussions, lectures, video shows were conducted around this year's team: "HIV/AIDS and violence against women". Around 10,000 persons, of which the vast majority were between 16 and 30 years of age, took part in the activities.

xix) Thailand

The Reproductive Health Response in Conflict Consortium organised a five-day course entitled "HIV/AIDS Prevention and Control for Humanitarian Workers" in Bangkok. The course aimed to deepen individual understanding of the complexities of HIV/AIDS and to equip participants with knowledge and skills to improve HIV/AIDS related programme design and implementation. Two UNHCR staff members from Thailand actively participated in the course together with representatives from numerous NGOs and CBOs. HIV and AIDS activities offered to the refugees from Myanmar differ greatly from primarily prevention activities to support and care activities such as antiretroviral therapy and home-based care.

xx) Uganda

In Uganda, funds were used to strengthen the VCT and PMTCT services and improve the monitoring of these programmes. The national HIV/AIDS officers frequently visited the refugee settlements to provide technical support. Sentinel surveillance among pregnant women in two Sudanese camps was begun. Results should be ready by in early 2005.

Seventeen additional VCT/PMTCT counsellors were jointly trained by IPs and the Ugandan Ministry of Health. Two new VCT sites were in opened in Kiryandongo camp. As a result of this intervention, VCT uptake improved. Unfortunately, the VCT services could not be expanded to all sites. Nakivale and Oruchinga camps still depend on irregular mobile VCT services. In Kyaka II settlement, VCT services are planned to expand in 2005.

To demystify HIV and AIDS and reduce discrimination and stigma, the staff working with the five HIV post test clubs received refresher training and IEC materials. Female staff were specifically targeted in this training. To reduce the level of idleness among adolescents and the youth, sports equipment was procured and distributed among youth groups.

xx) Zambia

HIV support was provided to a wide variety of sectors in the Zambia refugee operation in the three Angolan camps in the west as well as the two Congolese refugee camps in the north of the country. IPs working in health, education, and community development received additional funding to build upon HIV and AIDS programmes initiated in 2003. These include VCT, prevention and education programmes targeting in- and out-of-school youth, and home-based care. In addition, clinical services greatly improved through training on universal precautions and infection control, procurement of supplies to ensure universal precautions, training on confidential record management, and improved information management systems. Close collaboration with the UN Population Fund (UNFPA) helped address problems with supply of male condoms for the camps. IPs included District Health Teams, AHA, Aktion Afrika Hilfe, Christian Outreach and Development, and the Zambia Red Cross Society. While the Angolan refugees in the western camps continued to return to Angola throughout the year, it remained unsafe for the majority of Congolese refugees in the northern camps to return. This difference in the phase of the displacement cycle influenced programme design, with more short term interventions implemented in the west and longer term programming continuing in the north. For example, plans were developed together with the national Department of Health and the Centers for Disease Control and Prevention, to conduct sentinel HIV surveillance among pregnant women in the northern camps to establish a baseline against which the impact of HIV and AIDS interventions could be measured over time as well as to assist in programming. In the West, interventions focused more on ensuring a community-wide basic level of understanding of HIV and AIDS prior to return to Angola, and certifying skills and experience gained while in

Zambia so that returnees could contribute to nascent programmes in their communities of origin.

B) Positive Lives Exhibition

The Positive Lives Exhibition features photographs of people living with HIV. It aims to illuminate the positive human response to HIV and AIDS and provides a resource for HIV education, awareness and care. The exhibition was held in Kakuma and Dadaab refugee camps in Kenya. Based on the experiences in Dadaab, a comprehensive tool is being developed to capitalise on the momentum gained during the exhibition and enhance further discussion on HIV and AIDS related issues in the refugee setting. In Somalia, 20 pictures from the exhibition were used to support and facilitate the discussion on HIV and AIDS during training courses in Puntland and Somaliland.

Positive Lives Exhibition in Dadaab refugee camp, Kenya

C) Development of Information, Education and Communication Materials

To strengthen the HIV and AIDS prevention programmes in the field, numerous leaflets, posters, comics and booklets were developed, adapted, translated and distributed in the field. At country level, the IEC materials are used during awareness campaigns, for training of boys and girls as peer educators, and for training of refugee HIV and AIDS committees. Posters are placed in central areas such as health and community centres, market places and food distribution sites.

In South Africa, posters and leaflets were developed in several languages and distributed to all the HIV and AIDS programmes in Africa, including Algeria, Egypt and Yemen. New materials developed, adapted and printed included:

- How can you get HIV/AIDS posters in Spanish and Arabic
- Refugee Health Rights poster
- fliers on How to Talk to your Partner about Condoms in English, French and Portuguese
- Use a Condom flyers in French and English
- Pamphlets in English and French on HIV and AIDS titled Get the Facts Right
- The series Anita & Jaime/ James/ Jacques in French, English and Portuguese
- An Anti Retroviral Treatment sheet in French
- The *Famos Falar de SIDA* leaflet in Portuguese
- The *leaflet Previna se na DTS* in Portuguese.

In addition, materials developed previously were reprinted in several countries and sent to the field.

Six thousand posters entitled *"How can you get HIV/AIDS?"* were sent to countries in Central and East Africa in English and French. At the end of the year, 4500 copies of the same poster in Somali and Kiswahili were duplicated and distributed to the field. In August and September, adolescents and youths

in Dadaab camps in Kenya were engaged in HIV and AIDS awareness campaigns. They drew pictures and wrote short stories about HIV and AIDS; the outcomes were used to support the development of a brochure on HIV and AIDS in the Somali language. An overview of IEC materials developed by UNHCR and its IPs is available on UNHCR's HIV and AIDS website: *www.unhcr/hiv-aids.ch*.

D) Documentary on Refugee Participation in Fight against HIV and AIDS

In Kanembwa refugee camp in Tanzania, a documentary on living positively with HIV was created. The documentary follows the life of the first refugee in Tanzania who disclosed his positive HIV status. The documentary explores both the positive and negative community responses and the initiatives that the refugee community took over the years to fight and combat the stigma surrounding HIV and AIDS, as well as the prevention and awareness activities undertaken by the refugee community to combat the HIV epidemic. The documentary was made with the active participation of the refugee community.

