Refugees, HIV and AIDS:

Fighting HIV and AIDS Together with Refugees

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Report on UNHCR's HIV and AIDS Policies and Programmes for 2005

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1) Acronyms

AIDS	Acquired Immunodeficiency Syndrome
ART	Antiretroviral Therapy
BSS	Behavioural Surveillance Survey
CAR	Central African Republic
DRC	Democratic Republic of Congo
GLIA	Great Lakes Initiatives on AIDS
HBC	Home-Based Care
HIV	Human Immunodeficiency virus
IAAG	Inter-Agency Advisory Group
IASC	Inter-Agency Standing Committee
IEC	Information-Education-Communication
ILO	International Labour Organisation
IP	Implementing Partner
MAP	Multi-Country HIV/AIDS Program for Africa (World Bank)
MCH	Mother and Child Health
MRU	Mano River Union Initiative on AIDS
NACP	National AIDS Control Programme
NSP	National Strategic Plan
OCHA	Office for Coordination of Humanitarian Affairs
PEP	Post-Exposure Prophylaxis
PLWHAs	People Living with HIV and AIDS
PMTCT	Prevention of Mother-to-Child Transmission
ROC	Republic of Congo
STI	Sexually Transmitted Infection
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNESCO	United Nations Scientific and Cultural Organisation
UNFPA	United Funds Population Fund
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
VCT	Voluntary Counselling and Testing
WFP	World Food Program
WHO	World Health Organization

2) Executive Summary

UNHCR's 2005-2007 HIV and Refugees Strategic Plan was released in February 2005. This plan follows the successful implementation of the 2002-2004 strategic plan. The 2005-2007 plan was based on lessons learned during the past three years. It is more comprehensive and integrated than the former, reflecting a more mature HIV and AIDS programme at UNHCR.

In 2005, UNHCR received earmarked HIV funding from a number of donors at the global, regional and country level. In addition to the core UNHCR programmes that constitute the base of the HIV and AIDS programmes, the organisation received and spent approximately 1.5 Million US Dollars on HIV and AIDS programmes in 2005.

UNHCR expanded its HIV and AIDS programmes to Asia; a Senior HIV/AIDS Regional Coordinator in Asia joined four such Coordinators in Africa. Besides providing technical support to numerous countries in their regions, the Regional Coordinators undertook 22 field missions to assess and monitor UNHCR's programmes. Overall, 40 countries worldwide received HIV and AIDS funding and/or technical support; the most important points of these programmes are described for each country in this report.

UNHCR's Liaison Officer for UNAIDS focused on the important work of coordinating and integrating UNHCR's HIV and AIDS programmes with UNAIDS and its cosponsors in 2005. UNHCR fully supported the "Three Ones" principles and was involved in the country and regional consultations on Scaling up Towards Universal Access to HIV Prevention Treatment, Care and Support with the aim of near universal access to treatment by 2010. Furthermore, conflict-affected and displaced populations were included in various cosponsor and UNAIDS' documents (e.g. HIV Prevention Policy to Intensify HIV Prevention and its Action Plan, Consolidated Technical Support Plan and Division of Labour). At the country level, UNHCR expanded its close collaboration in UNAIDS-related activities in numerous countries.

Inter-agency cooperation expanded in 2005. UNHCR was an active partner in the recently developed United Nations System-Wide Work Programme on HIV/AIDS in Populations of Humanitarian Concern. This strong partnership supports a coherent coordination and partnership with UNAIDS cosponsors and the Secretariat, other UN agencies, and various implementing partners. UNFPA began supplying UNHCR with a more dependable condom supply that included approximately two million condoms in 2005. The various types of inter-agency collaboration are described in detail in this report.

Sub-regional initiatives, such as the Great Lakes Initiative on AIDS (GLIA), the Mano River Union Initiative on AIDS and the Oubangui-Chiari Initiative on AIDS continued to develop. Numerous assessment missions and surveys for GLIA were undertaken to ensure a smooth implementation in 2006.

The provision of guidance and support in response to field reports of HIV-related human rights violations against refugees and other persons of concern continued in 2005. The more serious incidents included mandatory HIV testing, detention and threats of refoulement of persons of concern. Capacity-building efforts with UNHCR staff continued. HIV was highlighted in the Note on International Protection that was submitted to the Standing Committee in June 2005. Research into the practice of HIV testing in the context of resettlement revealed a number of problematic areas, specifically informed consent, confidentiality and disclosure of HIV status, and pre-

and post-test counselling. In an effort to address the intersection of sexual violence, protection and HIV/AIDS, the HIV unit expanded its support to six country programmes with the provision of post-exposure prophylaxis following rape.

The results of behavioural surveillance surveys (BSSs) in Kenya and Rwanda among refugees and surrounding host populations were released and provided essential baseline information. BSSs were also conducted in Djibouti, Nepal, Mozambique and Tanzania. Antenatal care HIV sentinel surveillance results were released for Sudanese refugees in Uganda. Sentinel surveillance was undertaken in Dadaab refugee camps, Kenya (first half 2005); Dimma, Fugnido and Sherkole refugees camps, Ethiopia (April 2005); and Kala and Mwange refugee camps, Zambia (June-September 2005).

Numerous HIV/AIDS and refugee publications were released in 2005. These include a joint UNAIDS/UNHCR Best Practice collection titled *"Strategies to Support the HIV-Related Needs of Refugees and Host Populations"*; UNHCR's Field Experiences titled *"Evaluation of the introduction of post exposure prophylaxis in Kibondo, Tanzania"* and "*Community Conversations in Response to HIV/AIDS: A capacity building project with refugees and the host population, Republic of Congo";* a cartoon focusing on human rights, HIV/AIDS and stigma and discrimination of refugees for adolescents in both refugees and surrounding communities was created and will be published in 2006; and two articles were published on HIV and internally displaced persons and HIV, conflict and the media in Africa.

Data were collected from 30 countries in Africa, CASWANAME (Central Africa, South-West Asia, North Africa, and Middle East) and Asia representing 3,739,091 refugees in 35 urban areas and 228 camps/sites. The overall crude mortality and under-5 years of age mortality rates were acceptable according to regional standards in all countries with some unacceptably high mortality rates among individual sites. Condom distribution was insufficient to meet emergency levels in areas/sites in Asia, CASWANAME, and Central Africa; emergency levels were reached in West Africa and post-emergency levels were reached or nearly reached in East and Southern Africa. Universal precautions (i.e. sufficient needles/syringes, gloves and blood transfusion screened for HIV) was ≥75% in areas/sites in all regions/subregions except CASWANAME. Sexually transmitted infection (STI)-related issues (i.e. sufficient condoms, sufficient STI drugs, and use of syndromic approach) was ≥75% in areas/sites in all regions/subregions except CASWANAME and East Africa. Access to voluntary counselling and testing was ≥75% in areas/sites in Asia and Southern Africa and <50% in CASWANAME, Central Africa and West Africa. Access to prevention of mother-to-child transmission programmes was ≥75% in areas/sites in Asia and <50% in CASWANAME, Central Africa, Southern Africa and West Africa. Refugees had equal access to antiretroviral therapy (ART) compared with surrounding national populations in all urban areas and refugee sites in Asia and West Africa and ≥50% overall access in Asia, East Africa, and Southern Africa. Finally, refugee rape survivors had access to post-exposure prophylaxis in ≥50% of areas/sites in East and West Africa.

In 2006, UNHCR will continue to implement its 2005-2007 Strategic Plan. The organisation will strengthen its regional programmes in East and Central Africa with funds from GLIA, the World Bank, OPEC Fund and DFID. In Southern Africa, Botswana and Zambia will receive funding in 2006 from the US President's Emergency Plan for AIDS Relief. With these funds, UNHCR will be able to implement more comprehensive programmes. If funding allows, the HIV/AIDS unit will expand its programmes in CASWANAME and Eastern Europe.

3) Background

The HIV and AIDS programmes developed according to a response to the growing challenges of combating the epidemic among refugees and other persons of concern to UNHCR. In 2005, programme activities were implemented in line with the UNHCR's Strategic Plan for Refugees, HIV and AIDS 2005-2007 (Annexes 1 and 2).

The overall objectives of the programme are to combat HIV and AIDS among refugees, returnees and other persons of concern, as well as, to ensure that human rights of persons of concern to UNHCR who are infected or affected by the disease are duly respected.

Ten strategic objectives as outlined in the Strategic 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 Mobilization:** to increase funds and move beyond traditional donors to ensure the objectives stated in this Strategic Plan are achieved.

In addition to protection concerns and basic human rights principles, other fundamental approaches must be considered during all stages of programme implementation. These include the need to:

1. Integrate refugees into HIV policies, funding proposals and programmes of countries of asylum;
2. Address the needs of refugee women and children and mainstream gender and age;

3. Adopt a sub-regional approach reflecting the cycle of displacement; and
4. Advocate for the elimination of HIV-related discrimination against refugees and other persons of concern to UNHCR.

HIV and AIDS funds from Headquarters (HQ) for 2005 were allocated to support global, regional and country programmes to further enhance and support the development of comprehensive HIV and AIDS programmes and meet the objectives and strategies as outlined in the UNHCR Strategic Plan for Refugees, HIV and AIDS.

The primary beneficiaries of the activities were refugees, returnees and other persons of concern in Africa, Asia and the Central Africa, South-West Asia, North Africa, and Middle East (CASWANAME) regions. In addition global and regional activities were programmed to enhance capacity-building, coordination and mainstreaming of the HIV and AIDS in UNHCR's ongoing policies and activities.

4) Programme Implementation and Country Support

Four Senior HIV/AIDS Regional Coordinators continued working in Africa; they are based in Accra, Kinshasa, Nairobi and Pretoria. Furthermore, a fifth Senior HIV/AIDS Regional Coordinator began work for Asia based in Bangkok. In Geneva, the Senior HIV/AIDS Technical Officer, seconded from the Centers of Disease Control and Prevention and the HIV/AIDS Technical Officer also continued their work. In addition a Liaison Officer to UNAIDS was recruited to support the work related to UNHCR's cosponsorship of UNAIDS; due to HQ constraints, this person is currently based in Pretoria.

The HIV/AIDS Regional Coordinators and Technical Officers from Geneva undertook several missions to the field. These standardised assessment and monitoring missions to the field provided a picture of the current situation and enabled further planning for and follow-up of programme activities, as well as the opportunity to provide additional technical oversight to field operations. Furthermore the unit provided technical support to numerous other countries through consultation from Geneva or regional offices.

The mission reports are included in the annexes by region and date:

Thailand (Annexes 3 and 4), Bangladesh (Annex 5), Nepal (Annex 6), Thailand (Annex 7), Pakistan (Annex 8), India (Annex 9), Chad (Annex 10), Central African Republic (Annex 11), Burundi (Annex 12), Rwanda (Annex 13) Sudan (Annex 14), Ethiopia (Annex 15) Botswana (Annex 16), Ghana (Annex 17), Guinea (Annex 18) Sierra Leone (Annexes 19) Côte d'Ivoire (Annex 20), Ghana (Annex 21) Liberia (Annex 22), Nigeria (Annex 23) and Benin (Annex 24).

Based on the country assessment and evaluation missions as well as technical support from HQ and the regions, 40 countries received both funding and technical support for their HIV and AIDS programmes. The financial support is ***additional*** to the HIV and AIDS programmes financed through UNHCR's regular budget resources. They are meant to help countries who are just beginning or expanding their HIV programmes, as well as to fill in gaps. Over time, countries are expected to mainstream this additional funding provided by HQs.

A) Asia

Bangladesh

The Regional HIV/AIDS Coordinator conducted the first HIV mission to Bangladesh in order to review the HIV/AIDS and related activities in UNHCR's operations in May 2005. Bangladesh is hosting approximately 20,000 Rohingya refugees from Myanmar in two camps. HIV and AIDS programme activities that were conducted include the production of information, education and communication (IEC) materials, introduction of new sexually transmitted infection (STI) protocols including training of staff and distribution of infection prevention guidelines. A detailed plan has been developed to address key areas in 2006.

India

In November 2005, a mission was undertaken to India to review HIV and AIDS activities for urban refugees in Delhi. This was the first HIV/AIDS mission and was timed to correspond with the inaugural HIV and Asia Regional Directors' Forum. Due to funding constraints in the regular budget, the situation for refugees in Delhi is precarious with the subsistence allowance for those identified as vulnerable being inadequate to meet basic needs. A workplan with priority activities has been developed for 2006. Areas of focus will include management of STIs, access to Voluntary Counselling and Testing (VCT), support to persons living with HIV and AIDS (PLWHAs) and expansion of behaviour change communication activities.

Indonesia

HQ funds for HIV were allocated to Indonesia to continue their activities with urban refugees in Jakarta. The activities focused on training of peer educators and support of subsequent peer education. This has been carried out by the Implementing Partner (IP), Pulih.

Nepal

The Regional HIV/AIDS Coordinator for Asia reviewed the HIV and AIDS and related activities in UNHCR's operations in Nepal (seven Bhutanese refugee camps in eastern Nepal and the Tibetan transit centre in Kathmandu) in June 2005. Throughout the remainder of 2005, steady progress has been made in implementing priority recommendations from the mission report. HIV HQ funds were used for a Behavioural Surveillance Survey (BSS) that was conducted by a local agency. Field work was completed by the end of 2005 and the report is expected in early 2006. In addition, Population Services International assisted in piloting social marketing of urethritis treatment (an STI) in males in and around the Bhutanese camps. In addition, mobile VCT services to the Bhutanese camps were started by the IP AMDA and food distribution is now being used to disseminate HIV and AIDS messages. In the Tibetan transit centre, IEC materials were produced and distributed and World AIDS Day was commemorated for the first time in 2005.

Thailand

Funding was provided for the expansion of VCT activities in two camps, the development of a special HIV and AIDS issue for a distance learning magazine (the Health Messenger), the interim provision of antiretroviral therapy (ART) in three camps, development of a brochure on VCT, development of flipchart to be used as a counselling aid in VCT, adaptation of the "*HIV/AIDS: Stand up for Human Rights"* cartoon booklet into Myanmar language, and the strengthening of behaviour change activities for urban refugees. UNHCR also supported a VCT workshop for all agencies working in the refugee camps as well as, other agencies working along the border and the Ministry of Public Health. This workshop was facilitated by the

Research Institute of Health Sciences at Chiang Mai University. The workshop report is in Annex 25. UNHCR actively participated in the HIV and AIDS component of the United Nations Development Assistance Framework process. As a result, refugees and other conflict-affected populations have been mentioned as a neglected group in the Common Country Assessment. The national HIV/AIDS Strategic Plan is being revised and the importance of providing comprehensive HIV and AIDS services to refugees has been mentioned in the latest draft; this will be finalised in 2006.

B) Central Africa, South-West Asia, North Africa and the Middle East (CASWANAME)

Algeria

In Tindouf, training sessions on HIV and AIDS were organised for all UN staff working in the area with support of an expert consultant. HIV and AIDS awareness activities and basic universal precautionary measures in health facilities were undertaken in refugee sites in accordance with national guidelines.

