



HIV/AIDS and Refugees



HIV/AIDS youth group performing in Rhino refugee settlement , Uganda. 05/03

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HIV/AIDS Programmes among Refugees in South Africa, Namibia and Zambia

12 February to 7 March 2003

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Executive Summary

An assessment mission was undertaken from 12 February to 7 March 2003 to observe and assess HIV/AIDS related programmes for the urban refugee population in South Africa and in selected refugee camps in Namibia and Zambia. The objectives of the mission were to observe elements of existing HIV/AIDS programmes in these countries, make recommendations for improvement where necessary and explore the possibility of launching a limited number of targeted pilot programmes. In view of the impending voluntary repatriation exercise to Angola, the mission specifically focused on refugee camps in Namibia and Zambia hosting large populations of Angolan refugees.

South Africa

South Africa's liberal constitution provides numerous rights to refugees. UNHCR and its partners should continue to advocate with the Government to accept refugees into its grant programme for persons living with AIDS and to help to reduce xenophobia that affects refugee access to services. Furthermore, UNHCR and its implementing partners (IPs) should step up efforts to promote the integration of refugees into local HIV/AIDS programmes. Within each city, a mapping exercise should occur among the various IPs to show the approximate size and location of where the refugees are living. One can add various layers to improve programming: (e.g. location of HIV/AIDS and other services). HIV sentinel site data for the local population will show the HIV prevalence in the areas that the refugees are living.

An evaluation of existing **IEC materials** in terms of cultural appropriateness and content should be conducted to monitor the acceptance of the materials in the refugee communities, as well as to identify gaps where additional materials need to be developed/ translated.

Refugee peer educators among the IPs should continue to promote **voluntary testing and counselling (VCT)** among refugee communities. Translators that accompany refugees to VCT sites must be trained in confidentiality and South African health staff at VCT sites need to be sensitised to right of refugees to receive VCT with no discrimination.

Awareness campaigns for refugee women should include information on **prevention of mother to child transmission (PMTCT)**. As South Africa increases the number of PMTCT programmes to its population, UNHCR and IPs should promote refugee access.

Since April 2001, the South African Government provides **post-exposure prophylaxis (PEP)** in its hospitals for occupational exposure as well as sexual violence. Information on PEP should be included in refugee peer education and life skills training. IP social workers should also be aware of where PEP is available for referral of refugee clients in need. Refugees suffering from AIDS are no longer able to take care of themselves and become a burden on their family and friends. UNHCR should make relevant provisions in the 2004 budget to provide food for refugees with AIDS. Linkages should be established with local organisations/ programmes distributing food to people living with AIDS. UNHCR and JRS should advocate for the inclusion of refugees into Government **home based care (HBC)** programmes, including training, equipment and supervision. The Jesuit Refugee Service (JRS) HBC programme should be more closely linked to other support programmes provided by JRS, such as emergency accommodation and food for vulnerable refugees. IPs could continue to promote an open and accepting environment for people living with HIV/AIDS (PLWH/As); refugees who choose to openly declare their status should be supported to play an active role in their communities and should be helped/supported to ensure that they receive available services.

Counselling for HIV positive refugee parents should include the need to make plans for their children's future. Family tracing should be initiated at the earliest stage possible for refugee children of HIV positive parents to locate any relatives who may be able to care for them in the future. UNHCR and IPs

must work together to determine the most appropriate durable solution for orphaned refugee children, whether family reunification, local placement in foster care or other solution.

Given the situation of urban refugees in South Africa, it is not possible to estimate their HIV prevalence. However, a small follow-up **behavioural surveillance survey** (BSS) to measure the impact of programmes implemented following the 2000 survey is recommended.

Namibia and Zambia

UNHCR should advocate with host Governments and other agencies working in the area of HIV/AIDS to include refugees in their plans and programmes. For example, Zambia has been awarded funds from the Global Fund to Fight AIDS, Tuberculosis and Malaria. UNHCR should co-ordinate an effort on behalf of IPs to receive funds for HIV/AIDS programmes for refugees from the Global Fund to Fight HIV/AIDS, Tuberculosis (TB) and Malaria's country co-ordinating mechanism. The Angolan refugees are residing in areas that may have higher HIV prevalence than Angola itself and an organised repatriation programme will shortly begin. UNHCR Angola should work together with other UN agencies, Government and non-Governmental organisations (NGOs) to ensure that discrimination against returnees is addressed while establishing appropriate and co-ordinated programmes in districts of return to address the HIV/AIDS related needs of returnees.