On World AIDS Day, December 1, 2004, the documentary was first aired in the Kibondo refugee camps, followed by active discussions and festivities; it was broadcast on the national Tanzanian television station the same evening. The documentary is available in DVD and VHS formats in Swahili and Kirundi with a choice of French and English subtitles. It will be used for awareness raising activities in other refugee programmes. A website has been developed and information can be found on *www.stop-sida.org*.

E) HIV Awareness Packages for Returnees

HIV awareness packages for returnees were provided upon departure from the Democratic Republic of Congo and Namibia to Angola. These packages consisted of STI and HIV awareness messages together with condoms.

In Burundi, UNHCR and UNFPA developed HIV awareness packages for the returnees arriving from Tanzania at the entry points in Burundi. The packages consist of leaflets with STI and HIV awareness messages as well as condoms.

F) Condoms

UNHCR promotes a mixture of the ABC – Abstinence, Be faithful and Condoms – approach. Regarding condoms, many country programmes faced interrupted supplies. In West Africa, close links were established with the West Africa Regional Programme of USAID. Male condom supply for Cote d' Ivoire, Ghana, Guinea and Sierra Leone has been secured for 2005 through this collaboration.

In addition, the UNFPA Humanitarian Response Unit agreed to support the provision of both male and female condoms to refugee camps worldwide for the following two years (2005 and 2006).

G) Post Exposure Prophylaxis (PEP)

In December 2003, UNHCR, the International Rescue Committee and UNFPA started a pilot programme for the provision of PEP within the existing sexual and gender-based violence programme in Kibondo, Tanzania. An intern undertook a thorough evaluation of the intervention (Annex 6). The community response to PEP has been overwhelming positive and an increase in the number of rape survivors reporting to the clinic was observed. Based on this experience, UNFPA is funding an expansion of the PEP programme to the remaining refugee camps in Tanzania as well as the refugee programmes in Kenya and Uganda in 2005. Funds have been solicited through UNAIDS for the expansion of PEP in West Africa in 2005.

H) World AIDS DAY

In South Africa, a competition was organised for graphic design students to develop the logo for UNHCR for the 2005 World AIDS Day. The winning design was shared with UNHCR programmes worldwide. Stickers and T-shirts featuring the design were printed in many languages, including Arabic, English, French and Nepali. In the field, World AIDS Day was commemorated in conjunction with the 16 days of activism against violence. Many activities were organised for and by refugees in numerous countries. In Geneva, UNHCR joined UNAIDS and other cosponsors for a two hour commemoration around the theme: “women, girls, HIV and AIDS”.

Fighting HIV with refugees – World Aids Day Sticker

5) UNHCR’s HIV/AIDS Unit and Country Support and Missions

Four HIV/AIDS Regional Coordinators continued working in Africa. They are based in Pretoria since January 2003, in Nairobi since April 2003, in Kinshasa since October 2003, and in Accra since June 2004. In Geneva, the Senior HIV/AIDS Technical Officer, seconded from the Centers of Disease Control and Prevention and the HIV/AIDS Technical/Programme Officer continued their work.

The HIV/AIDS Regional Coordinators and the Technical Officers from Geneva undertook a number of missions to the field. In addition, the HIV/AIDS Regional Coordinators for Central and East and Horn of Africa undertook several assessment missions to the countries involved in the Great Lakes Initiative on AIDS (GLIA). During these missions, detailed work plans for the implementation of HIV/AIDS activities for the next four years were developed. In addition technical support was provided to other countries in the respective regions.

The assessment and monitoring missions to the field provided a clear picture of the current situation and enabled further planning for programme activities in 2004 and 2005. The missions reports are included in the annexes in date order: Annex 7 (Sudan), Annex 8 (Zambia), Annex 9 (Rwanda and Burundi), Annex 10 (Angola), Annex 11 (Katanga, DRC), Annex 12 (Sierra Leone), Annex 13 (Liberia), Annex 14 (Malawi), Annex 15 (Equator Province, DRC), Annex 16 (Cote d' Ivoire), Annex 17 (Namibia), Annex 18 (Guinea), Annex 19 (Yemen), Annex 20 (Ghana), Annex 21 (Mozambique), Annex 22 (Republic of Congo), Annex 23 (Liberia and Sierra Leone) and Annex 24 (Zambia). Furthermore, the HIV unit provided technical support and funding to numerous other countries in Africa, Asia, and Eastern Europe without undertaking field visits.

An HIV/AIDS unit meeting was organised in Nairobi (June 2004) with nearly all of the HIV/AIDS Regional coordinators and Technical Officers from Geneva. During the meeting, the key issues of HIV/AIDS coordination, programme implementation, surveillance, and monitoring and evaluation were discussed (Annex 25). During the annual Health-Nutrition-HIV Coordinators meeting of (Addis Ababa, September 2004) programming issues in the area of HIV prevention, protection and care and treatment were discussed in detail with the broader audience of participants (Annex 26).

6) Protection

Through regular field missions and increased awareness of the issue by UNHCR staff, the HIV/AIDS Regional Coordinators and other UNHCR staff uncovered an increasing amount of human rights violations in relation to HIV, AIDS and refugees. These ranged from breach of confidentiality in the VCT process to detention of asylum seekers who tested positive for HIV at an entry screening, to mandatory testing and isolation of refugees seeking medical treatment who tested positive for HIV. With the support of the HIV/AIDS Technical Unit in Geneva, the HIV/AIDS Regional Coordinators assisted country offices to challenge such practices and in a number of cases, remedial action ensued. Unfortunately, not all instances were rectified and similar practices continued in a number of countries; continuous lobbying and advocacy efforts are still required at all levels.

UNHCR initiated discussions with the countries regarding resettlement and VCT to improve pre- and post-test counselling, as well as ensure that proper procedures are followed for disclosure of HIV status, and that appropriate linkages exist between VCT, support and referral services.