Egypt

With support from OPEC Fund and UNAIDS, activities were implemented to improve awareness in HIV and AIDS prevention as well as, to reduce stigma and discrimination. HIV awareness guidelines were developed for teachers, peer educators and outreach workers to reach out respectively to school children, out-of school youths and adults with messages fostering prevention, care, support and treatment for PLWHAs. To avoid any misconceptions related to HIV/AIDS and refugees in an urban setting, the programme targeted both host and refugee communities. Foster care activities were also implemented for children at risk of abandonment from parents living with HIV and AIDS or from other abandonment risks. A memory book for these children was also designed to help them be rooted in their family and cultural identities and to recall family memories. PLWHAs among refugees and persons of concern are able to access the public hospitals for treatment of HIV-related illnesses and palliative care. Cooperation is ongoing with UNAIDS and the National AIDS Control Programme (NACP)[1] to reflect refugees and persons of concern in Egypt's National Strategic Plan (NSP) for 2006-2010 as well as, to enable refugees access to ART. UNHCR contributed to the world AIDS Day events in Egypt under the theme *"Stop AIDS - Keep the Promise"* the commemoration was enhanced by the participation of the United Nations Secretary-General's Special Envoy on AIDS for Asia and the Pacific, Dr. Nafis Sadek.

Lebanon

UNHCR is an active member of the UN theme group on HIV and AIDS. UNHCR contributed technically and financially in developing and implementing Lebanon's HIV and AIDS Strategic Plan. The office established a *"gentlemen's agreement"* with the NACP whereby the official inclusion of refugees in the national strategic plan is under study. Most of UNHCR's staff was trained in HIV and AIDS by professional trainers and several awareness sessions were organised for refugees in collaboration with the NACP, the Red Cross and the MECC. UNHCR also contributed to the production of HIV and AIDS leaflets and posters for refugee and public use. UNHCR took an active role in the Legal Framework and Legislation reform of HIV and AIDS in Lebanon.

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[1] Note that throughout this document, all National bodies responsible for HIV and AIDS will be designated NACPs.

Jordan
In Jordan, UNAIDS finalised a proposal for the Global Fund to Fight AIDS, Tuberculosis and Malaria that was constructed around the National Strategy. The strategy and proposals aim to keep Jordan as a low HIV prevalence country and to reduce the impact of HIV and AIDS in individuals, families and the community through full coverage of all infected and affected persons. UNHCR is a member of the HIV UN Theme group and contributed to the development of the HIV and AIDS National Strategy in Jordan where refugees are included as a vulnerable group that should benefit from prevention strategies. Some refugees, including youths, have been trained as peer trainers in HIV/AIDS and will begin training sessions this year.

Pakistan
The first HIV mission to Pakistan was undertaken in August 2005. During the remainder of the year, efforts were made to address some of the gaps identified but progress was severely set back by the earthquake which affected some of the refugee camps in North-West Frontier Province as well as, severely affecting the local (non-displaced) populations. HQ HIV funds to Pakistan were used to improve blood safety and infection prevention at the district hospital in Hangu, to train IP health providers in STI management, and to reproduce STI protocol wall charts and HIV transmission flipcharts. In addition, World AIDS Day was widely and enthusiastically commemorated in the camps and surrounding communities. UNHCR Pakistan is actively participating in the UN Implementation Support Plan for HIV and AIDS. The collaboration and coordination with stakeholders at national, provincial and district levels was improved significantly. Repatriation is ongoing from Pakistan to Afghanistan with approximately 600,000 people repatriated in 2005. There is reluctance to introduce an HIV and AIDS component to the repatriation package at this stage; this will be reconsidered when HIV and AIDS activities and awareness are more developed.

Yemen
The HIV and AIDS programme in Yemen focuses on strengthening health care delivery systems by providing essential equipments and supplies to strengthen universal precaution and essential drugs for STIs. Twenty-four mother and child health (MCH) staff members were trained on universal precaution and proper disposal of medical waste. In addition, UNHCR and its IPs organised a sixteen-day awareness and activism to sensitise the general population about HIV and gender violence. Youths, men and women were involved in drama, songs and poetry on various topics that included HIV and AIDS, violence against women and reproductive health. In collaboration with UNAIDS, the implementation of HIV awareness programme started in November 2005.

C) Central Africa and Great Lakes

Burundi
Burundi did not receive HIV funds from HQs in 2005 as additional funds from the Great Lakes Initiative on AIDS (GLIA) were expected to flow in 2005; however, this will not occur until 2006. The Regional HIV/AIDS Coordinator for Central Africa and the Great Lakes conducted two missions in 2005 to plan HIV and AIDS activities for GLIA. UNHCR conducted a planning workshop in Muyinga (July 2005). Attendees were IPs, refugees, and representatives from NACPs, the World Food Programme (WFP) and the UNHCR field office; an integrated action plan for both refugees and surrounding host populations is ready to be implemented as soon as GLIA funds become available. Community health workers conduct home-based care (HBC)

activities in the camp for PLWHAs. ART is not available for the refugees in the camp or for the local surrounding populations. Burundi, like many other countries, developed and is implementing a strategy to integrate HIV and AIDS into their voluntary repatriation programmes. IPs and field offices organised HIV and AIDS sensitization campaigns and condom distributions in the transit centres. One of the big challenges for the repatriation programme remains the follow-up in the areas of return of PLWHAs regarding activities such as, additional nutritional support, continuation of prophylactic for opportunistic infections, provision of prevention of mother-to-child transmission (PMTCT) programmes, and ART to PLWHAs.

Democratic Republic of Congo (DRC)
In addition to its immensity, DRC faces a complex situation composed of emergency, maintenance, repatriation, returnee and internally displaced persons (IDPs) programmes. The level of HIV and AIDS programmes is variable according to the situation. The minimum package is fully established in the relatively stable context, whereas, in return areas, where the approach is to support health districts and referral hospitals, basic HIV and AIDS activities are being progressively implemented; however, many do not yet meet the minimal HIV package as outlined in the Inter-Agency Standing Committee (IASC) Guidelines for HIV Interventions in Emergency Settings. An assessment and multi-sectoral planning mission and workshop were conducted in Libenge. This return zone in the Equator province will benefit from the World Bank-funded GLIA. The team in DRC organised various training sessions, notably on management of STIs for IP staff in the Eastern part of the country. Refugees and surrounding populations do not have access to ART as ART is just rolling out in DRC and not yet available in remote areas. Advocacy for the inclusion of refugees in the HIV/AIDS NSP and funding opportunities continued; the 1999-2007 NSP elaborated in July 1999 did not clearly include refugees and IDPs as beneficiaries of national HIV and AIDS programmes. The World Bank-funded Multi-Country AIDS Programme (MAP) includes refugees and IDPs, and will begin in early 2006.

Chad
During the first quarter of 2005, the Regional HIV/AIDS Coordinator conducted evaluation missions to assess HIV and AIDS programmes among refugees in the East (Sudanese) and the south (from CAR) of Chad. During the missions, UNHCR organised two workshops; the first in Abeche, aimed at orienting IPs on UNHCR's HIV and AIDS policies, strategies, and identification of priority areas for 2005-2006 and the second in Ndjamena, which gave the opportunity to all stakeholders and partners (including UN agencies) to position themselves in terms of funding, expertise and implementation capabilities against identified priorities. IPs, UNAIDS, other UN agencies and the NACP were actively involved in these exercises. After these workshops, the team conducted HIV and AIDS training and orientation sessions for refugee community leaders. Unfortunately, the IASC recommendations on HIV AIDS in emergency settings have not yet been completely implemented, HIV and AIDS prevention in health facilities (e.g. universal precautions and blood safety) is at an acceptable level while the community-based approach to prevent HIV infections (e.g. IEC, behaviour change and communication, and condom promotion and distribution) as well as, treatment of STIs are difficult to implement due to cultural and religious constraints, especially among the Sudanese refugees in the East). No ART available for refugees or surrounding populations.

The Central African Republic (CAR)
The HIV and AIDS programmes in CAR were the last in the region to be assessed (October 2005). The assessment of the activities in Molangue and Bangui (capital) shows that UNHCR and the IPs' interventions are at a minimal level. During the Regional Coordinator's mission to CAR, UNHCR organised an orientation and planning workshop with partners and the representatives from NACP. This workshop reached a consensus on the priorities for 2005 and 2006. For 2005, the HIV HQ funds served to procure various HIV and AIDS materials to sensitise and capacity-build staff and refugees. As in many other countries, follow-up and support of urban refugees and vulnerable groups need special action, especially for refugees on ART who need nutritional support in addition to money to purchase medications.

Republic of Congo (ROC)
With 2004 and 2005 HIV HQ funds, HIV and AIDS programmes in ROC have improved significantly. However, the geographical, logistical and climatic constraints make it difficult to reach the required minimal HIV standards in this country. The refugee sites are scattered along more than 200 Km alongside the river in the deep equatorial forest. This makes implementing the HIV strategies, such as mass awareness, systematic syphilis screening for pregnant women, and HBC a serious challenge. The *"Community Conversations,"* initiated in 2004 and completed in 2005, are 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 think and find some local solutions on HIV issues. During repatriation to DRC, HIV awareness sessions and condom distribution are undertaken in transit centres. People who have been trained as community conversation facilitators are likely become an important resource in their localities of origin although this cannot be completely verified as it is not possible to locate them all when they return.

Rwanda
In terms of the range of HIV and AIDS services available to refugees, the programmes in Rwanda are the most advanced among the six countries in Central Africa. In addition to the minimum HIV package that all the programmes offer, the refugees in Rwanda have access to VCT, PMTCT and ART services. The support from the NACP is vital to these services. Numerous missions to prepare for the integrated GLIA HIV programme for the refugees and surrounding communities were undertaken in 2005.

D) <u>East and Horn of Africa</u>

Ethiopia
In 2005, awareness programmes continued in Sherkole, Shimelba, and Dimma refugee camps, and to a limited extent in Kerberibeya camp. Efforts were made to scale up HIV and AIDS services. In July 2005, another VCT facility was opened in Sherkole camp bringing the camps with access to static VCT services to two; there is no mobile VCT service. Approximately 1,500 individuals from the refugee and surrounding host communities underwent VCT. Dimma, Fugnido as well as, Sherkole camps were included in the national antenatal care (ANC)-based sentinel surveillance survey; results are expected in the first quarter of 2006. In addition, national health facilities offering ART started enrolling refugees (camp and urban) in the ART programme, but uptake was limited because of poor access to HIIV testing (voluntary and diagnostic) services. However, HBC programmes are yet to be developed and started in the refugee settings in Ethiopia.

Kenya
The HIV and AIDS programmes in Kakuma refugee camp provide comprehensive services ranging from prevention, care, support and treatment. During the reporting period, ART was introduced in the refugee camp through Centres for Disease Control and Prevention and the International Rescue Committee. By the end of December 2005, 37 refugees were on ART and over 200 refugees were enrolled in the HBC programme and receive material and psychosocial support as well as, prophylaxis for opportunistic infections. During the reporting period, 24 health care providers were trained in clinical management of rape, including the provision of post-exposure prophylaxis (PEP).

The HIV programmes in Dadaab refugee camps continued to expand. Two VCT facilities were opened in 2005 and by December, 825 individuals had undergone VCT. In addition, four refugees were enrolled in the national ART programme. However, a HBC programme has yet to be developed in refugee settings in Dadaab camps. During the reporting period, 30 health care providers were trained in rape management including the provision of PEP drugs as well as, PMTCT. PEP kits were received in the last quarter of the year and in the first quarter of 2006, PMTCT and provision PEP is expected to commence. In 2005, the German Technical Cooperation health centre in Nairobi which cares for refugees was approved as a national ART site and started providing treatment to urban refugees.

Somalia
In Somalia the programme focused on the reception and reintegration of returnees from neighbouring countries. Returnees are expected to benefit from national HIV and AIDS services which are coordinated Somalia AIDS Coordinating Body. UNHCR is involved in the provision of essential services including HIV and AIDS services for approximately 400 Ethiopian refugees in Hargeisa. In July 2005, an ART programme started initially for refugees, but the programme has since evolved to be a national ART pilot-programme supported by the Ministry of Health of Somaliland, the UN Country Team and donors such the United Kingdom's Department for International Development. At present, more than 80 people are on ART of which eight are refugees. Unfortunately, HBC is not developed in Hargeisa and HIV positive individuals have limited support. However, the Ministry of Health and UN agencies have recognised this weakness and will implement such a programme in 2006.

Sudan
The programme in Eastern Sudan focused on HIV prevention and awareness through community-based initiatives such as, song, drama and peer education. The youth centres started to implement recreational and vocational training and peer education services. During the reporting period, 30 health care providers were trained in syndromic management of STIs and promotion of condoms, and clinic support staff was trained in universal precaution and disposal of medical waste. During a training mission on HIV and AIDS for UNHCR staff members, IPs, media and other relevant organisations, workshops and consultations were held in Es Showak, West Darfur, Malakal and Khartoum covering issues related to stigma, discrimination and human rights violations on the basis of perceived or actual HIV status (see Annex 14).

Tanzania
The HIV and AIDS programmes in Western Tanzania are providing comprehensive services that range from prevention, care and support. The PMTCT programme is well established; an estimated 90% of pregnant women attending ANC care enrolled in the PMTCT programme; of these, 30% of the women are counselled and tested

together with their partners. During the reporting period, 24 health care providers were trained in the clinical management of rape and provision of PEP to rape survivors. Approximately 200 HIV positive refugees publicly declared their sero-status and are living positively with HIV. In 2005, two refugees began ART on humanitarian grounds but the Ministry of Health declined to expand the national ART programme to all refugees in need of treatment. The refugee camps have well developed HBC programmes that enrol refugees as well as, surrounding host nationals. From September to December 2005, a BSS was conducted in Lugufu and Lukole refugee camps as well as, among the surrounding host populations; the BSS results are expected in by April 2006.

Uganda

Uganda has a comprehensive HIV and AIDS programme that continues to expand. In 2005, the upgrading skill of service providers was a major component of their programme with the training of 30 workers on syndromic management of STIs and of 24 health care providers on clinical rape management including prevention of HIV transmission through the provision of PEP. In addition, 24 lay counsellors were trained (e.g. traditional birth attendants and PLWHAs) to sensitise the community about VCT and to provide group counselling and individual home counselling services. The national ART programme is accessible to all refugees who meet the treatment criteria. The refugee HBC programme is linked to community-based organisations for PLWHAs who sensitise and support refugees to declare their status in public and encourage them to live positively with the illness.