Supervision and co-ordination of HIV/AIDS programmes in the various camps need to be improved. UNHCR protection, programme and community services staff from Branch and Sub-Offices should include HIV/AIDS programme monitoring during (more) regular field missions as well as ensure that monthly meetings of HIV/AIDS Inter-Agency Committees are held. These committees should develop work plans in order to co-ordinate and monitor their activities in the camps. In particular, health care and community outreach workers from the various IPs and Government run clinics in the camps should meet on a regular basis to ensure co-ordination, standardisation of messages, and avoid duplication of work.

IPs in the camps need to ensure an adequate supply of **male condoms** in camp at all times. This is a matter of co-ordination and planning, not inadequate supply. They need to change from the "on demand" condom distribution system to ensure that condoms are freely available for collection from numerous sites within the camps and to develop a system for monthly reporting of the consolidated number of condoms distributed through all outlets.

There are insufficient **IEC** materials in all camps. In addition to IEC materials sourced outside of asylum countries, UNHCR and the IPS should obtain English and relevant local language materials produced by the Ministry of Health and other organisations (e.g., USAID) in the country of asylum for secondary students and other English/ local language speakers in the camp population. Furthermore, under the auspices of the HIV/AIDS Co-ordination Committees, IPs must co-ordinate the work and messages provided by community outreach workers; this will require refresher training on HIV/AIDS education messages. School curricula should be examined and improvements made to life skills teaching that includes HIV/AIDS education; appropriate materials and training to the teachers needs to be provided. UNHCR should explore the possibility of linking mine awareness training with HIV/AIDS information and condom distribution during the pre-departure phase of the repatriation.

Laboratory testing for HIV at the refugee referral district hospitals needs to be improved. Testing algorithms need to be set, a consistent supply of HIV tests need to be provided, and laboratory technicians need further training. Refugees suffering from TB in the camps should be encouraged to go for VCT at the referral hospital after their programmes have been improved while the initiation of some pilot VCT sites in some camps should be investigated.

Training opportunities for clinic staff, midwives and traditional birth attendants (TBAs) on non-antiretroviral (ARV) methods to reduce PMTCT should be provided. UNHCR and IPs should be cautious in promoting PMTCT programmes in the Angolan camps as organised repatriation will begin shortly and such activities will not be available in the rural areas of Angola for many years.

Furthermore, clinic staff should also be trained on the provision of **prophylaxis for opportunistic infections** (OIs) following Government protocols.

UNHCR Branch Offices should ensure that all UN staff are aware of the use and availability of **PEP** and make the necessary provisions to ensure field level access to PEP. IPs should discuss with their organisations the possibility of providing PEP to their staff at camp level.

Teenage pregnancies are apparently a big problem in the Angolan refugee camps. Improved documentation of teenage pregnancies including agreement on ages and reporting methods needs to be implemented, as do education campaign and programmes designed to reduce teenage pregnancy.

Sexually transmitted infections (STIs) are not correctly diagnosed and treated in the camps, and partner tracing and treatment is inadequate. Training of clinic personnel on syndromic diagnosis and treatment of STIs is necessary. IPs must re-double their efforts by community health workers to educate refugees on prevention of STIs. Partner contact tracing needs to be actively improved and reporting done correctly. Overall reporting of STIs by syndrome needs to be improved; this will require further training. Activities of sexual gender based violence (SGBV) workers should be co-ordinated with those of other outreach programmes in the camps and SGBV reporting should be improved.

Supplemental feeding programmes for persons with chronic disease are insufficient in the camps. A system must be put in place to define who is eligible for enrolment in SFPs as well as discharge criteria. TB patients should receive supplemental feeding throughout their full treatment. HBC pilot programmes in some camps, in co-operation with UNHCR, Government departments and experienced non-Governmental organisations (NGOs) should be investigated. Pilot HBC programmes should also begin in the DRC camps in northern Zambia. Messages combating stigma and discrimination against PLWH/As should be reinforced at all levels, including through community outreach workers and members of the Inter-Agency Committees on HIV/AIDS. Refugees who wish to openly declare their status should be provided with support and counselling in the camp.