Stigma and discrimination against refugees living with HIV and AIDS continued within refugee communities, as well as the misperception among host communities that refugees were “bringing HIV”. Similar myths regarding returnees persisted in communities of return, such as in Angola. UNHCR and implementing partners supported a number of efforts to decrease such attitudes through providing basic HIV and AIDS information in refugee communities, promoting exchanges with host communities, including cooperation with local support groups of people living with HIV and AIDS, and working with local government in areas of return to promote acceptance and support for returnees.

Training courses for protection staff

In order to build the training capacity for protection staff, the HIV/AIDS Regional Coordinators provided training for UNHCR and IP staff on HIV/AIDS and refugees in the context of resettlement, voluntary repatriation and local integration. For example, specific training on HIV and AIDS was integrated into the distance Protection Learning Programme; a consultation session on HIV, AIDS and resettlement was held at regional Strategic Planning Meetings on Resettlement in Accra and Nairobi; and in many countries, HIV/AIDS was a strategic topic for 2006 Country Operations Planning meetings. In addition, the HIV/AIDS Technical Unit and Regional Technical Officers contributed regularly to the development of appropriate policies for UNHCR to standardise protection approaches to HIV and AIDS, including input to the Africa Protection Directions paper, the Resettlement Handbook, instructions for Country Operations Planning, the Annual Protection Report, and the Programme Manual (Annex 2). As UNHCR staff, particularly protection staff, became more familiar with protection concerns specific to HIV and AIDS, they were increasingly able to identify and appropriately respond to such issues.

7) Surveillance and Programmatic Research

A) Sentinel Surveillance

Sentinel Surveillance among pregnant women was undertaken in two Sudanese camps in Uganda as well as in Kakuma refugee camp, Kenya in collaboration with the Ministry of Health in both countries. Results are not yet published. Furthermore, Sentinel Surveillance among Congolese refugees living in Zambia was agreed upon and will be undertaken in early 2005 in conjunction with the Zambian government and the Centers for Disease Control and Prevention. Under GLIA, Sentinel Surveillance among the refugees and surrounding populations will be undertaken in 2005/06.

B) Behavioural Surveillance Surveys (BSS)

Under GLIA, with the support of the World Bank, a standard HIV BSS tool has been modified from traditional tools to include displacement and post-displacement/interaction components for both refugee and surrounding communities. The BSS are undertaken simultaneously or serially among both populations. Pilot BSS were carried out among refugees and surrounding host communities in Kibuye, Rwanda and Kakuma, Kenya. The tool will be finalised in 2005 and a manual written on how to undertaken, analyse and report on BSS in refugee and surrounding communities. Systematic BSS among refugee and surrounding populations using this tool will be undertaken in 2005 and 2006.

C) Programmatic Research

The HIV/AIDS, Food and Nutrition Programmatic Research implemented in 2003 resulted in the publication of a booklet: *Integration of HIV/AIDS activities with food and nutrition support in refugee settings: specific programme strategies.* (Annex 25). This document provides practical guidance for the UN and their partners as well as other organisations working with populations affected by an emergency. The 20 key strategies advocated in this booklet are listed in the table below.

The HIV unit published numerous articles in 2004 relating to HIV among conflict-affected and displaced populations (annexes 28 - 32).

INCORPORATING HIV AND AIDS-RELATED ACTIVITIES INTO FOOD AND NUTRITION PROGRAMS IN REFUGEE SETTINGS

Incorporating HIV/AIDS prevention into food and nutrition programs

- **Strategy 1** Incorporation into a general food distribution of activities designed to promote community engagement and action around HIV/AIDS prevention
- **Strategy 2** Incorporation of HIV/AIDS awareness and prevention activities into a supplementary feeding programme
- **Strategy 3** Incorporation of HIV/AIDS awareness and prevention activities into a therapeutic feeding programme
- **Strategy 4** Incorporation into a school feeding programme of activities designed to promote knowledge/engagement around HIV/AIDS among young people

Incorporating care and support for HIV/AIDS-affected, vulnerable groups into food and nutrition programs

- **Strategy 5** Modification of a general food distribution programme to better meet the needs of people affected by HIV/AIDS
- **Strategy 6** Modification of a supplementary feeding programme to better meet the needs of population subgroups affected by HIV/AIDS
- **Strategy 7** Support for HIV/AIDS-affected families and children through a school feeding programme
- **Strategy 8** Support for HIV/AIDS-affected families and children through provision of a complementary ration to foster families and orphanages
- **Strategy 9** Support for the establishment of home gardens and agricultural plots for PLWHA and HIV/AIDS- affected families
- **Strategy 10** Support for income-generating activities, microcredit and community banking, training and other capacity-building activities for PLWHA and HIV/AIDS-affected families
- **Strategy 11** Support for food-for-work (FFW) projects that employ or directly assist PLWHA and HIV/AIDS-affected families
- **Strategy 12** Support to enable and encourage participation by HIV-infected individuals in community groups formed by PLWHA

INCORPORATING FOOD AND NUTRITION ACTIVITIES INTO HIV AND AIDS PROGRAMS IN REFUGEE SETTINGS

Incorporating food and nutrition support into health care and treatment services for people living with HIV/AIDS

- **Strategy 13** Establishment of an inpatient hospital/clinic feeding programme with nutrition education
- **Strategy 14** Establishment of a hospital/clinic demonstration garden with nutrition education
- **Strategy 15** Integration of a supplementary ration and nutrition education into a home-based care programme
- **Strategy 16** Integration of a supplementary ration and nutrition education into an antiretroviral therapy programme

Incorporating food and nutrition resources to support training and capacity-building activities for clinic-based and community-based HIV/AIDS care providers, or support the establishment or continuation of community-level HIV/AIDS-related activities

- **Strategy 17** Support for training and other capacity-building activities for formal and traditional health care providers
- **Strategy 18** Support for training and other capacity-building activities for community resource persons who can play a vital role in HIV/AIDS prevention efforts
- **Strategy 19** Support to community health volunteers engaged in HIV/AIDS prevention or caring for PLWHA and HIV/AIDS-affected families
- **Strategy 20** Support to community awareness and mobilization activities of PLWHA

8) Inter Agency Collaboration

A) Inter Agency Advisory Group (IAAG) on AIDS

In February 2004, UNHCR hosted and chaired the IAAG. The theme was HIV and AIDS among conflict-affected and displaced populations. The meeting was officially opened by the High Commissioner for Refugees. During the meeting the importance of addressing HIV and AIDS and it's consequences for refugees and other persons of concern to UNHCR was stressed. The HIV/AIDS in the UN workplace was discussed and a presentation was made with the launch of the learning strategy on HIV/AIDS. The UNHCR paper and the report of the meeting are attached in Annex 33 and Annex 34.