E) Southern Africa

Angola

In 2005, UNHCR continued local capacity-building efforts with the Angolan Red Cross Society (ARCS). With UNHCR's support, ARCS began implementing HIV and AIDS programmes for returnees and host communities in Luau, Moxico province. The involvement of ARCS in Luau ensured the continuity of HIV and AIDS programmes initiated by Médecins sans Frontières, Belgium, who left the area in early in 2005. ARCS activities focused on improving basic HIV knowledge in the returnee and surrounding populations, largely through *"palestras"* or community dramas; this was an integral part of UNHCR's phased reintegration programme. A special focus was placed on messages against stigmatisation and discrimination directed towards Angolan returnees. Programmes also emphasised the importance of seeking VCT and care services. Capacity-building efforts were further supported through the Merck sponsorship of an ARCS Programme Officer to attend the July 2005 HEARD HIV/AIDS Programme Planning Course at the University of Kwazulu-Natal in Durban, South Africa. Continuity of ART for returnees who had started ART in their country of asylum remained a challenge as public sector ART exists largely outside of the main areas of return.

Botswana

The HIV and AIDS programme in Botswana remained focused on achieving refugee access to the national public sector ART programme. Unfortunately, the government did not change its policy of excluding refugees, despite a resolution from the Refugee Commissioners meeting held in Gaborone in August calling for a regional approach to ensuring refugee access ART in the Southern African Development Community. Advocacy efforts in this regard will remain a priority for 2006. The Office did succeed in obtaining refugee access to a private sector ART programme run by the Catholic Bishop in Francistown and submitted a successful funding proposal to the 2006 US

President's Emergency Plan for AIDS Relief. The support provided under this programme will be critical to the scaling up of youth HBC and other community-based programmes.

Malawi
In 2005, in addition to the on-going HIV and AIDS community awareness activities conducted by IPs and refugee community groups, VCT centres were established in both refugee camps. In addition, PMTCT services were offered to pregnant refugee women through the district hospitals. 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. These activities were all achieved with very limited funding. A limited number of refugees were enrolled in the national ART programme; the high level of stigma and discrimination within the refugee community precluded the uptake of VCT and other services which serve as an entry point for ART. Stigma reduction activities will form a critical part of the 2006 strategy in Malawi.

Mozambique
UNHCR Maputo entered into a new sub-agreement with Save the Children (UK) to conduct HIV and AIDS awareness activities in Marratane refugee camp. Critical to the direction of the HIV programme in Marratane camp was the completion of a BSS supported by the Regional HIV Coordinator. The results of this survey, which was completed in December, will guide programme strategies and prioritization in 2006. Refugees continued to access ART through the provincial hospital in Nampula.

Namibia
The Namibia programme has successfully integrated HIV and AIDS into the voluntary repatriation operation to Angola. The additional funding provided by UNHCR Headquarters was used to continue with community-based HIV and AIDS awareness training, particularly targeting refugee women and youth. In addition, IEC materials were developed in local languages at the camp level. The funding was also used to provide nutritional support to clients of the HBC programme and to procure clinic supplies to ensure universal precautions. With the conclusion of the organised repatriation programme to Angola and the relative stabilisation of the refugee population in Osire camp, negotiations with the Ministry of Health were re-opened regarding refugee access to the national ART programme.

South Africa
UNHCR supported the establishment of a new partnership between the Community AIDS Response (CARE), which is a local HBC provider, and UNHCR. CARE took over the refugee HBC programme started in 2003 by the Jesuit Refugee Service as part of UNHCR's efforts to integrate refugees into local initiatives and services. CARE recruited and trained six refugee volunteers as care givers, who also provide counselling and support to refugees seeking assistance at clinics in central Johannesburg as well as, Johannesburg public hospitals. In addition, refugees were included in CARE wellness, general counselling and support groups. In addition, a new partnership with Sediba Hope Centre, a local HBC provider in Pretoria, was entered into in November. Two refugee HBC persons were recruited and trained by Sediba. Planned Parenthood Association of South Africa (PPASA) continued with their Refugee Life Skills programme, employing six full-time refugee programme staff to conduct HIV and AIDS awareness training in the refugee communities in Durban, Cape Town, Johannesburg and Pretoria. Advocacy and training efforts with local HIV and AIDS service providers continued jointly between UNHCR, PPASA and other IPs.

The Regional HIV/AIDS Coordinator continued to build relationships with regional donors and medical and academic institutions, many of which are based in Pretoria and Johannesburg. In addition, collaboration continued with regional colleagues based at the UN Regional Inter Agency Coordination and Support Office on a number of initiatives. An important new relationship with the Treatment Action Campaign (TAC) was established, resulting in TAC treatment literacy training for refugees and IPs, TAC and IEC materials were translated into refugee languages, and refugees living with HIV and AIDS encouraged joining local TAC branches.

Zambia
In the Western Province, IPs continued with HIV and AIDS awareness activities within the voluntary repatriation programme. In addition, VCT was strengthened at the camp level. Refugees were granted free access to the national ART programme on par with nationals. An HIV and syphilis sentinel surveillance survey among pregnant women in Kala and Mwange camps was undertaken by the Centers for Disease Control and Prevention, the Tropical Disease Research Centre in Lusaka, UNHCR and IPs. This was the first such survey undertaken in the region. Survey results showed a significant difference between the refugee population (2.4% HIV prevalence) and the host communities (14 - 19% HIV prevalence). As a result of this collaboration, refugees will be included in the next national sentinel surveillance exercise to be undertaken in 2006. It is hoped that the inclusion of refugees in the national survey will result in their further inclusion in national programmes to combat HIV and AIDS. With support from Merck, the Regional HIV/AIDS Coordinator facilitated the participation of a UNHCR Field Officer to attend a five-day workshop on monitoring and evaluation of HIV and AIDS programmes conducted by the University of Kwazulu-Natal in Durban.

Zimbabwe
The Regional HIV/AIDS Coordinator undertook a first assessment mission to Zimbabwe in July. A standard assessment was undertaken, in collaboration with IPs and UNHCR field colleagues. As there were minimal HIV-related activities being undertaken in the camp, one of the key mission recommendations was to provide basic training on HIV and AIDS for IPs and the refugee community. This training was conducted by an IP trainer from South Africa in late October; the training also included the development of a strategic plan for HIV and AIDS for 2005-2006. In addition, a number of IEC materials, T-shirts and a video machine were procured and sent to Zimbabwe. It should be noted that UNHCR's refugee operation in Zimbabwe operates under very constrained circumstances, with high inflation severely impacting the annual budget. Despite this environment, UNHCR colleagues in Harare and Tongogara refugee camps were able to revitalise IP and refugee interest in HIV and AIDS, and to initiate a well-structured community-based HIV programme in the camp.

F) West Africa

Benin
In 2005, the HIV and AIDS programme in the refugee settings in Benin focused on care and treatment for PLWHAs. In the newly established Togolese refugee camps, UNHCR in collaboration with the Ministry of Health and the NACP organised three HIV sensitisation campaigns in the newly established Come and Agamé camps. The refugee population is included in the NSP. Furthermore, both urban and camp refugees have access to ART free of charge.

Côte d'Ivoire
In 2005, the UNHCR HIV and AIDS programme in Côte d'Ivoire focused on HIV community sensitisation and strengthening of the clinical management of rape, including the introduction of PEP. UNHCR provided funds to IPs to support community sensitisation on HIV, AIDS and STIs. IPs conducted sensitisation campaigns in transit centres in Abidjan, Tabou and the camp of Nicla. The revised NSP completed in September 2005 includes the refugees as vulnerable populations but does not list specific activities for them. Urban refugees have access to ART but both camp refugees and surrounding local communities do not.

Ghana
In 2005, the Ghanaian refugee programme focused on the strengthening of the HIV and AIDS prevention services. Forty billboards with HIV and AIDS awareness messages were developed in the Buduburam settlement. In addition various forms of teaching materials were provided to enhance proper condom usage. Twelve counsellors provide HBC services to chronically ill people including 17 PLWHAs in the Buduburam settlement. Twelve clinicians and midwives were trained as counsellors for the VCT and PMTCT programmes. Following this training, a PMTCT programme was established in the clinic of the Buduburam settlement in Ghana. UNHCR, in collaboration with UNFPA Ghana, held the Positive Lives Exhibition in Accra with more than 300 visitors and in Buduburam resettlement in Ghana with 1,402 attendances. Positive Lives focuses on the human stories of people affected by HIV and AIDS, and the social and emotional impact of the epidemic. In June 2005, UNHCR, in collaboration with UNFPA, trained 19 clinicians in Ghana on the clinical management of rape survivors; PEP services were established in refugee settings in the Buduburam settlement following the training. World AIDS Day was celebrated in the Buduburam settlement and Krisan camp on 1st December 2005; the event included religious ceremonies and sensitisation campaigns. The NSP includes the refugee population. Urban refugees have access to ART but must pay a small fee but ART is not yet accessible to rural communities and refugees in Ghana.

Guinea
Billboards with HIV and AIDS prevention and awareness messages were established in the refugee camps. The youth and community centres were further equipped with audiovisual materials. Training materials to ensure proper condom usage were procured. All peer educators attended a refresher course organised by the Guinean Red Cross. A VCT programme was established in Kountaya, Laine and Kouankan camps. HIV HQ funds financed the training of 12 HIV counsellors and 3 laboratory technicians. In July 2005, UNHCR, in collaboration with UNFPA, trained 20 clinicians in Guinea on the clinical management of rape survivors; this allowed us to introduce PEP services in the camp health centres. The national strategic plan targets refugees as high risk group but no specific activities are stated. Refugees do not have access to ART as yet.

Liberia
There are approximately 18,000 refugees in Liberia, mainly from Sierra Leone and Côte d'Ivoire. UNHCR also works with IDPs and returnees. In 2005, priority was given to HIV community awareness and the returnees' reintegration. UNHCR Liberia developed IEC materials such as posters and leaflets. The leaflets are provided to the returnees as part of the repatriation package. Also, sensitisation campaigns and condom distribution are ongoing activities at the returnees' arrival points. Three UNHCR staff attended a reproductive health logistics training in Accra, Ghana by USAID. Education and information sessions on HIV and AIDS were conducted for UNHCR and IPs staff in Monrovia. The newly developed NSP targets the refugees as a vulnerable group but there are no specific activities stated. ART is only available in the capital city; refugees do not have access in Liberia as yet.

Nigeria
UNHCR supported the development of IEC materials and procurement of equipment to support HIV prevention awareness activities for young people in Oru camp. Additional support was also provided to peer educators. The revised NSP (2006-2010) completed in October 2005 include refugees as a vulnerable population but no specific activities are stated. Urban and rural refugees access ART through the national programme. UNHCR Nigeria is in process of signing a memorandum of understanding with UNAIDS.

Sierra Leone
UNHCR supported the mission of a regional VCT expert to support the Ministry of Health to develop guidance and support for proper testing regime and training on VCT (report attached in Annex 26). UNHCR has funded the development of IEC materials such as posters and leaflets in use for sensitisation at clinics, youth centres and offices. IPs were provided funds to support community sensitisation on HIV/AIDS and STI issues. IPs conducted sensitisation sessions targeting different refugee groups such as, youth, women, general population, and mothers in all camps as well as, in urban settings. The revised NSP (2006 - 2010) includes refugees as a vulnerable group but no specific activities are stated. Officially, refugees have access to ART free of charge in Sierra Leone; however ART is not yet available in rural areas for local populations or refugees.

G) Europe

In Central and Eastern Europe (Ukraine, Albania, Bulgaria, and the Balkans, to name only a few of the countries) UNHCR cooperates with UNAIDS and participates in relevant work towards adequate protection and care for persons of concern with a heightened risk of living with HIV and AIDS. Relatively new national policies in some of the countries in conflict combined with nascent asylum systems require a comprehensive approach.

Russia
Starting in 2005, UNHCR and its partners closely cooperated with UNAIDS at the national level. In accordance with the relevant Russian legislation and as part of UNHCR's medical assistance programme, Magee Woman Care International, an American NGO in Moscow and the Russian Red Cross in St. Petersburg distributed HIV and health information (e.g. brochures on HIV/AIDS prevention in various languages) on hygiene, child-care, STIs and HIV/AIDS to asylum seekers and refugees. An educational programme for adolescents (e.g. lectures and training on preventive medicine, hygiene, STIs, and HIV/AIDS prevention) targeted women and adolescent girls. HIV and AIDS issues were also addressed through reproductive health care that included family planning, care for deliveries, paediatric services, and prevention of infectious diseases. A poster campaign and demonstration of relevant videos in clinics and community centres as well as, distribution of condoms were part of this programme.

Armenia
In December, UNHCR, UNAIDS and UNFPA signed an MoU to embark on a joint awareness campaign to support the NACP to strengthen the awareness of NGOs and persons at risk of STIs and HIV/AIDS. UNHCR is the chair of the HIV/AIDS UN Theme Group.

H) Regional and Global Programmes

Development of Information, Education and Communication Materials
UNHCR Pretoria continued to serve as the clearing-house for IEC materials for refugee programmes throughout the African continent. In South Africa, new information fliers on local HIV and AIDS services in the main provinces hosting refugees were developed by the Legal Aid unit at the University of Cape Town. Information cards on *"Managing disclosure of HIV status"* were developed by UNHCR Pretoria for UNHCR staff worldwide to assist colleagues in providing refugees with confidential support and appropriate referral. These cards have been translated into French, Arabic and Portugese (Annexes 27, 28, 29 and 30). In addition, numerous existing materials developed in 2003 and 2004 were re-printed and shipped per office requests.

Specific IEC materials were developed and distributed in the Asia Region through the support of UNHCR Bangkok. Materials on HIV and STIs were obtained in Tibetan language and reproduced in Nepal; a VCT brochure and counselling flipchart were developed in Myanmarese and will be used as a template for development in other populations; the cartoon booklet "*HIV/AIDS: Stand up for Human Rights"* was adapted and translated into Myanmarese and will be used in refugee populations from Myanmar throughout the region.

HIV Awareness Packages for Returnees
HIV awareness packages for returnees were provided upon departure from the DRC, Namibia and Zambia to Angola. Furthermore, returnees in Liberia and Burundi received packages consisting of HIV and STI awareness messages together with condoms.

Condoms
UNHCR continued with a mixture of the "ABC" approach – Abstinence, Be faithful and Condoms. In support of this approach, USAID supplied 2,286,000 male condoms to UNHCR programmes in Cote d' Ivoire, Ghana, Guinea and Sierra Leone. USAID and DELIVER, in collaboration with UNHCR, organised a five-day workshop on condom logistics in Accra, Ghana with participation from five countries in the region. The purpose of the workshop was to enable UNHCR and IPs to manage and monitor the distribution of male and female condoms in refugee operations. The Memorandum of Understanding with UNFPA was strengthened and in 2005 UNFPA donated a total of 2,000,000 million condoms to refugee programmes in nine countries in Africa and Asia. This support will be expanded in 2006 to additional sites.

World AIDS Day
World AIDS Day was commemorated in conjunction with the 16 days of activism against violence. At UNHCR HQs, the documentary *"Love in the Time of AIDS"* was launched together with *"UNHCR Cares"* the new UNHCR programme for HIV and AIDS in the workplace (Annex 31). UNHCR also joined UNAIDS, other cosponsors and NGOs in Geneva for a two-hour commemoration around the theme, *"Keeping the Promise."* Activities in numerous countries throughout the world were organised for and by refugees to strengthen their commitments to *"Keep the Promise."* In addition, UNHCR offices organised awareness activities for UNHCR staff and their dependants. UNHCR red ribbon pins were distributed to all country programmes.