IPs charged with monitoring and assisting **orphans** and unaccompanied minors must pay special attention to the nutritional status of such children, ensure they are able to regularly attend school and facilitate proper living arrangements for child headed households. As more parents die from AIDS, UNHCR, ICRC and IPs will have to be more pro-active in gathering information on surviving family members in order to facilitate family reunification. As the number of orphans among local host populations and in refugee communities will continue to rise, UNHCR will have to re-examine available durable solutions in order to promote solutions in line with the best interests of the child. A clear monitoring and reporting system for orphans needs to be developed.

HIV/AIDS and related **disease surveillance activities** are inadequate in the camps. Clinic staff should be trained on the WHO clinical case definition of AIDS and suspected AIDS cases should be reported. Deaths should be recorded according to the immediate cause of death, as well as the underlying cause of death in the central death register, as well as in the health information system submitted to UNHCR. Data for HIV prevalence among refugee blood donors are not possible as Namibia uses a central blood bank and Zambia uses forms to screen out high risk donors before testing. Discussions continue between UNHCR, UN agencies, Governments, bi-laterals and other organisations on the issue of implementing HIV sentinel surveillance in the camps; although these data would help in programme planning and evaluation, it must be ensured that the data would not be used to discriminate against refugees either in the host country or when they repatriate. UNHCR should explore the possibility of conducting BSS in selected camps in co-operation with experienced organisations.

HIV/AIDS and Refugees/Returnees Mission to Luanda, Angola

30 March - 3 April 2003

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Introduction

Despite the horrors and devastation of nearly three decades of conflict, or perhaps because of it, the HIV pandemic does not appear to be as severe in Angola as in the surrounding countries (see Epidemiology section below). Increased HIV risk factors due to war and displacement, such as increased risk taking/behavioural change, reduction in prevention and curative health centres, and gender-based violence may be outweighed by the reduction in mobility of and accessibility to the population. Men were not able to seek work in large cities and trucking routes were disrupted due to the conflict. On 4 April 2002, a peace accord was signed in Angola and stability has more or less existed since that time. Already, approximately 120,000 refugees have spontaneously repatriated from the Democratic Republic of Congo (DRC) and Zambia 1. Beginning in the second half of 2003, UNHCR and its implementing partners are planning to voluntarily repatriate approximately 170,000 refugees from DRC, Zambia and Namibia. A further 70,000 are expected to be repatriated in 2004. The Angolan refugees living in camps in Namibia and Zambia (see Assessment of HIV/AIDS Programs among Refugees in South Africa, Namibia, and Zambia, 12 February – 7 March 2003) may have increased HIV prevalence than the areas to which they are planning to return². The objectives of this mission were the following:

1. To meet with UNHCR Angola, the Government, other UN agencies, non-Governmental organisations (NGOs), and donors (see Appendix 1) to discuss the various HIV/AIDS programs currently being implemented in the refugee camps in Namibia and Zambia.
2. To directly and objectively address the issue of HIV prevalence among returning refugees.
3. To develop a plan of action to address HIV/AIDS programs in the areas of return.

EPIDEMIOLOGY (See Appendix 2)

Osire camp in Namibia (pop 17,574) is very isolated. It is surrounded by tens of kilometers of privately owned farms that are sparsely inhabited. Namibian Government sentinel surveillance data for the local population in the same district as the camp show an HIV prevalence of 25%. The three Zambian camps (total pop. 88,440) : Meheba (pop. 41,343), Mayukwayukwa (pop.21,582) and Nangweshi (pop. 25,515) have limited contact with the local population. Approximately half the population in Meheba and Mayukwayukwa came in the mid 1960s and the other half in 1999; Nangweshi's population arrived in 1999. Zambian Government sentinel surveillance for the local population in the same districts as the camps show an HIV prevalence of 15% (2002). The small camp of Ukwimi (pop. 2,308) is not discussed in this report. Given the results of previous antenatal care (ANC) sentinel surveillance studies in refugee camps in East Africa that showed consistently lower HIV prevalence among refugees in camps than the surrounding local populations, we conclude that the refugees in the camps in Zambia and Namibia have an estimated HIV prevalence of 5-10%. The factors that influence this conclusion are based on:

- Estimated baseline HIV prevalence of the refugee population before displacement.
- HIV prevalence of the surrounding populations.
- Location/isolation of the camps.

1 Source: Government of Angola.

2 Throughout this report, the term 'refugee returnees' refers to Angolan refugees being repatriated to Angola, either spontaneously or through the organised repatriation operation. The other group of returnees are the internally displaced persons who are returning to their places of origin.