B) Inter Agency Standing Committee (IASC) Reference Group on HIV/AIDS in Emergency Settings:

UNHCR continued to be an active member of the IASC Reference Group for HIV/AIDS and supported the distribution and implementation of the IASC guidelines for HIV/AIDS interventions in emergency settings (Annex 4 and 5). UNHCR was actively involved in the development of the training package that will increase HIV awareness and provide tools for persons in emergency settings. The training package focuses on training of and awareness raising among representatives, programme officers, as well as field, protection and IP staff on the importance of including HIV/AIDS as of the onset of the emergency (Annex 35).

C) Great Lakes Initiative on AIDS (GLIA):

UNHCR, UNAIDS Secretariat, the World Bank and the six GLIA countries (Burundi, Democratic Republic of Congo, Kenya, Rwanda, Tanzania and Uganda) continued to work closely on the GLIA. HIV VAR funds contributed to facilitate assessment missions in the respective countries, the development of detailed plans of implementation for the respective sites, and the undertaking of BSS in Rwanda and Kenya. In Geneva, the Technical Officers with strong support from the Legal and Programme Support Sections finalised the memorandum of understanding and the contract between the GLIA Secretariat and UNHCR; the former is expected to be signed in early 2005.

D) Initiative de Pays Riverains des Fleuves Congo, Oubangui et Chari (IFCOC):

UNHCR, DRC and RoC were involved in the establishment of the sub regional HIV/AIDS IFCOC initiative funded by the African Development Bank-funded to be implemented in CAR, Chad, DRC and RoC. Refugee sites in RoC and return areas in DRC are among the selected sites for IFCOC implementation which is scheduled to begin in 2005.

E) DRC's World Bank Multi-Country AIDS Project (MAP):

UNHCR in DRC successfully advocated in favour of the inclusion of refugees in the World Bank funded HIV/AIDS project in DRC (MAP). In 2004, UNHCR submitted a proposal and action plan that were accepted by DRC's National AIDS Control programme and supported by the World Bank. UNHCR in DRC will receive funding for five years to develop and implement multisectoral HIV and AIDS projects among refugees, surrounding populations and internally displaced persons present in UNHCR programme areas.

F) Mano River Union (MRU) AIDS Initiative:

Contacts began with the Regional Support Team Director for UNAIDS in West Africa to establish closer links between UNHCR and the MRU Initiative. A conference call was held among the director of the MRU, UNFP, UNAIDS and the African Development Bank to lay the ground work for improved communication and coordination.

G) UNFPA:

Collaboration with UNFPA focused on the PEP pilot programme in Tanzania, the provision of condoms in Africa, the development of HIV awareness packages in Burundi, and the touring of the Positive Lives Exhibition.

H) WFP and UNICEF

The joint UNHCR, WFP and UNICEF HIV/AIDS, Food and Nutrition programmatic research was finalised with the publication of the guidelines to improve HIV/AIDS interventions through food and nutrition interventions in refugee settings. UNHCR received additional earmarked funding from the US

Government to begin implementing the interventions. This will commence in two countries in 2005.

I) WHO

Together with WHO and UNFPA, the UNHCR HIV/AIDS unit worked on the update of the clinical guidelines for rape survivors (Annex 36- English and 37- French). The guidelines include a separate section on the provision of PEP to rape survivors. Feedback and experiences from the field have been included in this revised version. The document is available in both English and French.

Integration of HIV awareness – Sport activities and HIV awareness in Dadaab

9. UNAIDS Cosponsor

UNHCR became UNAIDS' 10th cosponsor on 24 June 2004; thus joining ILO, UNDP, UNESCO, UNFPA, UNICEF, UNODC, World Bank, WFP and WHO in the concerted effort to fight HIV (Annex 38). By becoming a cosponsor, UNHCR has been able to advocate more effectively for including and integrating refugees into host countries' HIV and AIDS strategic plans, policies

and programmes. This will complement UNHCR protection efforts and also contribute to reducing HIV stigma of and discrimination towards refugees. In addition, UNHCR benefits from the UNAIDS technical expertise and improved communication and coordination on HIV and AIDS initiatives.

At **country level**, UNHCR has become increasingly involved in UNAIDS-related activities. In **Egypt**, the UNHCR country office received funding through a joint UNAIDS proposal to the OPEC-fund to improve refugees' access to services similar to those provided to Egyptian nationals. In **Nigeria**, UNHCR also received funding from UNAIDS for the implementation of prevention activities among asylum seekers. In **Indonesia**, a UNAIDS workshop on HIV/AIDS and Narcotics took place, at which the UNHCR Representative gave a speech to highlight the special needs of refugees. In addition UNAIDS supported HIV training for asylum seekers in Indonesia. In **Pakistan**, a memorandum of understanding was signed between UNHCR and the other UNAIDS cosponsors to provide funding to support the recruitment of a national HIV programme officer for three years. In **Kyrgyzstan**, a UNV was recruited through contributions from UN agencies and joint UNHCR and UNAIDS HIV programme assessments took place in Indonesia (Annex 3) and Yemen (Annex 19).

10. 15th International AIDS conference in Bangkok

The Senior Technical Officer and two HIV/AIDS Regional Coordinators participated in the 15th International AIDS Conference in Bangkok. Together with other agencies, UNHCR co-organised a satellite session on HIV and mobile populations (Annex 39). In addition, UNHCR had accepted 11 abstracts and two posters for the conference on specific refugee, conflict and HIV- related topics (Annex 40).