Coordination Meetings
In February 2005, DRC hosted a regional HIV and AIDS workshop. IPs and UNHCR staff members came from Rwanda, Burundi, ROC, CAR and Chad. The objectives of the workshop were: (a) to improve the quality of existing programmes; (b) to standardise HIV and AIDS programmes in the region; and (c) to plan for 2005 programme activities. An HIV and AIDS resource package containing guidelines, policies, mission reports, and key publications were provided to the participants. Selected HIV and AIDS programmes were presented by NGOs to provide an example of what can be achieved in refugee settings as well as, to discuss ways to improve and adapt programmes to specific settings. The workshop report is attached in Annex 32.

An HIV/AIDS Unit meeting was organised in Pretoria (June 2005) with all of the HIV/AIDS Regional Coordinators, the HIV/AIDS Technical Officers and the Deputy Director of the Division of Operational Services. During the meeting key issues of HIV and AIDS coordination, programme implementation and priorities, standards, surveillance, monitoring and evaluation were discussed (Annex 33).

During the Annual Health, Nutrition and HIV Coordination Meeting in Geneva (October 2005), sessions on the links between HIV/AIDS and protection, a draft ART policy for refugees, and improving support to PLWHAs were conducted by the HIV/AIDS unit (Annex 34).

5) Interagency Collaboration

DRC's World Bank Multi-Country AIDS Programme (MAP)
UNHCR finalised the agreements for a 4-year contract under the World Bank-funded MAP in DRC. This financial support will contribute to reinforce HIV and AIDS activities in current refugee sites, allow the extension of interventions to return areas (e.g. Katanga, Kivus and Equator), and where possible, to IDPs in the six priority provinces in DRC.

Initiative de Pays Riverains des fleuves Congo, Oubangui et Chari
UNHCR is involved in the design of the Oubangui-Chari Initiative that composes the four countries of Chad, ROC, DRC and CAR. Refugees, returnees, IDPs and host surrounding populations will be able to benefit from these funding mechanisms in the near future.

Great Lakes Initiative on AIDS (GLIA)
The goal of GLIA is to contribute to the reduction of HIV infections and to mitigate the socio-economic impact of the epidemic by developing regional collaboration and implementing interventions that can add value to the efforts of each individual country. Recognising that the region is adversely affected by civil strife and protracted conflict resulting in internal displacement of people and refugees, and that these populations are underserved and vulnerable to HIV infection and its negative consequences, six countries (i.e. Burundi, DRC, Kenya, Rwanda, Tanzania and Uganda) teamed with UNAIDS, UNHCR and the World Bank to address the needs of conflict-affected populations and their surrounding host communities. The first component of the project - HIV and AIDS support to refugees, affected surrounding communities, IDPs, and returnees was allocated US$ 8 million. These funds will strengthen prevention, care, treatment and mitigation services to refugees in 8 camps and settlements and their surrounding host communities over a four-year period beginning in early 2006.

In April 2005, UNHCR and the six GLIA countries signed a Memorandum of Understanding which states the roles and responsibilities of UNHCR and GLIA; a management contract will be signed in March 2006. The project is expected to commence in March/April 2006 with the World Bank disbursing the funds to UNHCR for the first 18 months of the four-year project. Work plans and their associated budgets for all sites were developed through participatory stakeholders workshops in 2005 and have been submitted to the respective Ministries of Health in each country for endorsement as well as, the GLIA Secretariat. Under GLIA, in addition to the pilot BSSs in Kenya and Rwanda in 2004, UNHCR conducted joint (UNHCR and host countries NACPs) HIV/AIDS situational analysis and elaborated 18-month action plans for each site.

Inter-Agency Advisory Group (IAAG) on AIDS
In February 2005, UNHCR handed over the chair of the IAAG to UNIFEM. UNHCR gave a presentation of the achievements as chair of the IAAG for HIV and AIDS among conflict-affected and displaced populations.

Inter-Agency Standing Committee (IASC) Reference Group on HIV/AIDS in Emergencies
UNHCR took an active role in the IASC. Regional training workshops in West Africa, East and Southern Africa were held in which UNHCR actively participated. The IASC reference group temporarily disbanded, as planned, after the implementation of the guidelines. As of November 2006, the group will commence and start working on the updated guidelines for HIV/AIDS in emergencies.

International Labour Organization (ILO)
With support from Merck, UNHCR and the ILO jointly organised a three-day regional workshop aimed at helping IPs to develop workplace policies on HIV and AIDS. The workshop brought together 18 organisations from eight different countries in the Southern African region to discuss ways to develop new or, improve existing policies on HIV and AIDS for their own staff. All participants at the workshop left with a draft policy to present to their organisation for review and adoption. This pilot project will be repeated in other regions of the world in 2006. A CD-Rom *"Resource Pack"* was developed which contains all of the workshop materials in order to assist other UNHCR offices and IPs to replicate the exercise. The report of the workshop is attached in Annex 35.

Mano River Union (MRU) AIDS Initiative
The MRU is a regional development initiative that includes Guinea, Liberia and Sierra Leone. The goal of the MRU/AIDS Initiative is to reinforce peace efforts in the sub-region by promoting HIV and AIDS as a cross-border, unifying theme to complement existing and ongoing humanitarian assistance efforts. The principal implementer of the programme is UNFPA. The initiative aims to reduce the transmission of HIV among vulnerable populations in the post-conflict context, including refugees, IDPs, returnees, host populations and uniformed services. At present, most of the programming is occurring in refugee-affected areas but not in the refugee sites themselves. The main aim of UNHCR in the MRU/AIDS Initiative is to ensure that refugees have access to many of the programmes being implemented in the surrounding host sites and to ensure complementarity of services.

Office for Coordination of Humanitarian Affairs (OCHA)
UNHCR and OCHA undertook research in HIV/AIDS and IDPs in the eight OCHA priority countries. A presentation and the publication of this document will occur in early 2006.

UN Educational, Scientific and Cultural Organization (UNESCO)
In close collaboration with UNESCO, a draft paper on HIV and AIDS for UNESCO entitled, *"Guidebook for Planning Education in Emergencies and Reconstruction"* was developed. The publication will be finalised and published in early 2006.

UN Population Fund (UNFPA)
Collaboration with UNFPA focused on the provision of condoms to several country programmes, the touring of the Positive Lives Exhibition, and the support to the clinical management of rape, including provision of PEP. Facilitators from UNFPA and UNHCR conducted training courses on clinical management of rape in Côte d'Ivoire, Guinea, Ghana, Kenya, Tanzania and Uganda. More information is outlined in the respective country reports above (section 4).

World Food Programme (WFP) and the UN Children's Fund (UNICEF)
Since 2003, UNHCR, WFP and UNICEF in collaboration with the governments of Uganda and Zambia, have jointly undertaken the *"Programme for the Integration of HIV/AIDS, Food and Nutrition Activities in Refugee Settings."* The main objectives of these projects are to integrate HIV/AIDS activities with nutrition and food support and to implement programme strategies based on each unique refugee situation.

In Uganda, the programme is implemented through an NGO called Feed the Children Uganda in Kyaka II resettlement site in Northern Uganda. Demonstration gardens have been established in different locations and are being used to train the beneficiaries in vegetable and fruit growing. IEC materials were developed in four languages (Badha, Kinya-Rwanda, Lutoro and Swahili) and volunteers were trained in methods of disseminating information on HIV/AIDS and nutrition. In addition, drama groups, with a total of 126 members, have been trained in effective communication skills using music and drama.

In Zambia, drama performances, sketches by peer educators, condom distribution and leaflet distribution were used as tools for community engagement on issues of integrating HIV and AIDS with nutrition support at the site of food distribution. In addition, training in the various aspects of HIV/AIDS and nutrition for HBC workers, health workers, community workers, youth leaders and peer educators was carried out.

World Health Organization (WHO)
UNHCR participated in WHO technical consultation meetings on access to PEP in occupational and non occupational settings and universal access to prevention and treatment. Technical discussions on an ART policy for refugees occurred.

6) UNAIDS Cosponsor

The Liaison Officer for UNHCR/UNAIDS, in consultation with the Global Coordinator, ensured UNHCR's involvement in all relevant meetings, enhanced the collaboration between UNHCR, UNAIDS Secretariat and other cosponsors, partners and stakeholders. The Liaison Officer facilitated the flow of UNAIDS related documents and information and supported UNHCR to meet its obligations and smoothly fit into the network. These efforts contributed to increased cooperation and coordination since UNHCR became the 10th UNAIDS cosponsor. UNHCR's cosponsorship of UNAIDS has been a broad platform to ensure that people of concern to UNHCR are appropriately included in the global HIV/AIDS agenda. UNHCR fully supported the "Three Ones" principles and joined the international community in overcoming key

barriers to its implementation. UNHCR supported and was involved in the country and regional consultations on Scaling up Towards Universal Access to HIV Prevention Treatment, Care and Support with the aim of near universal access to treatment by 2010. Furthermore, conflict-affected and displaced populations were included into various cosponsor and UNAIDS' documents (e.g. HIV Prevention Policy to Intensify HIV Prevention and its action Plan, Consolidated Technical Support Plan and Division of labour, review of UBW 2006-2007 indicators, development of UBW Performance Monitoring Framework). UNHCR was an active partner in the recently developed United Nations System-Wide Work Programme on HIV/AIDS in Populations of Humanitarian Concern. This strong partnership supports a coherent coordination and partnership with UNAIDS cosponsors and the Secretariat, other UN agencies, and various implementing partners.

At the country level, UNHCR expanded its close collaboration in UNAIDS-related activities in numerous countries including Botswana (UNAIDS supported an HIV/AIDS Coordinator who worked in the Dukwi refugee camp), Djibouti (HCR officer received funds from the Global Fund to Fight AIDS, Tuberculosis and Malaria with facilitation by UNAIDS), Ethiopia (UNAIDS provided financial support for the deployment of a national HIV/AIDS Technical Officer to UNHCR), Egypt (UNAIDS provided funds to UNHCR for HIV and AIDS programmes through OPEC Fund), Jordan (refugees benefited from national and UNAIDS training activities organised on HIV awareness), Kyrgyzstan (a UN Volunteer continued working in the UNAIDS office through contributions from all UNAIDS cosponsors), Pakistan (an HIV/AIDS National Officer continued working through joint contributions of the UNAIDS cosponsors), and Yemen (UNHCR received contributions through the UNAIDS PAF project).

7) <u>Protection</u>

HIV/AIDS Regional Coordinators, supported by the HIV Unit and the Division of Protection Services in Geneva, continued to provide guidance and support in response to field reports of HIV-related human rights violations against refugees and other persons of concern. The more serious incidents included mandatory HIV testing, detention and threats of refoulement of persons of concern. The wider challenge of community-based stigma and discrimination persisted, although creative initiatives such as, the use of the *"Positive Lives"* photo exhibition and the development of a video portraying refugees living positively with HIV helped to encourage community dialogue around HIV and AIDS. Aside from the obvious risks of physical and psychological harm, high levels of stigma and discrimination continued to discourage uptake of critical HIV and AIDS services, such as VCT. Promoting understanding and acceptance of people living with HIV and AIDS will therefore remain at the core of UNHCR's efforts in 2006.

Capacity-building efforts with UNHCR staff continued, with training on HIV incorporated into many field level protection workshops and strategic planning meetings. Regional HIV/AIDS Coordinators participated in the Strategic Planning Meetings on Resettlement held in Nairobi, Accra and Bangkok, highlighting the challenges of protecting refugees from HIV related discrimination and specific issues related to resettlement of refugees with HIV. The HIV Unit also provided input to key policy documents such as the Best Interest Determination Guidelines for Refugee Children, the Note on International Protection, and revised Instructions for the Annual Protection Report.

HIV and AIDS continued to be highlighted in the Note on International Protection, which was submitted to the Standing Committee in June 2005. It contained the following two paragraphs on HIV and AIDS (numbers 22 and 23):

"HIV and AIDS prevention and response are essential components in the protection of refugees, returnees and other persons of concern. Refugees do not necessarily have high HIV prevalence rates, but they may become disproportionately vulnerable to HIV due to the environment in which they find themselves. Refugee women and adolescents are often more susceptible to HIV due to factors including inadequate knowledge, gender discrimination and violence, insufficient access to HIV prevention services and inability to negotiate safe sex. Refugee children exposed to HIV through rape or orphaned by AIDS are also more likely to suffer hardship, withdraw from school, become vulnerable to abuse or contract the virus themselves. In the resettlement context, where HIV testing is undertaken, protection problems also arose in camps where applicants who were rejected were often assumed to be HIV positive and faced ostracism and discrimination as a result."

"Activities during the reporting period included efforts to promote provision of voluntary counselling and testing to refugees, to counter prejudice and discrimination and to integrate refugee concerns, including non-discriminatory access to antiretroviral therapy and prevention of mother-to-child transmission, into HIV/AIDS policies in host States. In one example, volunteers in one Botswana refugee camp trained fellow refugees, refugee men formed a community initiative called "Sex, Men and AIDS" and refugee women launched a "Peace Messengers" group to tackle sexual violence, HIV and AIDS. In Pakistan, UNHCR organized a cultural show on street children at risk of HIV at an NGO-run drop-in centre on World AIDS Day."

ExCom Conclusion No. 102 (LVI) – 2005 on International Protection also addressed the issue of HIV and AIDS. At paragraph (w) the Executive Committee:

"Acknowledges that access to HIV and AIDS prevention, care and treatment, as far as possible in a manner comparable with the services available to the local hosting community, is increasingly recognized by States as an essential component in the protection of refugees, returnees and other persons of concern; encourages UNHCR to pursue activities in this regard, in close collaboration with relevant partners, in particular in the implementation of the objectives agreed in the UNAIDS Unified Budget Work Plan, ensuring specific emphasis on the rights of refugee women and children affected by the pandemic; and notes the recommendations of the Global Task Team on Improving AIDS Coordination among Multilateral Institutions and International Donors;"

Although not formally binding, ExCom Conclusions provide authoritative guidance on the interpretation of the international protection regime for refugees and other persons of concern.

Research into the practice of HIV testing in the context of resettlement revealed a number of problematic areas, specifically informed consent, confidentiality and disclosure of HIV status, pre and post-test counselling. UNHCR's colleagues in the field and at HQs have highlighted these concerns to the respective resettlement countries at a number of levels; collaborative efforts to improve HIV testing in the context of resettlement will continue in 2006.

In an effort to address the intersection of sexual violence, protection and HIV/AIDS, the HIV Unit expanded its support to six country programmes with the provision of PEP following rape. In-country training courses for clinical staff were organised in Côte d'Ivoire, Ghana, Guinea, Kenya, Tanzania and Uganda. The training courses focused on the clinical management of rape survivors in line with the WHO/UNHCR *"Clinical Management Guidelines for Rape Survivors, 2004."* Specific attention was paid to the medical examination, collection of forensic evidence, treatment and care, including presumptive treatment for STIs and prevention of transmission of HIV. Specific guidance was provided on the introduction of PEP in the broader sexual gender-based violence programmes.