- Amount of mixing among the refugees and local populations.
- Amount of time the refugees have been living in the camps.

ANC sentinel surveillance in Angola in 2001 showed an HIV prevalence rate of 8.6% in Luanda and 2.6-4.4% in two provinces (see Appendix 3). ANC sentinel surveillance for 2002

undertaken by the Government and WHO are still pending. However, there are questions about the latter survey's methodology and thus results may be biased. (Apparently pregnant women were asked if they wanted to participate in a survey with a form to be filled and blood to be taken; number of refusals were not recorded. We were not able to see a protocol for the survey and thus were unable to confirm if this was the case). Unofficial results are the following:

- Luanda: urban areas (3 sites) approximately 8%; peri-urban areas approximately 3-4%.
- Five provinces: 1.8-3.0% (not know number of sites per province; specifically if one urban and rural site were chosen in each province).

Numbers of other groups for comparison:

Refugee returnees: approximate numbers to be repatriated through the repatriation operation of UNHCR (2003).

DRC Zambia Namibia

Spontaneous 40,000-50,000 4,000-10,000 0

Assisted 50,000 32,000 16,000

Therefore, approximately 98,000 returnees from the camps and 44,000-60,000 spontaneous settlers. Approximately 20,000 people may return outside the expected repatriation. Overall 142,000-178,000 refugee returnees are expected.

Residents of Luanda: 3 million (estimated HIV prevalence 5-10%; same as for the approximately 105,000 refugees in the camps in Namibia and Zambia).

Commercial Sex Workers (CSW): (HIV prevalence 32.8% in 2001 in Luanda; see Appendix 2).

Military: unofficial estimate of 6%.

UNHCR POLICY

Protection of refugees

- Promotion of the right of return as a basic human right.
- There should be no mandatory HIV testing.
- Avoid any form of discriminatory treatment and/or stigmatisation of refugee returnees due the HIV/AIDS.

HIV/AIDS (refer to UNHCR Strategic Plan for HIV/AIDS and Refugees 2002-2004; see Appendix 4)

- Prevention.
- Care and treatment.
- Surveillance, monitoring and evaluation (M&E).

UNHCR PLAN OF ACTION

Refugee camps

(See Assessment of HIV/AIDS Programs among Refugees in South Africa, Namibia, and Zambia, 12 February – 7 March 2003)

Living in camps:

- Existing programs have *prevention* (community and reproductive health workers, peer educators, education in schools, condom distribution, sexually transmitted infections [STIs] treatment, care and treatment (basic health care, treatment of opportunistic infections [OIs], TB treatment), surveillance, M&E (behaviour surveillance surveys, STI reporting, antenatal care syphilis testing).
- Augmentation and standardisation of current programs will occur for 2003.
- Pilot programs in some camps: voluntary testing and counselling (VCT), home-based care (HBC) will occur in 2003.

Pre-departure:

- Combine HIV/AIDS prevention measures with landmine training, including education, pamphlets, condom distribution. Provide supply of condoms to returning health and community workers.
- Spontaneously settled refugees who wish to receive assistance from UNHCR will also undergo such training.

Note:

- Camp refugees have better HIV/AIDS knowledge than Angolans.
- Camp refugees have trained health and community workers, teachers, and peer educators that will benefit Angola upon return.
- Work with Angolan Government to accredit their training in countries of asylum.

Angola

Arrival in Angola:

- At reception centres, provide HIV education, pamphlets, condoms, and peer education training for

returnees and local community.

- Basic HIV/AIDS package provided to nearby health post, centres hospitals using IASC matrix (see Appendix 5).

Living in Angola:

- HIV/AIDS programs for **ALL** Angolans in refugee returnee municipalities (non-displaced, internally displaced (IDP), returnees), beginning with basic HIV/AIDS package and then expanding to more comprehensive programs.
- Follow lead of Angolan Government and the National HIV/AIDS Strategic Plan and protocols (when completed).
- Co-ordinate with UN agencies and NGOs; strengthen Government systems and avoid establishing parallel structures:
 - Develop 2003 proposal with WHO/UNHCR together with Angolan Government and UNAIDS; include UNICEF in planning as they have received funds for HIV/AIDS and returnees and will be able to undertake various activities in these provinces; concentrate on core HIV/AIDS activities outlined in the IASC matrix (see Appendix 5).
 - Develop more comprehensive HIV/AIDS proposals/programmes for the key provinces with numerous returnees for 2004 with WHO/UNICEF/UNHCR together with Angolan Government and UNAIDS.
 - Ensure that sufficient expertise and resources do not go solely to Moxico province but also to the other important provinces where returnees will be coming (Kuando Kubango, Zaire, Uige, and possibly Lunda Sul).