11. Interns

The HIV/AIDS unit has been working with four interns from Colombia University and the London School of Hygiene and Tropical Medicine. They were placed in Uganda to support the programme with the development of standardised VCT data collection; in Dadaab refugee camp, Kenya to support the development of HIV and AIDS programmes; in Kibondo, Tanzania for the evaluation of the introduction of PEP; and in Opungo, Republic of Congo to support and enhance the HIV and AIDS programmes.

12. Consultants

Three short-term external consultants supported the refugee and HIV/AIDS programmes in UNHCR in 2004. An initial assessment of the feasibility of submitting a joint proposal for East Africa to Global Fund on AIDS, Tuberculosis and Malaria was undertaken. The HCR consultant supported UNHCR with the collection of HIV-related baseline data and information.

With support from UNAIDS, a consultant began writing on a joint UNHCR-UNAIDS policy brief on HIV/AIDS policies and programming in refugee settings. The document will be finalised in 2005. A third consultant worked on a joint UNHCR-WFP-UNICR-UNAIDS Best Practice publication of programme strategies for integration of HIV and AIDS, food and nutrition activities in refugee settings. This document will also be finalised in 2005.

13. Plans for 2005

UNHCR will begin the implementation of its strategic plan for 2005-2007 which provides a very detailed overview of planned activities (Annexes 41- English and 42- French). The 10 main objectives of the plan are:

1) **Protection** - to ensure that refugees, asylum-seekers and other persons of concern who are affected by HIV and AIDS can live in dignity, free from discrimination, and that their human rights are respected, including their non-discriminatory enjoyment of the highest attainable standard of physical and mental health;
2) **Coordination and Mainstreaming** - to ensure that HIV policies and interventions for refugees are coordinated, mainstreamed and integrated with those at the international, regional, sub-regional, country and organisational levels;
3) **Durable Solutions** - to develop and incorporate HIV policies and interventions into UNHCR's programmes for durable solutions, including voluntary repatriation, local integration and resettlement, in order to mitigate the long-term effects of HIV;
4) **Advocacy** - to advocate for HIV-related protection, policy and programme integration, and sub-regional initiatives for refugees and other persons of concern in a consistent and sustained manner at all levels;
5) **Quality HIV Programming** - to ensure appropriate, integrated HIV interventions for refugees, returnees and other persons of concern, in concert with national programmes in host countries and countries of return;
6) **Prevention** - to reduce HIV transmission and HIV morbidity through the implementation of culturally and linguistically appropriate health and community-based interventions;
7) **Support, Care and Treatment** - to reduce HIV morbidity and mortality; this includes access to antiretroviral therapy when available to surrounding host populations when appropriate;
8) **Assessment, Surveillance, Monitoring and Evaluation** - to improve programme implementation and evaluation;
9) **Training and Capacity Building** - to improve HIV-related skills and capacities of UNHCR, its partners and refugees; and,
10) **Resource Mobilisation** - to increase funds and move beyond traditional donors to ensure the objectives stated in this Strategic Plan are achieved.

III) Country HIV Data

[1] baseline in sub-Saharan Africa for non-emergency is 0.5 deaths/10,000/day
[2] 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 counseled on MTCT an offered voluntary test/# women who had 1st ANC visit =%
[6] # women who counseled on MTCT, offered voluntary test during 1st ANC visit and accepted test /# women who had 1st ANC visit, were counseled on MTCT and offered voluntary test =%
SNP=service not provided; NR = not reported; RI = reported incorrectly; NA = not applicable

	Ethiopia	Ethiopia	Ethiopia	Ethiopia	Ethiopia	Ethiopia	Ethiopia	Kenya	Kenya	Sudan
	Shimbela	Bonga	Dimma	Fugnido	Kebribeyah	Sherkole	Yarenja	Dadaab	Kakuma	all camps
										7 sites
Total population	7,331	18,773	19,252	31,976	10,324	15,999	4,599	138,618	86,167	83,909
Mortality Rates (MR)										
Crude MR (deaths/10,000/day)[1]	0.28	0.32	0.04	0.05	0.12	0.21	0.21	0.35	0.32	NR
<5 yrs MR (deaths/10,000/day)[2]	0.94	0.58	RI	RI	0.21	0.48	0.36	0.73	0.72	NR
Universal precautions										
sufficient[3] needles / syringes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No
sufficient[3] gloves	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No
blood transfusion screened for HIV	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
STI data										
No of condoms distributed[4]	0.3	0.01	0.6	0.1	0.02	0.02	0.02	0.4	RI	NR
sufficient[3] condoms	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No
sufficient[3] STI drugs	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No
STI syndromic approach	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
incidence male urethral discharge (new cases/1000 males/month)	73.00	69.00	37.00	52.00	35.00	2.00	75.00	RI	RI	72.00
incidence genital ulcer disease (new cases/1000 persons/month)	1.00	46.00	3.00	6.00	13.00	1.00	13.00	Ri	RI	2.00
% syphilis pregnant women 1st visit ANC	SNP	SNP	22.7%	SNP	SNP	2.2%	0.5%	1.4%	3.3%	SNP
VCT										
Access to VCT	No	No	Yes	No	No	No	No	Yes	Yes	No
PMTCT										
Access to PMTCT	No	No	No	No	No	No	No	No	Yes	No
# persons pre test counselling	NA	NA	NA	NA	NA	NA	NA	NA	NR	NA
% PMTCT uptake # 1[5]	NA	NA	NA	NA	NA	NA	NA	NA	NR	NA
% PMTCT uptake # 2[6]	NA	NA	NA	NA	NA	NA	NA	NA	NR	NA
% HIV prevalence of PMTCT clients	NA	NA	NA	NA	NA	NA	NA	NA	1.6%	NA
Sentinel surveillance among pregnant women	SNP	SNP	in 2005	in 2005	SNP	in 2005	SNP	0.6% in 2003	5.0% in 2002	4.1% in 2002
Latest HIV or RH BSS/KAPB	SNP	SNP	SNP	SNP	SNP	SNP	SNP	SNP	Jan-05	Nov-02