8) Surveillance and Research

Behavioural Surveillance Surveys (BSSs)

The results from the BSSs using GLIA and UNHCR funds in Rwanda and Kenya among refugees and surrounding host populations were released (Annexes 36 and 37). The results have provided essential baseline information on the HIV and AIDS knowledge, attitudes and practices of these populations. Additional data regarding sexual violence, migration, employment and interaction between the two communities will guide UNHCR, Government and its IPs in improving the delivery of programmes. BSSs were also conducted in mid to late 2005 in Djibouti, Nepal, Mozambique and Tanzania. The results will be published in 2006.

Sentinel Surveillance Surveys

ANC/HIV sentinel surveillance was undertaken in the following sites: Dadaab refugee camps, Kenya (first half 2005); Kali health centre, Palorinya settlement, Moyo district and Rwenyawawa health centre, Kyangwali settlement, Hoima district, Uganda (late 2004), Ethiopia – Dimma, Fugnido and Sherkole refugees camps were included in the national sentinel surveillance that started in April 2005, and Zambia – Kala and Mwange refugee camps (June-September 2005). The results have so far only been released for Kenya and Uganda.

Dadaab refugee camps, Kenya: The HIV prevalence among pregnant women was 1.4% (95% CI: 0.5%-2.2%; n=700) compared to 0.6% (95% CI: 0.01%-1.1%; n=700) in 2003. The HIV prevalence among STI patients was 1.7% (95% CI: 0.4% - 3.6%; N=300) in 2005 compared with 2.0% (95% CI: 0.4-3.6%; N=300) in 2003. Note that there is no statistical difference between the HIV prevalence among pregnant women or STI patients from 2003 to 2005.

Kali Health Centre, Palorinya settlement, Moyo district and Rwenyawawa Health Centre Kyangwali Settlement, Hoima District, Uganda: The HIV prevalence in Kali and Rwenyawawa refugee settlements was 1% (95% CI: 0.3%-1.8%; N=664) and 2.7% (95% CI: 1.3%-4.0%; N=552), respectively. The surrounding host population in Kali and Rwenyawawa had an HIV prevalence of 5.9% (95% CI: 1.7%-10.1%; N=118) and 2.8% (95% CI:-1.0-6.6%; N=71), respectively. Note that the sample size was calculated only for the refugees and thus the power for the surrounding host population was insufficient to make a proper comparison between the two groups.

9) New Publications in 2005

Best Practice Document UNAIDS - UNHCR

A joint UNAIDS/UNHCR Best Practice collection was published in October 2005 entitled, *"Strategies to Support the HIV-related Needs of Refugees and Host Populations."* The objectives of this best practice collection is to demonstrate the value of and the need for the inclusion and integration of refugees into HIV/AIDS national NSPs, policies, programmes and funding, and to promote the effectiveness of sub-regional initiatives when working with displaced populations. The Best Practice is published in English, French and Russian (Annexes 38, 39 and 40).

Field Experiences
Two field experiences were published in 2005 based on the field work from interns with UNHCR. The field experiences entitled, *T*the *Evaluation of the Introduction of Post Exposure Prophylaxis in Kibondo, Tanzania"* highlights the experiences of introducing PEP as a component of the clinical management of rape and addresses import gaps and challenges. (Annex 41).

The "*Community Conversations in Response to HIV/AIDS, A capacity-building project with refugees and the host population, Republic of Congo"* describes the key role that communities themselves play in the development of HIV awareness and prevention programmes. The document highlights the powerful capacity of communities to learn themselves, increase knowledge and change behaviour (Annex 42).

Cartoon
A cartoon focusing on human rights, HIV/AIDS and stigma and discrimination of refugees for adolescents in both refugees and surrounding communities was created. The cartoon addresses the cycle of displacement and the consequences of the HIV epidemic on refugee life and surrounding communities. It addresses HIV prevention, care and treatment, HIV stigma and discrimination, VCT, living positively with HIV and AIDS, HIV and repatriation as well as, interactions between refugee populations and surrounding communities. It will be published in early 2006.**Other Publications**
The HIV Unit published two articles in 2005 relating to HIV among conflict-affected and displaced populations:

1. HIV/AIDS *in* ***Internally Displaced Persons in 8 Priority Countries****,* Spiegel P., Harroff-Tavel H.Geneva: UNHCR and IDD, OCHA, 2005 (Annex 43).
2. *AIDS, Conflict and the Media in Africa: Risks in Reporting Bad Data badly.* Emerg Themes Epidemiol 2005; 2:12 Lowicki-Zucca M., Spiegel P., Ciantia F. (Annex 44).

10) International Conference on AIDS and Sexually Transmitted Diseases in Africa Conference in Nigeria

UNHCR actively participated in the 14th International Conference on AIDS and Sexually Transmitted Diseases in Africa which was held in Abuja, Nigeria from 4-9 December 2005. The theme of the conference was *"HIV/AIDS and Family."* The Senior HIV Technical Advisor from Geneva, the Regional HIV Coordinator for West Africa, the UNHCR Representative from Nigeria and two other staff from UNHCR Nigeria represented UNHCR. UNHCR was involved in round table events, satellite sessions and oral abstract sessions. Several presentations on HIV/AIDS, conflict and refugees were conducted by UNHCR staff. Additionally, UNHCR organised a five-day showing of the *"Positive Lives"* photo exhibition during the event. More than 300 persons visited the UNHCR stand daily. UNHCR also projected the film *"Love in the Time of AIDS"* during the event.

11) Interns

The HIV/AIDS Unit worked with nine interns from, the Columbia University, the New York Law School, Stanford University, the London School of Hygiene and Tropical Medicine, the University of Leuven, the University of Georgetown, Washington DC, and the Aalborg University in Copenhagen. Two interns were placed in Rwanda to support the development of comprehensive HIV and AIDS programmes and the establishment of VCT programmes. One intern supported the development UNHCR's female condom strategy; she was based in Kenya and in the Kakuma refugee camp.

The fourth intern supported the development of IEC materials from the Nairobi Regional Office. The intern in the Republic of Congo strengthened the earlier established *"Community Conversations"* projects. An intern also worked in Botswana reviewing clinical records in the Dukwi refugee camp to examine at proxy indicators of the impact of HIV and AIDS on the refugee population. An intern from the New York School of Law based in Pretoria, South Africa, conducted research among panel physicians contracted to perform medical examinations on resettlement applicants, which includes a mandatory HIV test. Finally, two interns worked in Geneva, to support the Technical Officers with the development of the HIV and IDP paper as well as, with the analysis of BSSs to learn from earlier experiences and to contribute to their improvement in the future.

12) Plans for 2006

UNHCR will continue with the implementation of its Strategic Plan for 2005-2007. An HIV Unit will be established under the Division of Operational Services and continued technical support will be provided by five regional HIV/AIDS Coordinators based in Accra, Bangkok, Kinshasa, Nairobi and Pretoria as well as, the Technical Officers in Geneva.

UNHCR will strengthen its regional programmes in East and Central Africa with funds from GLIA, the World Bank, OPEC Fund and DFID.

In Southern Africa, Botswana and Zambia will receive funding in 2006 from the US President's Emergency Plan for AIDS Relief. With these funds, UNHCR will be able to implement more comprehensive programmes.

The HIV Liaison Officer will continue to improve and streamline its work with UNAIDS at the global and country level. UNHCRs country offices will continue to be actively involved in the United Nations theme groups and will actively advocate for refugees to be included in NSPs as well as, at the country level and regional donor proposals.

Subject to funding, the HIV Unit will expand its programmes in CASWANAME and Eastern Europe.

13) Statement of Expenditure

1 January – 31 December 2005[2]

I. GRANTS RECEIVED 2005:	Amount in US$
AB Contributions 05/AB/VAR/CM/267	
Australian Government	118,404.82
Canada Government	320,000.00
USA Government	400,000.00
	838,404.82
OR II Contributions 05/AB/VAR/CM/267	
Danish Government	77,062.00
Merck	75,000.00
UNAIDS	193,753.00
	345,815.00
Direct Country Contributions OR II	
UNAIDS / OPEC Fund Egypt	40,000.00
UNAIDS / PAF Yemen	25,000.00
	65,000.00
Contributions in Kind	
PRM - Post Snr. Technical Officer HIV/AIDS Geneva	250,000.00
Post Exposure Prophylaxis kits	16,150.00
Training Clinical Management of Rape (East Africa)	15,000.00
UNFPA Condoms	34,015.00
USAID Condoms and logistical training (West Africa)	80,000.00
	395,165.00
Total Funds (including in-kind)	**1,564,384.82**

II. EXPENDITURE PROJECTS BY (SUB)REGION:	Amount in US$
East Africa	**281,966.33**
Central Africa	**186,394.33**
Southern Africa	**231,394.33**
West Africa	**206,394.33**
Asia	**232,594.33**
Eastern Europe	**20,000.00**
Regional / Global Activities	**296,720.33**
Total Expenditures	**1,455,463.98**

[2] Note that these figures are additional to the core UNHCR programmes that constitute the base of the HIV and AIDS programmes; this includes expenditures for protection, community services, education, health, environment, wat/san and age-gender-diversity mainstreaming.

Asia: 3 camps/sites or groups of camps/sites and 1 urban site (4 countries)	*Pop Estimate*	*CMR*	*U5MR*	*No. condoms distr*	*Male Urethr DC*	*Genital Ulcer DC*	*% Syphilis ANC*	*% HIV PMTCT*	*ART received*
Mean	68,485	0.23	0.37	0.03	0.03	0.04	0.2	0	15.7
Median	62,458	0.29	0.40	0.04	0.03	0.04	0.2	0	2
Minimum	11,311	0.10	0.15	0.01	0	0.01	0.01	0	0
Maximum	137,714	0.30	0.57	0.04	0.06	0.06	0.4	0	45
Sum	273,940								47
Count	4	3	3	3	2	2	2	0	3
NR or RI	0	1	1	1	2	2	2	3	0
SNP							0		
Total Count	4	4	4	4	4	4	4	3 (100%)	3 (100%)

	Y	%	N	%	NR	%	Total
Universal Precautions							
Sufficient[3] needles / syringes	4	100%	0	0%	0	0%	4
Sufficient[3] gloves	4	100%	0	0%	0	0%	4
Blood transfusion screened for HIV	3	75%	0	0%	1	25%	4
STI data							
Sufficient[3] condoms	4	100%	0	0%	0	0%	4
Sufficient[3] STI drugs	4	100%	0	0%	0	0%	4
STI syndromic approach	3	75%	1	25%	0	0%	4
VCT							
Access to VCT	3	75%	1	25%	0	0%	4
PMTCT							
Access to PMTCT	3	75%	1	25%	0	0%	4
Antiretroviral Therapy (ART)							
Do local population have access to ART	3	75%	1	25%	0	0%	4
Do refugees have access to ART	3	75%	1	25%	0	0%	4
PEP available Post Rape							
PEP available Post Rape	1	25%	3	75%	0	0%	4

Interpretation
CMR and U5MR-Acceptable
Condom distribution-Insufficient; not even reaching ER level
Universal precautions-OK at 75-100%; want 100% for all
STI supplies-OK at 75-100%; want 100% for all
VCT-Good at 75% access
PMTCT-Good at 75% access
ART-Good at 75% access local and refs
PEP-Insufficient at 25%
Sites reporting data-Insufficient; need to disaggregate by camp and improve overall reporting

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

ASIA	Bangladesh	India	Nepal	Thailand
UNHCR HIV DATA 2005	All camps (2)	urban	All Camps (7)	All camps (9)
Total population	20,000	11,311	104,915	137,714
Mortality Rates (MR)				
Crude MR (deaths/10,000/day)[1]	0.29	NR	0.30	0.10
<5 yrs MR (deaths/10,000/day)[2]	0.57	NR	0.40	0.15
Universal precautions				
Sufficient[3] needles / syringes	Yes	Yes	Yes	Yes
Sufficient[3] gloves	Yes	Yes	Yes	Yes
Blood transfusion screened for HIV	Yes	NR	Yes	Yes
Information-Education-Communication (IEC) Materials				
Do culturally appropriate IEC exist for refugees in camp[4]	No	No	Yes	Yes
If yes, is there a sufficient supply[5]	Yes		Yes	Yes
STI data				
No of condoms distributed[6]	0.01	NR	0.04	0.04 (2 camps)
Sufficient[3] condoms	Yes	Yes	Yes	Yes
Sufficient[3] STI drugs	Yes	Yes	Yes	Yes
STI syndromic approach	Yes	No	Yes	Yes
Incidence male urethral discharge (new cases/1000 males/month)	0.1	NR	0.0	NR
Incidence genital ulcer disease (new cases/1000 persons/month)	0.0	NR	0.06	NR
% syphilis pregnant women 1st visit ANC	0.4	NR	0.01	NR
VCT				
Access to VCT	No	Yes	Yes	Yes
If yes, in refugee site or outside of site		outside	mobile clinic	camp
No. persons tested/month		NR	50	9 (2 camps)
PMTCT				
Access to PMTCT	No	Yes	Yes	Yes
If yes, in refugee site or outside of site		outside	outside	Camp
% of pregnant women who accept PMTCT		NR	NR	NR
No. pregnant women tested/month		NR	NR	NR
% HIV prevalence of PMTCT clients		NR	NR	NR
Antiretroviral Therapy (ART)				
Do local population have access to ART	No	Yes	Yes	Yes
Do refugees have access to ART	No	Yes	Yes	Yes
If yes, how many are receiving ART now		2	0	> 45
Post Exposure Prophylaxis Rape Survivors				
PEP available Post Rape	No	No	No	Yes
Surveillance/Surveys				
Sentinel surveillance among pregnant women	SNP	SNP	SNP	0.26 (2 camps)
Latest HIV or RH BSS/KAPB	SNP	SNP	2005	2002 (3 camps)

1 CMR baseline in Middle East and North Africa for non-emergency is 0.16 deaths/10,000/day
2 U5MR baseline for Middle East and North Africa is 0.36 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 =%
NP=service not provided; NR = not reported; RI = reported incorrectly; Y=yes; N=no

CASWANAME: 1 group of camps and 2 urban sites (3 countries)	*Pop Estimate*	*CMR*	*U5MR*	*No. condoms distr*	*Male Urethr DC*	*Genital Ulcer DC*	*% Syphilis ANC*	*% HIV PMTCT*	*ART received*
Mean	449,759	0.2	0.4	0.0			0.3	1.0	
Median	40,000	0.2	0.4	0.0			0.3	1.0	
Minimum	18,870	0.2	0.4	0.0			0.3	1.0	
Maximum	1,290,408	0.2	0.4	0.0			0.3	1.0	
Sum	1,349,278								
Count	3	1	1	2	0	0	1	1	0
NR or RI	0	2	2	1	3	3	2	0	0
SNP							0		
Total Count	3	3	3	3	3	3	3	1 (100%)	0