Advocacy

UNHCR should make concrete efforts to discredit unfounded rumours of high HIV prevalence among returning refugees - both in the capital and in the provinces. On 31 March, the Deputy Administrator of Cazumbo municipality in Moxico province, one of the returnee provinces, stated in an open meeting that 70% of the refugee returnees were HIV positive. Last year, the previous Governor of Uige province, another important returnee province, stated that returnees with AIDS should not be allowed to return. Important officials have used terms such as “Trojan horse” and “time bomb” to describe the refugees return in terms of HIV; this is incorrect. A UN official purportedly claimed that Angolan refugees in the Zambian camps have been serologically tested and found to have the same prevalence of the surrounding population. This is incorrect; Angolan refugees in Zambia or Namibia have never undergone population-based anonymous or ANC sentinel surveillance anonymous and unlinked HIV testing.

OTHER GROUPS OF CONCERN REGARDING HIV TRANSMISSION FOR ANGOLAN GOVERNMENT

- Persons living in Luanda.
- Workers and merchants: truck drivers, diamond miners, oil workers, traders.
- Commercial sex workers (CSWs).
- Armed forces.
- Demobilised soldiers.

CONSIDERATIONS FOR HIV/AIDS NATIONAL POLICY

- Complete National HIV/AIDS Strategic Plan and related protocols.
- With limited resources, the Strategic Plan should prioritise (not in order of priority):
 - Urban centres, especially Luanda
 - Refugee returnee areas
 - Transport corridors
 - Commercial sex workers
 - Armed forces
 - Demobilised soldiers
- Surveillance:
 - Antenatal sentinel surveillance should use accepted and published protocol and should not disaggregate according to groups

- Behavioural surveillance surveys
- Should stress primary HIV prevention for women and youth as priority groups.

OTHER RECOMMENDATIONS FOR UNHCR BO ANGOLA

- Monthly HIV/AIDS meetings between UNHCR, other UN agencies, and NGOs should occur to discuss programming in key provinces of return.
- Regional HIV/AIDS Co-ordinator should undertake mission to Angola:
 - Follow-up on recommendations in this report
 - Hold HIV/AIDS in main returnee areas meeting with partners
 - Visit main returnee sites
- Regional Health Co-ordinator should undertake mission to Angola:
 - Standardise health posts and medical referral procedures for reception centres
 - Develop health proposals together with Angolan Government, other UN agencies and NGOs for key provinces of return
 - Visit refugee camps in Angola proper (primarily DRC refugees)
- UNHCR has limited duration of responsibility for returnees. However, since they will be returning over several years, UNHCR presence in the key provinces of return will be required. UNHCR, other UN agencies, NGOs and donors should recognise that Angola is going through a reconstruction period. There needs to be improved and sustained coordination between humanitarian agencies, development agencies, and donors.

HIV/AIDS Programmes among Refugees in Tanzania, Uganda and Kenya

23 April to 9 May 2003

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Executive Summary

An introductory mission to assess the HIV/AIDS programmes in Tanzania, Uganda and Kenya was undertaken from the 23 April to 9 May 2003. The UNHCR Regional Technical Advisor for HIV/AIDS for the Horn and East of Africa together with the UNHCR HIV/AIDS Technical/Programme Officer from Geneva conducted the mission. The objectives of the mission were:

1. Introduction and familiarisation of the Regional Technical Advisor for HIV/AIDS with the programmes in Tanzania, Uganda and Kenya.
2. Establish links with the other UN agencies and governments in the region.
3. Follow up on the previous missions made by the Senior Technical Advisor for HIV/AIDS
4. Follow up on HIV/AIDS programmes that receive extra budgetary support from UNHCR HQ.