	Tanzania	Tanzania	Tanzania	Tanzania	Tanzania	Tanzania	Tanzania	Tanzania	Tanzania
	Nyaragusu	Lugufu	Mtabila and Muyovosi	Lukole A/B	Mkwugwa	Kanembwa	Karago	Nduta	Mtendeli
Total population	61,387	94,050	93,734	81,688	1,857	15,860	6,875	33,912	30,907
Mortality Rates (MR)									
Crude MR (deaths/10,000/day)[1]	0.39	0.39	0.73	0.30	0.21	0.30	0.30	0.31	0.23
<5 yrs MR (deaths/10,000/day)[2]	1.09	1.37	RI	0.80	0.43	0.64	0.40	1.25	0.50
Universal precautions									
sufficient[3] needles / syringes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
sufficient[3] gloves	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
blood transfusion screened for HIV	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
STI data									
No of condoms distributed[4]	0.004	0.01	0.31	0.60	0.32	0.04	0.2	0.03	0.03
sufficient[3] condoms	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes
sufficient[3] STI drugs	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
STI syndromic approach	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
incidence male urethral discharge (new cases/1000 males/month)	228	RI	91	RI	NR	NR	NR	NR	NR
incidence genital ulcer disease (new cases/1000 persons/month)	215	RI	63	RI	NR	NR	NR	NR	NR
% syphilis pregnant women 1st visit ANC	8.2%	2.2%	12.3%	1.6%	3.7%	2.0%	0.9%	0.5%	1.1%
VCT									
Access to VCT	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
PMTCT									
Access to PMTCT	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
# persons pre test counselling	2,896	4,565	4,349	4,534	325	612	623	1,632	1,408
% PMTCT uptake # 1[5]	100%	98.2%	99.8%	98.8%	49.8%	100%	100%	95%	100%
% PMTCT uptake # 2[6]	89.6%	100%	99.8%	100%	100%	100%	100%	100%	100%
% HIV prevalence of PMTCT clients	1.2%	1.3%	1.4%	1.7%	0.0%	1.0%	1.0%	1.2%	0.7%
Sentinel surveillance among pregnant women	2.5% in 2002		Invalidated	1.6% in 2002	1.6% in 2002				
Latest HIV or RH BSS/KAPB	Jun-05	SNP	Oct-00	1998	SNP	SNP	Jan-02	SNP	Jul-01

	Uganda	Uganda	Uganda	Uganda	Uganda	Uganda	Uganda	Uganda	Namibia	Zambia	Zambia	Zambia
	Madi Okollo	Palorinya Moyo	Arua	Nakivale	Kyangwali	Ikafe	Kiryandongo	Oruchinga	Osire	Nangweshi	Mwange	Mayuk-wayaukwa
Total population	7,464	35,964	49,050	15,789	18,128	9,719	15,466	4,205	11,286	20,809	24,145	7,227
Mortality Rates (MR)												
Crude MR (deaths/10,000/day)[1]	0.03	0.18	0.10	0.40	0,20	0.14	0.08	0.35	0.50	0.30	0.10	0.19
<5 yrs MR (deaths/10,000/day)[2]	0.15	0.46	0.32	0.53	0.68	0.44	0.08	0.51	1.60	0.86	0.20	0.30
Universal precautions												
sufficient[3] needles / syringes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes
sufficient[3] gloves	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes
blood transfusion screened for HIV	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
STI data												
No of condoms distributed[4]	0.1	0.2	0.2	0.3	NR	NR	1.4	0.7	4.0	0.5	0.1	0.7
sufficient[3] condoms	No	Yes	No	No	No	No	Yes	No	Yes	Yes	Yes	Yes
sufficient[3] STI drugs	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes
STI syndromic approach	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
incidence male urethral discharge (new cases/1000 males/month)	23.0	0.6	8.4	11.0	6.1	2.0	2.3	10.0	0.5	0.4	0.4	4.5
incidence genital ulcer disease (new cases/1000 persons/month)	NR	0.8	5.8	8.0	1.4	1.0	2.1	7.0	0.4	0.6	0.3	3.9
% syphilis pregnant women 1st visit ANC	SNP	15.3%	21.9%	7.0%	1.5%	0.i6%	1.6%	5.0%	2.3%	NR	5.7%	NR
VCT												
Access to VCT	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	No
PMTCT												
Access to PMTCT	No	Yes	No	No	Yes	No	No	No	No	No	No	No
# persons pre test counselling	NA	91	NA	NA	400	N/A	NA	NA	NA	NA	NA	NA
% PMTCT uptake # 1[5]	NA	100%	NA	NA	99	NA	NA	NA	NA	NA	NA	NA
% PMTCT uptake # 2[6]	NA	100%	NA	NA	100	NA	NA	NA	NA	NA	NA	NA
% HIV prevalence of PMTCT clients	NA	1.1%	NA	NA	6%	NA	NA	NA	NA	NA	NA	NA
Sentinel surveillance among pregnant women	SNP	2004/05; data pending	SNP	SNP	2004/05; data pending	SNP	SNP	SNP	SNP	SNP	in 2005 (and Kala camp)	SNP
Latest HIV or RH BSS/KAPB	SNP	2001	SNP	Sep-01	SNP	SNP	SNP	Jun-02	SNP	May-03	SNP	May-03