	Y	**%**	**N**	**%**	**NR**	**%**	**Total**
Universal Precautions							
Sufficient[3] needles / syringes	2	67%	0	0%	1	33%	3
Sufficient[3] gloves	2	67%	0	0%	1	33%	3
Blood transfusion screened for HIV	1	33%	0	0%	2	67%	3
STI data							
Sufficient[3] condoms	2	67%	0	0%	1	33%	3
Sufficient[3] STI drugs	2	67%	0	0%	1	33%	3
STI syndromic approach	2	67%	0	0%	1	33%	3
VCT							
Access to VCT	1	33%	2	67%	0	0%	3
PMTCT							
Access to PMTCT	1	33%	2	67%	0	0%	3
Antiretroviral Therapy (ART)							
Do local population have access to ART	1	33%	2	67%	0	0%	3
Do refugees have access to ART	0	0%	3	100%	0	0%	3
PEP available Post Rape							
PEP available Post Rape	0	0%	3	100%	0	0%	3

Interpretation
CMR and U5MR-Acceptable
Condom distribution-Insufficient; not even reaching ER level
Universal precautions-Unacceptable at 33-66%
STI supplies-OK at 67%;want 100% for all
VCT-Insufficient at 33% access
PMTCT-Insufficient at 33% access
ART-Unacceptable at 0% access refs and 33% locals; want equity and increase for both groups
PEP-Unacceptable at 0%
Sites reporting data-Insufficient; need to disaggregate by camp and improve overall reporting

1 CMR baseline in Middle East and North Africa for non-emergency is 0.16 deaths/10,000/day
2 U5MR baseline for Middle East and North Africa is 0.36 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 =%
NP=service not provided; NR = not reported; RI = reported incorrectly; Y=yes; N=no

CASWANAME	Egypt	Pakistan	Yemen
UNHCR HIV DATA 2005	Urban	138 Camps	Urban
Total population	18,870	1,290,408	40,000
Mortality Rates (MR)			
Crude MR (deaths/10,000/day)[1]	NR	0.20	RI
<5 yrs MR (deaths/10,000/day)[2]	NR	0.40	RI
Universal precautions			
Sufficient[3] needles / syringes	NR	Yes	Yes
Sufficient[3] gloves	NR	Yes	Yes
Blood transfusion screened for HIV	NR	Yes	NR
Information-Education-Communication (IEC) Materials			
Do culturally appropriate IEC exist for refugees in camp[4]	Yes	Yes	Yes
If yes, is there a sufficient supply[5]	Yes	Yes	Yes
STI data			
No of condoms distributed[6]	NR	0.01	0.003
Sufficient[3] condoms	NR	Yes	Yes
Sufficient[3] STI drugs	NR	Yes	Yes
STI syndromic approach	NR	Yes	Yes
Incidence male urethral discharge (new cases/1000 males/month)	NR	NR	RI
Incidence genital ulcer disease (new cases/1000 persons/month)	NR	NR	RI
% syphilis pregnant women 1st visit ANC	NR	0.3	RI
VCT			
Access to VCT	Yes	No	No
If yes, in refugee site or outside of site	outside		
No. persons tested/month	65		
PMTCT			
Access to PMTCT	Yes	No	No
If yes, in refugee site or outside of site	outside		
% of pregnant women who accept PMTCT	99.8		
No. pregnant women tested/month	52		
% HIV prevalence of PMTCT clients	1.0		
Antiretroviral Therapy (ART)			
Do local population have access to ART	Yes	No	No
Do refugees have access to ART	No	No	No
If yes, how many are receiving ART now			
Post Exposure Prophylaxis Rape Survivors			
PEP available Post Rape	No	No	No
Surveillance/Surveys			
Sentinel surveillance among pregnant women	Yes	SNP	SNP
Latest HIV or RH BSS/KAPB	SNP	2000	SNP

1 Baseline in Middle East and North Africa for non-emergency is 0.16 deaths/10,000/day
2 Baseline for Middle East and North Africa is 0.36 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 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 =%
NP=service not provided; NR = not reported; RI = reported incorrectly; Y=yes; N=no

Central Africa: 29 camps/sites or groups of camps/sites and 6 urban sites (6 countries)	*Pop Estimate*	*CMR*	*U5MR*	*No. condoms distr*	*Male Urethr DC*	*Genital Ulcer DC*	*% Syphilis ANC*	*% HIV PMTCT*	*ART received*
Mean	11,316	0.34	0.47	0.4	3.8	0.8	14.7	4.5	5.8
Median	10,881	0.15	0.35	0.2	2.8	0.4	12.0	4.5	5
Minimum	448	0.0	0.0	0.002	0.03	0.0	0.0	0	2
Maximum	34,100	3	2	3.9	9.3	5.4	40.0	9	11
Sum	328,176								23
Count	29	29	29	18	16	15	11	2	4
NR or RI	6	6	6	17	19	20	6	8	2
SNP							18		
Total Count	35	35	35	35	35	35	35	10 (100%)	6 (100%)

	Y	%	N	%	NR	%	Total
Universal Precautions							
Sufficient[3] needles / syringes	27	77%	7	20%	1	3%	35
Sufficient[3] gloves	27	77%	7	20%	1	3%	35
Blood transfusion screened for HIV	34	97%	0		1	3%	35
STI data							
Sufficient[3] condoms	27	77%	2	6%	6	17%	35
Sufficient[3] STI drugs	27	77%	4	11%	4	11%	35
STI syndromic approach	31	89%	2	6%	2	6%	35
VCT							
Access to VCT	11	31%	23	66%	1	3%	35
PMTCT							
Access to PMTCT	10	29%	23	66%	2	6%	35
Antiretroviral Therapy (ART)							
Do local population have access to ART	8	23%	21	60%	6	17%	35
Do refugees have access to ART	6	17%	23	66%	6	17%	35
PEP available Post Rape							
PEP available Post Rape	14	40%	18	51%	3	9%	35

Interpretation
CMR and U5MR-Acceptable overall but some sites too high
Condom distribution-Insufficient; not even reaching ER level
Universal precautions-OK at 77-97%; want 100%
STI supplies-OK at 77-89%; want 100%
VCT-Insufficient at 31% access
PMTCT-Insufficient at 29% access
ART-Insufficient at 17% access refs and 23% locals; want equity and increase for both groups
PEP-Insufficient at 40%
Sites reporting data-Insufficient

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 =%
NP=service not provided; NR = not reported; RI = reported incorrectly; Y=yes; N=no

CENTRAL AFRICA	Burundi	Brundi	Burundi	DRC	DRC	DRC	DRC	DRC	DRC	DRC
UNHCR HIV DATA 2005	Gasarowe	Gihinga	Urban	Aru (4sites)	Kahemba	Kinvula	Urban (Lumbubashi)	Urban (Kinshasa)	Urban (Bukavu)	Libenge
Total population	6,500	2,600	NR	10,881	5,470	6,531	448	2,733	NR	NR
Mortality Rates (MR)										
Crude MR (deaths/10,000/day)[1]	0.14	1.00	NR	0.17	0.11	0.10	0	0.13	0	NR
<5 yrs MR (deaths/10,000/day)[2]	0.17	2.00	NR	0.26	0.26	0.35	0	0.42	0	NR
Universal precautions										
Sufficient[3] needles / syringes	Yes	Yes	Yes	No	Yes	No	No	Yes	Yes	No
Sufficient[3] gloves	Yes	Yes	Yes	No	Yes	No	No	Yes	Yes	No
Blood transfusion screened for HIV	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Information-Education-Communication (IEC) Materials										
Do culturally appropriate IEC exist for refugees in camp[4]	No	No	NR	Yes	Yes	Yes	Yes	Yes	Yes	Yes
If yes, is there a sufficient supply[5]			NR	No	Yes	Yes	Yes	Yes	No	No
STI data										
No of condoms distributed[6]	0.3	NR	NR	0.2	0.2	0.04	0.05	0.3	NR	NR
Sufficient[3] condoms	Yes	NR	NR	Yes	Yes	No	Yes	Yes	Yes	NR
Sufficient[3] STI drugs	Yes	Yes	Yes	No	Yes	No	Yes	Yes	Yes	NR
STI syndromic approach	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	NR
Incidence male urethral discharge (new cases/1000 males/month)	5.6	NR	Yes	9.3	1.4	3.1	9.3	7.3	NR	NR
Incidence genital ulcer disease (new cases/1000 persons/month)	0.6	NR	NR	0.3	0.1	0.4	5.4	0.5	NR	NR
% syphilis pregnant women 1st visit ANC	NR	SNP	NR	12.0	1.7	SNP	0	NR	SNP	NR
VCT										
Access to VCT	Yes	Yes	Yes	No	No	No	Yes	Yes	No	No
If yes, in refugee site or outside of site	outside	outside	outside				outside	outside		
No. persons tested/month	NR	NR	NR				NR	0.9		
PMTCT										
Access to PMTCT	Yes	Yes	Yes	No	No	No	Yes	Yes	No	No
If yes, in refugee site or outside of site	outside	outside	outside				outside	outside		
% of pregnant women who accept PMTCT	NR	NR	NR				100	NR		
No. pregnant women tested/month	NR	NR	NR				1	2		
% HIV prevalence of PMTCT clients	NR	NR	NR				9	0		
Antiretroviral Therapy (ART)										
Do local population have access to ART	Yes	No	Yes	Yes	NR	NR	No	No	NR	NR
Do refugees have access to ART	Yes	No	Yes	Yes	NR	NR	No	No	NR	NR
If yes, how many are receiving ART now	3	NA	NR	NR						
Post Exposure Prophylaxis Rape Survivors										
PEP available Post Rape	No	No	No	No	No	No	No	No	No	No
Surveillance/Surveys							0	0		
Sentinel surveillance among pregnant women	SNP	SNP	SNP	SNP	SNP	SNP	SNP	SNP	SNP	SNP
Latest HIV or RH BSS/KAPB	SNP	SNP	SNP	SNP	SNP	SNP	SNP	SNP	SNP	SNP

CENTRAL AFRICA	ROC	ROC	ROC	ROC	ROC	Rwanda	Rwanda	Rwanda	RCA	RCA	RCA
UNHCR HIV DATA 2005	Zone de Loukolela	Zone de Impfondo	Betou	Urban (Pointe Noire)	Urban (Brazza)	Kiziba	Gihembe	Nyabiheke	Mboki	Molangue	Urban
Total population	6,508	34,100	17,560	478	3,082	17,380	14,980	5,206	NR	937	6,230
Mortality Rates (MR)											
Crude MR (deaths/10,000/day)[1]	0.09	0.07	0.15	0	1.30	3.00	0.02	0.00	NR	0.18	0.29
<5 yrs MR (deaths/10,000/day)[2]	0.23	0.29	0.40	0	2.00	0.46	0.73	0.00	NR	0.56	0.35
Universal precautions											
Sufficient[3] needles / syringes	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes	NR	No	No
Sufficient[3] gloves	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes	NR	No	No
Blood transfusion screened for HIV	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	NR	Yes	Yes
Information-Education-Communication (IEC) Materials											
Do culturally appropriate IEC exist for refugees in camp[4]	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	NR	Yes	Yes
If yes, is there a sufficient supply[5]	No	No	Yes	Yes	Yes	No	Yes	Yes	NR	No	No
STI data											
No of condoms distributed[6]	RI	RI	1.4	3.9	0.2	1.0	0.1	0	NR	0.2	0.1
Sufficient[3] condoms	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	NR	Yes	Yes
Sufficient[3] STI drugs	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	NR	no	no
STI syndromic approach	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	NR	yes	no
Incidence male urethral discharge (new cases/1000 males/month)	0.3	1.9	8.2	NR	3.0	NR	0.03	7.5	NR	RI	0.6
Incidence genital ulcer disease (new cases/1000 persons/month)	0	0.4	0.7	NR	0	NR	0.0	RI	NR	RI	0
% syphilis pregnant women 1st visit ANC	SNP	SNP	SNP	SNP	SNP	NR	3.9	5.7	NR	SNP	0
VCT											
Access to VCT	No	No	No	Yes	Yes	Yes	Yes	Yes	NR	No	Yes
If yes, in refugee site or outside of site				in town	in town	outside	outside	outside			NR
No. persons tested/month				NR	NR	NR	73	NR			NR
PMTCT											
Access to PMTCT	No	No	No	Yes	Yes	Yes	Yes	NR	NR	No	Yes
If yes, in refugee site or outside of site				NR	NR	outside	outside				NR
% of pregnant women who accept PMTCT				NR	NR	NR	NR	NR	NR		NR
No. pregnant women tested/month				NR	NR	NR	NR	NR	NR		NR
% HIV prevalence of PMTCT clients				NR	NR	NR	NR	NR	NR		NR
Antiretroviral Therapy (ART)											
Do local population have access to ART	No	No	No	Yes	Yes	Yes	Yes	NR	NR	No	Yes
Do refugees have access to ART	No	No	No	No	No	Yes	Yes	NR	NR	No	Yes
If yes, how many are receiving ART now						7	11				2
Post Exposure Prophylaxis Rape Survivors											
PEP available Post Rape	No	No	No	No	No	No	No	No	NR	NR	NR
Surveillance/Surveys											
Sentinel surveillance among pregnant women	SNP	SNP	SNP	SNP	SNP	SNP	1.5% in '02	SNP	NR	SNP	SNP

CENTRAL AFRICA	CHAD	CHAD	CHAD	CHAD	CHAD	CHAD	CHAD	CHAD	CHAD	CHAD	CHAD	CHAD	CHAD	CHAD
UNHCR HIV DATA 2005	Oure-cassoni	Iridimi	Touloum	Amnabak	Mile	Kounoungo	Gaga	Farchana	Bredjing	Treguine	Djabal	Goz-Amer	Amboko	Yaroungo
Total population	18,646	15,000	19,779	16,134	12,344	10,818	4,242	17,485	27,485	14,448	13,559	16,612	NR	NR
Mortality Rates (MR)														
Crude MR (deaths/10,000/day)[1]	0.13	0.30	0.30	0.07	0.18	0.14	NA	0.60	0.30	0.50	0.20	0.27	NR	NR
<5 yrs MR (deaths/10,000/day)[2]	0.34	0.60	0.40	0.11	0.45	0.22	NA	0.70	0.20	1.10	0.32	0.74	NR	NR
Universal precautions														
Sufficient[3] needles / syringes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Sufficient[3] gloves	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Blood transfusion screened for HIV	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Information-Education-Communication (IEC) Materials														
Do culturally appropriate IEC exist for refugees in camp[4]	No	No	No	No	No	No	No	No	No	No	No	No	No	No
If yes, is there a sufficient supply[5]														
STI data														
No of condoms distributed[6]	NR	NR	0.002	NR	NR	NR	NR	NR	NR	0.04	0.02	0.02	NR	NR
Sufficient[3] condoms	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	NR	NR
Sufficient[3] STI drugs	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	NR	NR
STI syndromic approach	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Incidence male urethral discharge (new cases/1000 males/month)	NR	NR	NR	NR	NR	NR	NR	2.5	RI	0.4	0.6	NR	NR	NR
Incidence genital ulcer disease (new cases/1000 persons/month)	NR	NR	NR	NR	NR	NR	NR	2.6	RI	0.2	0.6	NR	NR	NR
% syphilis pregnant women 1st visit ANC	SNP	38.0	40.0	16.8	29.7	14.1	SNP	SNP	SNP	SNP	SNP	SNP	SNP	SNP
VCT														
Access to VCT	No	No	No	No	No	No	No	No	No	No	No	No	No	No
If yes, in refugee site or outside of site														
No. persons tested/month														
PMTCT														
Access to PMTCT	No	No	No	No	No	No	No	No	No	No	No	No	No	No
If yes, in refugee site or outside of site														
% of pregnant women who accept PMTCT														
No. pregnant women tested/month														
% HIV prevalence of PMTCT clients														
Antiretroviral Therapy (ART)														
Do local population have access to ART	No	No	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	No	No
If yes, how many are receiving ART now														
Post Exposure Prophylaxis Rape Survivors														
PEP available Post Rape	Yes	Yes	Yes	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	SNP	SNP	SNP
Latest HIV or RH BSS/KAPB	SNP	SNP	SNP	SNP	SNP	SNP	SNP	SNP	SNP	SNP	SNP	SNP	SNP	SNP