HIV/AIDS **awareness and education** are well developed in most of the refugee camps and settlements. The awareness and sensitisation campaigns are well conducted, especially in Uganda and Tanzania. While the focus of the programmes are heading in a more care and treatment direction, it is important to emphasise that the reduction in HIV/AIDS prevalence in Uganda was primarily due to increased awareness and education of the population. Therefore, continued attention should be paid to prevention programmes. **Universal precautions** in health facilities, especially by organising refresher training for staff working for waste disposal by incineration, is necessary to reduce the occupational risk. **Condom** use is openly discussed in Uganda and it is no longer a taboo. However, most of the persons met, including health professionals, do not sufficiently prioritise this intervention. **Voluntary counselling and testing (VCT)** programmes are well established in Tanzania and Kakuma refugee camp. In Uganda, the refugees have minimal access to VCT services. Facilities are far from the settlements and outreach programmes have not been established. In Kakuma, Kenya, a strong link with the **tuberculosis (TB)** programme has been established. Other refugee settings should adopt a similar approach. In Tanzania, **prevention of mother-to-child transmission (PMTCT)** expanded in a short period of time to all of the refugee camps. It is important to document the process and experiences in all refugee camps very carefully; strengthening of the monitoring and evaluation components is required. In Kakuma, more attention should be paid to the counselling for feeding options of HIV+ mothers. In Uganda, VCT services must be established more comprehensively and strengthened in the few areas where they exist. **Home Based Care (HBC)** Programmes need to be established as well.

The treatment of **opportunistic infections (OIs)** differs throughout the refugee programmes within and between countries. The standardised protocols from the Ministry of Health (MOH) or WHO need to be adapted in the Ugandan settlement programmes. HBC programmes have been established in Tanzania and many lessons have been learned that need to be shared among the various partners. A good framework for co-ordination between health and community services has been developed by NPA in Ngara, Tanzania. The **nutritional support** varies between countries and refugee camps/settlements. Dialogue with WFP is required in all three countries. Introduction of **Antiretroviral drugs (ARVs)** in refugee settings was a point of discussion everywhere. It is important that UNHCR develops a policy for ARVs in refugee situations.

Behavioural surveillance surveys (BSS) have not recently been undertaken in Tanzania and Uganda. Unfortunately, standardised studies for refugee settings have not yet been developed despite an agreement to do so at the December 2002 HIV/AIDS Tri-country workshop. UNHCR HQ should take initiative to develop a standardised BSS questionnaire for refugee settings. **Sentinel surveillance** has been undertaken in Tanzania and Kenya. In Uganda, UNHCR has not established sufficient links with the National AIDS Control Programme (NACP) and other agencies for the inclusion of refugee settlements and the surrounding population in the yearly Ugandan surveillance, as discussed during the first assessment mission and the HIV tri-county workshop.

Co-ordination and integration across sectors have not been adequately established in all countries despite discussion during the first assessment missions and the HIV tri-county workshop. There is overlap of work in many areas. In some places, two or three NGOs (health and community services NGOs) working on **home-based care** (HBC) programmes can be found in one camp. Co-operation between agencies needs to be addressed both at the camp and country levels. We suggest establishing a task force at camp level that promotes the multi-sectoral approach of HIV/AIDS prevention and care, improves the collaboration between the agencies, and divides the tasks among them. This task force will plan all HIV/AIDS activities in the camp. Refugees need to be integrally involved in this initiative. This will improve community participation, fight against discrimination, reduce stigma, and encourage **people living with HIV/AIDS** (PLWH/As) to speak out and participate fully in the HIV/AIDS programmes.

Mission Report: HIV/AIDS Programmes among Refugees in Ethiopia.

May14 – June 14, 2003

Dr. Abdikarim Musse, Regional Coordinator for HIV/AIDS in East and Horn of Africa

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I. EXECUTIVE SUMMARY

An exploratory mission was undertaken by the regional HIV/AIDS co-ordinator from 13 May to 13 June 03. The main objectives were:

- Observe the reproductive health and HIV/AIDS programmes in the refugee camps.
- Scale up HIV/AIDS programmes in the refugee camps.
- Promote implementing partners multi-sectoral response to HIV/AIDS epidemic among the refugees.
- Promote interagency collaboration with UN and other government agencies.
- Liaise with colleagues and organizations working on HIV/AIDS in the area.

A total of six refugee camps in the east and west of Ethiopia were visited.

All agencies and organisations that met, at both camp level and central level, are concerned about HIV/AIDS among the refugees.

The **reproductive health** programme in the refugee camps needs to be strengthened through training of staff and making reference charts and manuals available. In addition screening of pregnant women for syphilis according to protocols needs to be established. Sexual Gender-Based Violence (**SGBV**) programme needs to be strengthened in the areas of protection, health and community services.