	Ghana	Guinea	Guinea	Guinea	Guinea	Guinea	Guinea	Guinea	Liberia
	Bududuram	Telikoro	Kountaya	Borea	Nonah	Kola	Kouankan	Laine	
Total population	1,990	6,055	9,747	4,320	3,904	6,286	1,908	1,578	1,983
Mortality Rates (MR)									
Crude MR (deaths/10,000/day)[1]	0.17	0.17	0.80	0.37	0.50	0.30	0.20	0.20	RI
<5 yrs MR (deaths/10,000/day)[2]	0.35	0.41	RI	1.24	RI	RI	0.30	RI	RI
Universal precautions									
sufficient[3] needles / syringes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
sufficient[3] gloves	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
blood transfusion screened for HIV	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
STI data									
No of condoms distributed[4]	0.55	RI	RI	RI	RI	RI	RI	RI	NR
sufficient[3] condoms	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
sufficient[3] STI drugs	Yes	No	No	No	Yes	Yes	Yes	Yes	Yes
STI syndromic approach	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	
incidence male urethral discharge (new cases/1000 males/month)	3.1	7.7	11.7	3.1	12.5	36.0	20.0	21.0	NR
incidence genital ulcer disease (new cases/1000 persons/month)	NR	3.6	4.7	9.9	9.3	10.0	13.5	11.3	NR
% syphilis pregnant women 1st visit ANC	SNP	24%	20%	15%	SNP	SNP	18%	SNP	NR
VCT									
Access to VCT	Yes	No	No	No	No	No	No	No	No
PMTCT									
Access to PMTCT	In capital	No	No	No	No	No	No	No	No
# persons pre test counselling	NR	NA	NA	NA	NA	NA	NA	NA	NA
% PMTCT uptake # 1[5]	NR	NA	NA	NA	NA	NA	NA	NA	NA
% PMTCT uptake # 2[6]	NR	NA	NA	NA	NA	NA	NA	NA	NA
% HIV prevalence of PMTCT clients	NR	NA	NA	NA	NA	NA	NA	NA	NA
Sentinel surveillance among pregnant women	SNP	SNP	SNP	SNP	SNP	SNP	SNP	SNP	SNP
Latest HIV or RH BSS/KAPB	SNP	SNP	SNP	SNP	SNP	SNP	SNP	SNP	SNP

	Sierra Leone	Sierra Leone	Sierra Leone	Sierra Leone	Sierra Leone	Sierra Leone	Sierra Leone	Sierra Leone
	Taima	Gondama	Bandajuma	Jimmi Bagbo	Gerihun	Jembe	Tobanda	Largo
Total population	5,803	7,952	4,618	5,615	5,780	6,587	7,656	7,056
Mortality Rates (MR)								
Crude MR (deaths/10,000/day)[1]	0.10	0.30	0.10	0.30	0.20	0.30	0.10	0.10
<5 yrs MR (deaths/10,000/day)[2]	0.20	0.40	0.20	0.40	0.20	0.40	0.1	0.6
Universal precautions								
sufficient[3] needles / syringes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
sufficient[3] gloves	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
blood transfusion screened for HIV	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
STI data								
No of condoms distributed[4]	RI	0.39	0.59	0.49	0.45	0.51	0.53	0.58
sufficient[3] condoms	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
sufficient[3] STI drugs	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
STI syndromic approach	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
incidence male urethral discharge (new cases/1000 males/month)	NR	NR	NR	NR	NR	NR	NR	NR
incidence genital ulcer disease (new cases/1000 persons/month)	NR	NR	NR	NR	NR	NR	NR	NR
% syphilis pregnant women 1st visit ANC	NR	SNP	SNP	SNP	SNP	SNP	SNP	SNP
VCT								
Access to VCT	No	No	No	No	No	No	No	No
PMTCT								
Access to PMTCT	No	No	No	No	No	No	No	No
# persons pre test counselling	NA	NA	NA	NA	NA	NA	NA	NA
% PMTCT uptake # 1[5]	NA	NA	NA	NA	NA	NA	NA	NA
% PMTCT uptake # 2[6]	NA	NA	NA	NA	NA	NA	NA	NA
% HIV prevalence of PMTCT clients	NA	NA	NA	NA	NA	NA	NA	NA
Sentinel surveillance among pregnant women	SNP	SNP	SNP	SNP	SNP	SNP	SNP	SNP
Latest HIV or RH BSS/KAPB	SNP	SNP	SNP	SNP	SNP	SNP	SNP	SNP

	Burundi	DRC	DRC	DRC	DRC	DRC	DRC	ROC	ROC	ROC	Rwanda	Rwanda
	Gasarowe	Aru (4sites)	Kahemba	Kisenge	Nkondo	Kileuka	Kinvula	Zone de Loukolela	Zone de Impfondo	zone Betou	Kiziba	Gihembe
Total population	5,670	10,534	6,020	15,915	2,444	2,533	6,481	6,074	34,100	17,560	17,627	19,983
Mortality Rates (MR)												
Crude MR (deaths/10,000/day)[1]	0.11	0.61	0.09	0.08	0.09	0.21	0.14	0.15	0.09	0.31	0.08	0.33
<5 yrs MR (deaths/10,000/day)[2]	NR	RI	0.29	0.24	0.19	0.62	NR	0.34	0.26	0.90	0.14	0.60
Universal precautions												
sufficient[3] needles / syringes	No	No	Yes	No	No	Yes	No	No	no	no	No	No
sufficient[3] gloves	No	No	Yes	No	No	Yes	No	No	no	no	No	No
blood transfusion screened for HIV	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
STI data												
No of condoms distributed[4]	0.83	0.26	0.76	0.25	0.26	0.4	0.07	1.18	0.58	NR	0.2	RI
sufficient[3] condoms	No	No	No	No	No	Yes	No	No	No	No	Yes	Yes
sufficient[3] STI drugs	No	No	Yes	No	No	Yes	No	No	No	No	No	No
STI syndromic approach	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes
incidence male urethral discharge (new cases/1000 males/month)	2.4	15.1	1.4	8.0	1.5	0.3	3.9	NR	1.1	NR	0.7	9.0
incidence genital ulcer disease (new cases/1000 persons/month)	NR	0.7	0.2	0.6	0.0	1.5	4.2	NR	NR	NR	0.2	7.0
% syphilis pregnant women 1st visit ANC	NR	10.2%	SNP	SNP	SNP0	11.8%	SNP	SNP	SNP	SNP	NR	0.8%
VCT												
Access to VCT	Yes	No	No	No	No	No	No	No	No	No	Yes	Yes
PMTCT												
Access to PMTCT	No	No	No	No	No	No	No	No	No	No	No	Yes
# persons pre test counselling	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NR
% PMTCT uptake # 1[5]	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NR
% PMTCT uptake # 2[6]	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NR
% HIV prevalence of PMTCT clients	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NR
Sentinel surveillance among pregnant women	SNP	SNP	SNP	SNP	SNP	SNP	SNP	SNP	SNP	SNP	SNP	1.5% in 2002
Latest HIV or RH BSS/KAPB	SNP	SNP	SNP	SNP	SNP	SNP	SNP	SNP	SNP	SNP	SNP	Nov-04