East Africa: 35 camps/sites or groups of camps/sites (6 countries)	*Pop Estimate*	*CMR*	*U5MR*	*No. condoms distr*	*Male Urethr DC*	*Genital Ulcer DC*	*% Syphilis ANC*	*% HIV PMTCT*	*ART received*
Mean	27,935	0.21	0.74	0.7	1.9	1.0	2.0	4.3	5.5
Median	16,267	0.12	0.7	0.7	1.1	0.4	1.9	1.5	3.5
Minimum	1,364	0.02	0.1	0.1	0.1	0.0	0.0	0.8	0
Maximum	127,523	0.9	2.4	2.4	9.1	4.6	7.0	17	37
Sum	977,713								88
Count	35	33	27	27	26	31	18	14	16
NR or RI	0	2	8	8	9	4	8	5	2
SNP							9		
Total Count	35	35	35	35	35	35	35	19 (100%)	18 (100%)

	Y	%	N	%	NR	%	Total
Universal Precautions							
Sufficient[3] needles / syringes	33	94%	2	6%	0	0%	35
Sufficient[3] gloves	32	91%	3	9%	0	0%	35
Blood transfusion screened for HIV	35	100%	0		0	0%	35
STI data							
Sufficient[3] condoms	24	69%	11	31%	0	0%	35
Sufficient[3] STI drugs	25	71%	10	29%	0	0%	35
STI syndromic approach	35	100%	0	0%	0	0%	35
VCT							
Access to VCT	24	69%	11	31%	0	0%	35
PMTCT							
Access to PMTCT	19	54%	16	46%	0	0%	35
Antiretroviral Therapy (ART)							
Do local population have access to ART	19	54%	16	46%	0	0%	35
Do refugees have access to ART	18	51%	17	49%	0	0%	35
PEP available Post Rape							
PEP available Post Rape	21	60%	14	40%	0	0%	35

Interpretation
CMR and U5MR-Acceptable overall but some sites too high
Condom distribution-Sufficient; nearly reaching non-ER level
Universal precautions-Good at 91-100%; want 100%
STI supplies-OK at 69-100%; want 100%
VCT-OK at 60% access; needs to increase
PMTCT-OK at 54% access; needs to increase
ART-OK at 51% access refs and 54% locals; needs to increase
PEP-OK at 60%; want 100%
Sites reporting data-Insufficient

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 =%
NP=service not provided; NR = not reported; RI = reported incorrectly; Y=yes; N=no

EAST AFRICA	**Ethiopia**	**Ethiopia**	**Ethiopia**	**Ethiopia**	**Ethiopia**	**Ethiopia**	**Ethiopia**	**Sudan**	**Sudan**	**Sudan**	**Sudan**	**Sudan**	**Sudan**
UNHCR HIV DATA 2005	Shimbela	Bonga	Dimma	Fugnido	Kebribeyah	Sherkole	Yarenja	Kilo 26	Um Gargour	Girba	Abuda	Suki	Fau 25
Total population	10,740	18,405	8,599	25,759	15,175	16,267	4,203	17,913	9,572	8,934	3,752	3,098	1,364
Mortality Rates (MR)													
Crude MR (deaths/10,000/day)[1]	0.12	0.09	0.05	0.02	0.06	0.23	NA	0.04	0.06	0.09	0.08	0.06	0.15
<5 yrs MR (deaths/10,000/day)[2]	0.32	0.20	RI	RI	0.11	0.40	NA	RI	RI	0.28	0.24	1.08	1.27
Universal precautions													
Sufficient[3] needles / syringes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Sufficient[3] gloves	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Blood transfusion screened for HIV	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Information-Education-Communication (IEC) Materials													
Do culturally appropriate IEC exist for refugees in camp[4]	Yes	No	Yes	No	Yes	No	No	Yes	Yes	Yes	Yes	Yes	Yes
If yes, is there a sufficient supply[5]	No		No		No			No	No	No	No	No	No
STI data													
No of condoms distributed[6]	0.3	0.05	1.3	0.1	0.04	0.1	0.2	NR	NR	NR	NR	NR	NR
Sufficient[3] condoms	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	No	No	No	No	No
Sufficient[3] STI drugs	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	No	No	No	No	No
STI syndromic approach	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Incidence male urethral discharge (new cases/1000 males/month)	1.2	0.3	0.1	0.3	0.4	0.1	1.0	RI	RI	RI	RI	RI	RI
Incidence genital ulcer disease (new cases/1000 persons/month)	NR	0.01	0.02	0.05	0.02	0.1	0.02	0.60	RI	0.05	0	0	0
% syphilis pregnant women 1st visit ANC	0	NR	NR	NR	NR	NR	0	SNP	SNP	SNP	SNP	SNP	SNP
VCT													
Access to VCT	No	No	Yes	No	No	Yes	No	No	No	No	No	No	No
If yes, in refugee site or outside of site			site			site							
No. persons tested/month			35			98							
PMTCT													
Access to PMTCT	No	No	No	No	No	No	No	No	No	No	No	No	No
If yes, in refugee site or outside of site													
% of pregnant women who accept PMTCT													
No. pregnant women tested/month													
% HIV prevalence of PMTCT clients													
Antiretroviral Therapy (ART)													
Do local population have access to ART	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	No	No	No	No	No
Do refugees have access to ART	No	Yes	Yes	Yes	Yes	Yes	No	No	No	No	No	No	No
If yes, how many are receiving ART now		0	0	0	0	1							
Post Exposure Prophylaxis Rape Survivors													
PEP available Post Rape	No	No	No	No	No	No	No	No	No	No	No	No	No
Surveillance/Surveys													
Sentinel surveillance pregnant women	SNP	SNP	2005	2005	SNP	2005	SNP						
Latest HIV or RH BSS/KAP	2004	SNP	2003	SNP	SNP	2004	2004	SNP	SNP	SNP	SNP	SNP	SNP

EAST AFRICA	Djibouti	Kenya	Kenya	Tanzania	Tanzania	Tanzania	Tanzania	Tanzania	Tanzania	Tanzania	Tanzania	Tanzania
UNHCR HIV DATA 2005	Ali Adde	Dadaab	Kakuma	Nyarag-usu	Lugufu	Mtabila/ Muyovos i	Lukole A/B	Mkwug-wa	Kanem-bwa	Karago (Closed)	Nduta	Mtendeli
Total population	10,084	127,523	91,969	61,473	90,871	78,158	49,194	2,280	14,198	3,184	25,656	27,438
Mortality Rates (MR)												
Crude MR (deaths/10,000/day)[1]	0.05	0.11	0.09	0.28	0.30	0.40	0.30	0.50	0.40	0.20	0.20	0.30
<5 yrs MR (deaths/10,000/day)[2]	RI	0.28	RI	0.81	1.20	1.10	0.80	2.40	0.80	0.50	0.70	0.70
Universal precautions												
Sufficient[3] needles / syringes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Sufficient[3] gloves	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Blood transfusion screened for HIV	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Information-Education-Communication (IEC) Materials												
Do culturally appropriate IEC exist for refugees in camp[4]	Yes	No	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
If yes, is there a sufficient supply[5]	Yes			NR	NR	NR	NR	NR	NR	NR	NR	NR
STI data												
No of condoms distributed[6]	0.04	0.004	1.9	2.2	2.7	1.6	2.3	4.0	1.0	3.6	1.0	1.0
Sufficient[3] condoms	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Sufficient[3] STI drugs	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	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)	5.4	RI	1.0	0.1	2.9	0.4	1.3	1.6	0.8	3.8	5.4	1.3
Incidence genital ulcer disease (new cases/1000 persons/month)	0.3	1.5	1.8	0.04	0.4	0.1	0.3	3.0	1.0	3.0	2.3	3.5
% syphilis pregnant women 1st visit ANC	SNP	0.1	2.6	1.9	2.8	3.6	NR	0.2	0	0	0.3	0
VCT												
Access to VCT	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
If yes, in refugee site or outside of site	outside	site	site	site	site	site	site	site	site	site	site	site
No. persons tested/month	NR	68	153	135	172	70	425	23	86	25	166	345
PMTCT												
Access to PMTCT	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
If yes, in refugee site or outside of site		site	site	site	site	site	site	site	site	site	site	site
% of pregnant women who accept PMTCT		NR	99.0%	90.0%	99.4%	100.0%	100.0%	79.0%	85.0%	37.0%	94.0%	97.0%
No. pregnant women tested/month		NR	313	177	385	75	236	67	513	50	RI	RI
% HIV prevalence of PMTCT clients		NR	1.4	0.80	1.40	1.00	2.00	1.50	0.80	4.80	0.80	0.80
Antiretroviral Therapy (ART)												
Do local population have access to ART	Yes	Yes	Yes	No	No	No	No	No	No	No	No	No
Do refugees have access to ART	Yes	Yes	Yes	No	No	No	Yes	No	No	No	No	No
If yes, how many are receiving ART now	NR	4	37				4					
Post Exposure Prophylaxis Rape Survivors												
PEP available Post Rape	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Surveillance/Surveys												
Sentinel surveillance pregnant women	SNP	1.4% in 2005	5.0% in 2002		1.8% in 2003	4.5% in 2003	1.6% in 2003	SNP	SNP		SNP	1.7% in 2003
Latest HIV or RH BSS/KAP	SNP	SNP	2004	2005	2005	SNP	2005	SNP	SNP	SNP	SNP	SNP

EAST AFRICA	Uganda	Uganda	Uganda	Uganda	Uganda	Uganda	Uganda	Uganda	Uganda	Uganda
UNHCR HIV DATA 2005	Nakivale	Oruchinga	Ikafe	Kiryandongo	Rhino Camp	Imvepi	Palorinya	Kyaka II	Kyangwali	Adjumani
Total population	15,537	41,515	9,826	15,802	19,699	23,206	34,690	14,400	43,309	33,920
Mortality Rates (MR)										
Crude MR (deaths/10,000/day)[1]	0.49	NR	0.10	0.12	0.03	0.02	0.12	0.90	0.60	0.35
<5 yrs MR (deaths/10,000/day)[2]	0.80	NR	0.40	0.23	0.10	0.10	0.32	2.00	2.00	0.86
Universal precautions										
Sufficient[3] needles / syringes	Yes	No	Yes	yes	Yes	Yes	Yes	Yes	Yes	No
Sufficient[3] gloves	Yes	No	Yes	yes	Yes	Yes	Yes	No	Yes	No
Blood transfusion screened for HIV	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Information-Education-Communication (IEC) Materials										
Do culturally appropriate IEC exist for refugees in camp[4]	Yes	No	Yes	Yes	No	No	Yes	No	Yes	Yes
If yes, is there a sufficient supply[5]	Yes	No	Yes	Yes	No	No	No	No	No	No
STI data										
No of condoms distributed[6]	0.5	0.8	0.1	0 .2	2.4	1.5	0.3	0.4	1.9	3.2
Sufficient[3] condoms	Yes	Yes	No	Yes	No	No	Yes	Yes	Yes	No
Sufficient[3] STI drugs	Yes	Yes	Yes	Yes	No	No	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)	9.1	RI	1.4	4.7	1.2	0.4	0.7	RI	3.2	0.2
Incidence genital ulcer disease (new cases/1000 persons/month)	RI	NR	0.4	3.4	1.0	0.5	1.2	1.0	4.6	0.7
% syphilis pregnant women 1st visit ANC	2.0	SNP	4.5	6.1	RI	NR	7.0	SNP	2.4	2.0
VCT										
Access to VCT	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
If yes, in refugee site or outside of site	site	outside	site	site	site	site	site	site	site	site
No. persons tested/month	144	25	62	39	17.3	30	24	60	320	95
PMTCT										
Access to PMTCT	No	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
If yes, in refugee site or outside of site			outside	outside	outside	outside	outside	outside	site	outside
% of pregnant women who accept PMTCT			RI	9.1%	NR	NR	NR	2%	87.3%	24%
No. pregnant women tested/month			RI	4	NR	NR	NR	5	2478	76
% HIV prevalence of PMTCT clients			RI	16.7	NR	NR	NR	17.0	5.1	5.7
Antiretroviral Therapy (ART)										
Do local population have access to ART	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes
Do refugees have access to ART	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes
If yes, how many are receiving ART now	3	7	0	3	5	13	NR	4		7
Post Exposure Prophylaxis Rape Survivors										
PEP available Post Rape	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Surveillance/Surveys										
Sentinel surveillance pregnant women	SNP	SNP	SNP	SNP	SNP	SNP	1.0% in 2004	SNP	2.7% in 2004	SNP
Latest HIV or RH BSS/KAP	May 2006		SNP	Mar-04	SMP	SNP	2001	SNP	SNP	SNP

Southern Africa: 9 camps/sites (4 countries)	*Pop Estimate*	*CMR*	*U5MR*	*No. condoms distr*	*Male Urethr DC*	*Genital Ulcer DC*	*% Syphilis ANC*	*% HIV PMTCT*	*ART received*
Mean	10,390	0.38	0.64	0.9	0.7	0.9	4.3	4.2	4.25
Median	6,500	0.3	0.47	1.0	0.3	0.2	3.4	2.8	3
Minimum	2,700	0.005	0.001	0.3	0.0002	0.00004	0.4	1.2	0
Maximum	20,093	1.5	1.9	2.0	3	3	10	10	16
Sum	93,514								34
Count	9	9	9	9	7	6	7	4	8
NR or RI	0	0	0	0	2	3	2	0	0
SNP							0		
Total Count	9	9	9	9	9	9	9	4 (100%)	8 (100%)