Although ensuring **blood safety** is a policy of Ethiopia, blood is not screened systematically in some of the rural hospitals visited. In addition, **universal precautions** in the health facilities in the refugee camps should be improved, by organising refresher training for all staff and ensuring that protective gears are available. **Behavioural change and communication** (BCC) programmes on HIV/AIDS are organised ad-hoc basis. There is a lack of Information, education, communication materials in local languages. **Condom** distribution and supply is irregular and much resistance and rumours towards condoms were observed particularly among the Somali refugees. In the Somali refugee camps strong campaigns on harmful traditional practices are organised. **Voluntary Counselling and Testing** programmes are not available nor are programmes for the prevention of mother to child transmission.

The treatment and prevention of Sexually Transmitted Infections (STIs) needs to be strengthened by training in the syndromic management approach. It is important to ensure that essential drugs are available. There are currently no programmes for treatment of opportunistic infections. Home-based care (**HBC**) programmes are also not yet in place. Given the high prevalence of HIV/AIDS in the local community, demand for HBC in the camps could be high in the future. It is important to establish comprehensive, well co-ordinated HBC programmes in a multi-sectoral approach. Lessons can be learned from Kenya and Tanzania.

The scale and the magnitude of HIV infection in the refugee camps are not known. **Sentinel surveillance** studies to estimate the rates among pregnant women and STI patients have never been conducted. **Knowledge, Attitude, Behaviour Practices** studies have been carried out in Bonga by AMREF and in Sherkole by the International Rescue Committee (IRC) focused on young people. Both studies show that the knowledge levels of refugees on condoms, HIV/AIDS, and family planning are low. The implementation of further BCC studies is important.

A few vertical short-term programmes addressing HIV/AIDS have been implemented so far. Given that the HIV/AIDS programmes in Ethiopia will receive a boost after funding of the project proposal that is a result of this mission, it is important that from the start a multisectoral approach will be adopted between agencies and organisations at both camp and country level. It is suggested that a **multi-sectoral task force** at camp level be established, that promotes the multi-sectoral approach of HIV/AIDS prevention and care and improves the collaboration between the agencies and divides the tasks between them. **Refugees** need to be integrally involved in this initiative.

HIV/AIDS Programmes in Uganda

July 2003

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Executive Summary

Uganda was among one of the first African countries to be affected by the human immunodeficiency virus (HIV) pandemic. Due to concerted multi-sectoral interventions, HIV prevalence began to decline in the 1990s. In 2000, the overall antenatal prevalence rate was 6.1% and in 2001 it was 6.5%. In refugee settlements, however, HIV interventions were not systematically evaluated nor had sentinel surveillance been conducted.

Since 2000, HIV interventions in refugee settlements have increased. Static and outreach **voluntary counselling and testing** (VCT) is now available in all grade three health centres and plans are underway to discontinue the outreach VCT clinics. By August 2003, all district hospitals will be providing **prevention of mother-to-child transmission** (PMTCT) services and it is expected that refugees will be referred to these centres instead.

Universal precautions against HIV have been adhered to, but the disposal of sharp instruments has not been correctly carried out. A central blood donor unit collects donations, screens and then distributes the blood. All facilities have access to safe blood. The supply of disposable needles, syringes and consumable supplies is adequate and maternity units have protective gear. The supply of male condoms is steady and adequate while female condoms are not available at all units.

Information, education and communication (IEC) interventions have intensified and village level education campaigns observed. In May 2003, the Branch Office received funds from Headquarters to support HIV activities and the disbursement of funds to implementing partners (IPs) has advanced. These funds are expected to meet shortfalls that normally would not be covered by the UNHCR regular budget.

The HIV/AIDS programme has experienced some challenging problems. Used needles, syringes, dressings and swabs have been disposed of in open pits and waste rarely burnt because of a lack of fuel. Most health centres have no incinerators. The distribution outlets for condoms are limited and special groups have not been targeted. There are very few models of the male penis in health centres – this does not help to educate or demonstrate how condoms are put on, removed and disposed of.