IV) List of Abbreviations

AHA	Africa Humanitarian Action
AIDS	Acquired Immune Deficiency Syndrome
BSS	Behavioural Surveillance Surveys
DRC	Democratic Republic of Congo
GLIA	Great Lakes Initiative for AIDS
HIV	Human Immunodeficiency Virus
IAAG	Inter Agency Advisory Group
IASC	Inter Agency Standing Committee
IEC	Information, Education and Communication
IFOC	Initiative de Pays Riverains des Fleuves Oubangui, Congo et Chari
ILO	International Labour Organization
IP	Implementing Partner
MRU	Mano River Union Initiative
PEP	Post Exposure Prophylaxis
PLWH/As	People Living with HIV and AIDS
PMTCT	Prevention of Mother to Child Transmission
PPASA	Planned Parenthood Association of South Africa
ROC	Republic of Congo
SACB	Somali Aid Coordination Board
SAHARA	Social Aspects of HIV/AIDS Research Alliance Resource
STI	Sexually Transmitted Infection
TAC	Treatment Action Campaign
UNODC	United Nations Office on Drugs and Crime
UNDP	United Nations Development Programme
UNESCO	United Nations Education Scientific and Cultural Organization
UNFPA	United Nations Population Fund
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
UNV	United Nations Volunteer
VCT	Voluntary Counselling and Testing
WHO	World Health Organization
WFP	World Food Programme

V) Annexes listed on CD Rom

Annex 1. UNHCR Strategic Plan for Refugees and HIV/AIDS, 2002–2004
Annex 2. UNHCR Programme Manual, Chapter four, paragraph 2.5
Annex 3. Mission report UNAIDS / UNHCR Indonesia
Annex 4. IASC guidelines for HIV/AIDS interventions in emergencies
Annex 5. IASC directives concernant les interventions relatives au VIH/SIDA dans les situations d'urgence
Annex 6. Altaras, Robin : Intern report: Introduction of Post Exposure Prophylaxis in Kibondo, Tanzania
Annex 7. Njogu P. HIV/AIDS Assessment Mission in Refugee Camps in El-Showak, Sudan
Annex 8. Bruns L. Monitoring Mission: HIV/AIDS Programmes in Refugee Camps in Zambia
Annex 9. Yiweza DD. Etat des lieux des programmes VIH/SIDA en faveur des réfugiés au Rwanda et au Burundi
Annex 10. Bruns L, Bonelli F. HIV/AIDS Programmes in Returnee Areas in Angola: monitoring and Support Mission
Annex 11. Yiweza DD, Mission VIH SIDA au Katanga (RDC)
Annex 12. Diallo B, Spiegel P. HIV/AIDS and Refugees Mission Report in Sierra Leone
Annex 13. Diallo B, Yiweza DD, Obura E. HIV/AIDS and Refugees Mission Report in Liberia
Annex 14. Bruns L. Monitoring Mission: HIV/AIDS Programmes in Refugee Camps in Malawi
Annex 15. Yiweza DD, et al, Etats des lieux en matière de soins de santé primaires et VIH/SIDA dans la province de l'Equateur
Annex 16. Diallo B. Le programme de lutte contre le SIDA dans les camps de réfugiés en Côte d'Ivoire
Annex 17. Bruns L. Monitoring Mission: HIV/AIDS Programmes in osire Refugee Camp, Namibia
Annex 18. Diallo B. Le programme de lutte contre le SIDA dans les camps de réfugiés en Guinée
Annex 19. Njogu P, Semini I, Mortay I. HIV/AIDS assessment mission In Refugee Camp Setting in Yemen
Annex 20. Diallo B. Assessment of HIV and AIDS Programmes for Refugees in Ghana
Annex 21. Bruns L, Kalala JP. HIV/AIDS and Monitoring Mission: Mozambique
Annex 22. Yiweza DD, Suivi et évaluation des programmes VIH/SIDA en RDC
Annex 23. Diallo B. Follow-up Mission of HIV/AIDS programmes In Liberia and Sierra Leone
Annex 24. Bruns L, Yiweza DD. HIV/AIDS and Monitoring Mission: Zambia
Annex 25. HIV/AIDS Coordination Meeting in Nairobi – Report
Annex 26. Health, Nutrition, HIV coordinators meeting in Addis Ababa - Report
Annex 27. Integration of HIV/AIDS activities with food and nutrition support in refugee settings, specific programme strategies, UNHCR and WFP
Annex 28. UNAIDS. Report on the Global AIDS Epidemic: AIDS and conflict–a growing problem worldwide. Geneva: UNAIDS, 2004: 175-181
Annex 29. Spiegel P, Nankoe A. UNHCR, HIV/AIDS and refugees: lessons learned. *Forced Migration Review* 2004;19:21-23
Annex 30. Spiegel PB. HIV/AIDS among Conflict-affected and Displaced Populations: Dispelling Myths and Taking Action. *Disasters* 2004;28 (3):322-39
Annex 31. Griekspoor A, Spiegel P, Alids W, Harvey P. The health sector gap in the southern Africa crisis in 2002/2003. *Disasters* 2004;28(4):388-404
Annex 32. Connolly MA, Gayer M, Ryan MJ, Salama P, Spiegel P, Heymann DL. Communicable diseases in complex emergencies: impact and challenges. *Lancet* 2004; 364(9449):1974-83

Annex 33. UNHCR Inter Agency Advisory Group on AIDS paper
Annex 34. Report of IAAG 2004 meeting
Annex 35. IASC Training package for HIV/AIDS interventions in Emergencies
Annex 36. Guidelines for Clinical guidelines for Rape survivors, WHO and UNHCR
Annex 37. Gestion clinique des Victimes de Viol, OMS et HCR
Annex 38. UNAIDS statement on UNHCR 10th UNAIDS cosponsor
Annex 39. Report of 15th International AIDS conference in Bangkok
Annex 40. Abstracts and poster presentations 15th Int. AIDS conference in Bangkok
Annex 41. UNHCR Strategic Plan, Refugees and HIV and AIDS 2005-2007
Annex 42. Les Réfugiés, le VIH et le SIDA : Plan Stratégique du HCR pour 2005-2007

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