	Y	**%**	**N**	**%**	**NR**	**%**	**Total**
Universal Precautions							
Sufficient[3] needles / syringes	9	100%	0	0%	0	0%	9
Sufficient[3] gloves	9	100%	0	0%	0	0%	9
Blood transfusion screened for HIV	9	100%	0		0	0%	9
STI data							
Sufficient[3] condoms	9	100%	0	0%	0	0%	9
Sufficient[3] STI drugs	9	100%	0	0%	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	4	44%	5	56%	0	0%	9
Antiretroviral Therapy (ART)							
Do local population have access to ART	9	100%	0	0%	0	0%	9
Do refugees have access to ART	7	78%	2	22%	0	0%	9
PEP available Post Rape							
PEP available Post Rape	3	33%	5	56%	1	11%	9

Interpretation
CMR and U5MR-Acceptable overall but some sites too high
Condom distribution-Sufficient; reaching non-ER level
Universal precautions-Excellent at 100%
STI supplies-Excellent at 100%
VCT-Excellent at 100% access
PMTCT-Insufficient at 54% access; needs to go higher
ART-Good at 78% access refs and 100% locals; need equity with locals
PEP-Insufficient at 33%
Sites reporting data-Good

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 =%
NP=service not provided; NR = not reported; RI = reported incorrectly; Y=yes; N=no

SOUTHERN AFRICA	Botswana	Malawi	Malawi	Namibia	Zambia	Zambia	Zambia	Zambia	Zambia
UNHCR HIV DATA 2005	Dukwi	Luwani	Dzaleka	Osire	Mwange	Kala	Mayukwayukwa	Nangweshi	Maheba
Total Population	3,108	2,700	5,073	6,500	20,093	18,422	6,247	16,656	14,715
Mortality Rates (MR)									
Crude MR (deaths/1000/month)[1]	0.45	0.005	0.02	0.40	0.20	1.50	0.11	0.30	0.4
<5 yrs MR (deaths/1000/month)[2]	1.90	0	0.08	1.05	0.41	0.50	0.47	0.98	0.40
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
Information-Education-Communication (IEC) Materials									
Do culturally appropriate IEC exist for refugees in camp[4]	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
If yes, is there a sufficient supply[5]	No	Yes	No	No	Yes	No	No	No	No
STI data									
No of condoms distributed[6]	0.3	0.9	0.3	0.3	1.3	2.0	1.0	1.0	1.0
Sufficient[3] condoms	Yes	Yes	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)	0.01	1.0	0.3	3.0	0.5	NR	0	0	NR
Incidence genital ulcer disease (new cases/1000 persons/month)	0.007	2.0	0.3	3.0	0.1	NR	0.00004	NR	NR
% syphilis pregnant women 1st visit ANC	NR	4.0	0.5	0.4	3.0	8.6	10.0	NR	3.4
VCT									
Access to VCT	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
If yes, in refugee site or outside of site	site	site	site	outside	site	site	site	site	site
No. persons tested/month	28	20	17	11	10	30	14	50	15
PMTCT									
Access to PMTCT	No	Yes	Yes	Yes	No	Yes	No	No	No
If yes, in refugee site or outside of site		outside	site	site		site			
% of pregnant women who accept PMTCT		12%	26%	85%		15%			
No. pregnant women tested/month		20	8	15		60			
% HIV prevalence of PMTCT clients		10.0	4.0	1.6		1.2			
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	No	Yes	Yes	negotiatng with gov't	Yes	Yes	Yes	Yes	Yes
If yes, how many are receiving ART now		5	16	1	1	3	3	0	5
Post Exposure Prophylaxis Rape Survivors									
PEP available Post Rape	NR	No	No	Yes	Yes	Yes	No	No	No
Surveillance/Surveys									
Sentinel surveillance among pregnant women	SNP	SNP	SNP	SNP	1.2% in 2005	3.4% in 2005	SNP	SNP	SNP
Latest HIV or RH BSS/KAPB	SNP	SNP	SNP	SNP	SNP	SNP	SNP	SNP	SNP

West Africa: 22 camps/sites or groups of camps/sites (7 countries)	*Pop Estimate*	*CMR*	*U5MR*	*No. condoms distr*	*Male Urethr DC*	*Genital Ulcer DC*	*% Syphilis ANC*	*% HIV PMTCT*	*ART received*
Mean	31,151	0.22	0.49	0.5	10.7	11.2	0	4.0	6
Median	4,270	0.15	0.50	0.5	11.5	12.8	0	4.0	3
Minimum	714	0.03	0.04	0.02	1.8	0.6	0	4.0	1
Maximum	558,400	0.9	2	1.0	20.0	20.0	0	4.0	22
Sum	716,470								30
Count	23	23	23	20	14	14	0	1	5
NR or RI	0	0	0	3	9	9	0	2	0
SNP							23		
Total Count	23	23	23	23	23	23	23	3 (100%)	5 (100%)

	Y	%	N	%	NR	%	Total
Universal Precautions							
Sufficient[3] needles / syringes	23	100%	0	0%	0	0%	23
Sufficient[3] gloves	23	100%	0	0%	0	0%	23
Blood transfusion screened for HIV	23	100%	0		0	0%	23
STI data							
Sufficient[3] condoms	22	96%	1	4%	0	0%	23
Sufficient[3] STI drugs	23	100%	0	0%	0	0%	23
STI syndromic approach	23	100%	0	0%	0	0%	23
VCT							
Access to VCT	5	22%	18	78%	0	0%	23
PMTCT							
Access to PMTCT	3	13%	20	87%	0	0%	23
Antiretroviral Therapy (ART)							
Do local population have access to ART	5	22%	18	78%	0	0%	23
Do refugees have access to ART	5	22%	18	78%	0	0%	23
PEP available Post Rape							
PEP available Post Rape	18	78%	5	22%	0	0%	23

Interpretation
CMR and U5MR-Acceptable overall but some sites too high
Condom distribution-Insufficient; reaching ER level but not non-ER level
Universal precautions-Excellent at 100%
STI supplies-Good at 96-100%; want 100%
VCT-Insufficient at 22% access
PMTCT-Insufficient at 13% access
ART-Insufficient at 22% access for refs and locals
PEP-Good at 78%; want 100%
Sites reporting data-OK; could be improved for STI reporting

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 =%
NP=service not provided; NR = not reported; RI = reported incorrectly; Y=yes; N=no

WEST AFRICA	Cote d'Ivoire	Ghana	Ghana	Guinea	Guinea	Guinea	Guinea	Guinea	Guinea	Guinea	Liberia
UNHCR HIV DATA 2005	Nicla	Buduburam	Krisan	Kontaya	Telikore	Borea	Nonah	Kola	Kouankan	Laine	
Total population	6,054	40,419	1,650	7,479	3,421	1,379	3,585	6,530	16,202	22,174	558,400
Mortality Rates (MR)											
Crude MR (deaths/10,000/day)[1]	0.1	0.5	0.03	0.6	0.2	0.4	0.9	0.03	0.05	0.2	0.15
<5 yrs MR (deaths/10,000/day)[2]	0.5	1	0.2	2	0.7	0.9	0.18	0.13	0.13	0.12	0.16
Universal precautions											
Sufficient[3] needles / syringes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Sufficient[3] gloves	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Blood transfusion screened for HIV	Yes	Yes	N/A	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Information-Education-Communication (IEC) Materials											
Do culturally appropriate IEC exist for refugees in camp[4]	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
If yes, is there a sufficient supply[5]	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No
STI data											
No of condoms distributed[6]	1	0.47	0.75	0.76	0.5	0.5	0.5	0.5	0.5	0.5	0.02
Sufficient[3] condoms	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Sufficient[3] STI drugs	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
STI syndromic approach	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Incidence male urethral discharge (new cases/1000 males/month)	NR	2.1	1.8	12.5	10.5	11.5	11.52	12.9	12.9	13.2	20
Incidence genital ulcer disease (new cases/1000 persons/month)	NR	0.75	0.6	13.6	12.4	13.8	13.1	11.08	18.2	20	5.14
% syphilis pregnant women 1st visit ANC	SNP	SNP	SNP	SNP	SNP	SNP	SNP	SNP	SNP	SNP	SNP
VCT											
Access to VCT	No	Yes	No	No	No	No	No	No	No	No	No
If yes, in refugee site or outside of site		In site									
No. persons tested/month		26									
PMTCT											
Access to PMTCT	No	Yes	No	No	No	No	No	No	No	No	No
If yes, in refugee site or outside of site		In site									
% of pregnant women who accept PMTCT		44.0									
No. pregnant women tested/month		37									
% HIV prevalence of PMTCT clients		4.0									
Antiretroviral Therapy (ART)											
Do local population have access to ART	Yes	Yes	No	No	No	No	No	No	No	No	No
Do refugees have access to ART	Yes	Yes	No	No	No	No	No	No	No	No	No
If yes, how many are receiving ART now	1	3									
Post Exposure Prophylaxis Rape Survivors											
PEP available Post Rape	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No
Surveillance/Surveys											
Sentinel surveillance among pregnant women	SNP	SNP	SNP	SNP	SNP	SNP	SNP	SNP	SNP	SNP	SNP
Latest HIV or RH BSS/KAPB	SNP	SNP	SNP	SNP	SNP	SNP	SNP	SNP	SNP	SNP	SNP

WEST AFRICA	Benin	Benin	Benin	Nigeria	Sierra Leone	Sierra Leone	Sierra Leone	Sierra Leone	Sierra Leone	Sierra Leone	Sierra Leone	Sierra Leone
UNHCR HIV DATA 2005	Agame	Come	Kpomasse	Oru	Taima	Gondama	Bandajuma	Jimmi Bagbo	Gerihun	Jembe	Tobanda	Largo
Total population	9,326	1,300	714	5,676	4503	4087	3373	4270	3167	3695	4207	4859
Mortality Rates (MR)												
Crude MR (deaths/10,000/day)[1]	0.06	0.06	0.03	0.3	0.1	0.3	0.1	0.2	0.3	0.1	0.1	0.2
<5 yrs MR (deaths/10,000/day)[2]	0.32	0.32	0.6	0.5	0.5	0.5	0.04	0.5	0.7	0.5	0.3	0.5
Universal precautions												
Sufficient[3] needles / syringes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Sufficient[3] gloves	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Blood transfusion screened for HIV	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Information-Education-Communication (IEC) Materials												
Do culturally appropriate IEC exist for refugees in camp[4]	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
If yes, is there a sufficient supply[5]	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
STI data												
No of condoms distributed[6]	NR	NR	NR	0.3	0.3	0.36	0.42	0.33	0.45	0.38	0.36	0.31
Sufficient[3] condoms	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Sufficient[3] STI drugs	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	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)	13.2	11.5	6.1	10.4	NR	NR	NR	NR	NR	NR	NR	NR
Incidence genital ulcer disease (new cases/1000 persons/month)	14.9	13.6	8.1	11.3	NR	NR	NR	NR	NR	NR	NR	NR
% syphilis pregnant women 1st visit ANC	SNP	SNP	SNP	SNP	SNP	SNP	SNP	SNP	SNP	SNP	SNP	SNP
VCT												
Access to VCT	Yes	Yes	Yes	Yes	No	No	No	No	No	No	No	No
If yes, in refugee site or outside of site	outside	outside	NA	outside								
No. persons tested/month	NR	NR	NA	NR								
PMTCT												
Access to PMTCT	Yes	Yes	No	No	No	No	No	No	No	No	No	No
If yes, in refugee site or outside of site	outside	outside										
% of pregnant women who accept PMTCT	NR	NR										
No. pregnant women tested/month	NR	NR										
% HIV prevalence of PMTCT clients	NR	NR										
Antiretroviral Therapy (ART)												
Do local population have access to ART	Yes	Yes	No	Yes	No	No	No	No	No	No	No	No
Do refugees have access to ART	Yes	Yes	No	Yes	No	No	No	No	No	No	No	No
If yes, how many are receiving ART now	22	3		1								
Post Exposure Prophylaxis Rape Survivors												
PEP available Post Rape	No	No	No	No	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	SNP
Latest HIV or RH BSS/KAPB	SNP	SNP	SNP	SNP	SNP	SNP	SNP	SNP	SNP	SNP	SNP	SNP

15) Annexes on CD-ROM

1. UNHCR Strategic Plan for Refugees, HIV and AIDS, 2005 – 2007
2. Plan Stratégique du HCR pour 2005-2007 pour les réfugies, le VIH et le SIDA
3. Mission report Thailand, Apr 2005
4. Mission report Thailand, May 2005
5. Mission report Bangladesh, May 2005
6. Mission report Nepal, Jun 2005
7. Mission report Thailand, Jul 2005
8. Mission report Pakistan, Aug 2005
9. Mission report India, Nov 2005
10. Mission report Chad, Mar 2005
11. Mission report Central African Republic, Oct 2005
12. Mission report Burundi, Dec 2005
13. Mission report Rwanda, Dec 2005
14. Mission / training report Sudan, Sep 2005
15. Mission report Ethiopia, Dec 2005
16. Mission report Botswana, Feb 2005
17. Mission report Ghana, Feb 2005
18. Mission report Guinea, Apr 2005
19. Mission report Sierra Leone, May 2005
20. Mission report Cote d' Ivoire, Jun 2005
21. Mission report Ghana II, May 2005
22. Mission report Liberia, Jul 2005
23. Mission report Nigeria, Aug 2005
24. Mission report Benin, Sep 2005
25. Mission report VCT workshop Thailand, Oct 2005
26. Training report VCT in Sierra Leone, Mar 2005
27. Managing Disclosure Cards (English)
28. Managing Disclosure Cards (French)
29. Managing Disclosure Cards (Arabic)
30. Managing Disclosure Cards (Portugese)
31. UNHCR Programme for HIV and AIDS in the workplace
32. Report Regional HIV/AIDS Workshop Central Africa, Feb 2005
33. Report HIV/AIDS Unit Workshop, Jun 2005
34. Report Annual Health, Nutrition and HIV Coordination Meeting, Sep 2005
35. Report workshop workplace policies on HIV and AIDS for NGO's, Sep 2005
36. Behavioural Surveillance Survey Rwanda, Sep 2004
37. Behavioural Surveillance Survey Kenya, Nov 2004
38. Strategies to support the HIV-related needs of refugees and host populations, UNHCR/UNAIDS, 2005
39. Strategies to support the HIV-related needs of refugees and host populations, UNHCR/UNAIDS, 2005 (Russian)
40. Stratégies pour la prise en charge des besoins relatifs au VIH des réfugies et populations hôtes, 2005
41. Altaras R, Schilperoord M, Evaluation of the introduction of refugees and host populations, Tanzania, Field Experience UNHCR, 2005
42. Bard E, Schilperoord M, Community Conversations in Response to HIV/AIDS; a capacity building project with refugees and the host population, Republic of Congo, Field Experience UNHCR, 2005
43. Spiegel P, Harroff-Tavel H. *HIV/AIDS in internally displaced persons in 8 priority countries.* Geneva: UNHCR and IDD, OCHA, 2005
44. Lowicki-Zucca M, Spiegel P, Ciantia F. *AIDS, conflict and the media in Africa: risks in reporting bad data badly.* Emerg Themes Epidemiol 2005;2:12