The supply of **essential drugs** for treating sexually transmitted infections (STIs), tuberculosis (TB) and some opportunistic infections (OIs) is not regular. The stock of ciprofloxacin and streptomycin (for TB relapse cases) is depleted. Moreover, in some health centres, supplies of first line anti-TB drugs is inadequate. Supervision of patients on daily observed therapy (DOT) is sub-optimal, the default rate high and household **TB** contacts not investigated. The TB programme is vertical and the non-governmental organisation (NGO) /District Director of Health Service (DDHS) supervisors rarely know about the problems TB patients encounter or are aware of their follow-up and management.

Health care providers are not adequately trained or supervised to treat **STIs and OIs**. Similarly, the VCT/PMTCT interventions face major challenges. Group counselling is the norm and in some cases post-test counselling takes no more than five minutes.

VCT services are not well co-ordinated or supported. Due to work pressure in the VCT centre, many nurses inadvertently neglect their traditional responsibilities.

There is some indication that supportive **supervision** and on-the-job training is rarely conducted. Many supervisors appear to concentrate more on administrative issues rather than on providing much needed technical support.

In view of the above, it is recommended to:

- Construct incinerators in all health centres. Supervise and sensitise staff on the disposal of sharps and medical waste.
- Increase the number of condom outlets. Procure penis models. Intensify educational programmes about condom use and target special groups during condom distribution.
- Prepare and ensure that at least 2 sites are ready and operational for sentinel surveillance by January 2004.
- Monitor the VCT/PMTCT workload per health centre and, if necessary, advise the Branch Office to increase the number of health workers.
- Actively interact with stakeholders (namely the AIDS Information Centre (AIC), AIDS Control Programme (ACP), UNAIDS, WHO, UNICEF, NGOs) and highlight the need for coordination and support post-VCT services.
- Develop a comprehensive post-VCT programme that includes life-long counselling, programmes for people living with HIV/AIDS (PLWHA), family planning (FP), condom use, OIs, antiretrovirals (ARVs), nutritional support as well as home-based care (HBC)
- Ensure an adequate supply of drugs to treat STIs, TB and OIs. In addition, with the support of the ACP, train health care workers on the syndromic/clinical management of STIs/AIDS and the use of OI prophylaxis and management. If necessary, Headquarters could finance the training.
- The UNHCR Health Coordinator should put pressure on supervisors and ensure that technical support and on-the-job training for primary health care workers is provided. In addition, a significant proportion of the Health Coordinator's time should be spent on fieldwork and providing technical support.

ETAT DE LIEU DES PROGRAMMES VIH/SIDA EN FAVEUR DES REFUGIES

République Démocratique du Congo & République du Congo

Novembre 2003

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Executive Summary

1. General Policy

The countries of the Democratic Republic of Congo (DRC) and the Republic of Congo (RoC) have National HIV/AIDS Strategic Plans (NSPs) and normative HIV/AIDS protocols and guidelines [e.g. training modules for sexually transmitted Infections (STIs), voluntary counselling and testing (VCT)]. Both NSPs refer to refugees as well as displaced people vulnerable populations. However, this does not appear in the formulation of their HIV/AIDS interventions. There are no programmes specifically targeted at refugees.

In DRC, recently approved HIV/AIDS proposals from the World Bank and the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) have included refugees. Likewise, sub-regional initiatives such as the Great Lakes Initiative on HIV/AIDS (GLIA) and Oubangui Chari include refugees as a high-risk population and specific interventions are being considered to target them.

The World Bank's Multi-country AIDS Programme (MAP) budget of \$130 million USD (now in the evaluation phase) are incorporating specific intervention for refugee and returnee populations. DRC has recently received \$113 million USD in the 3rd round. Specific actions for refugees will hopefully be possible upon formulation of procedures.

DRC will shortly welcome returnees from RoC, the Central African Republic, Zambia, and Tanzania, among other countries. These groups have been included in the different financing plans currently under elaboration, including GLIA.

DRC HIV/AIDS and related guidelines and policies:

- HIV/AIDS strategic framework
- Strategic plan 1999 - 2008
- Interim Plan 2001 - 2003
- Training module in VCT
- Training module in management of opportunistic infections (OIs)
- Guide for antiretroviral treatment (ART)
- Norms and directives for VCT (2002)
- VCT Practical guide (2002)
- Norms and directives on the prevention and transmission from mother to child (PMTCT)
- Practical guide for STI management

In RoC, the UNHCR should equally follow up the various financing plans which are being formulated (MAP, GFATM, and Oubangui-Chari) and continue to advocate for the inclusion of refugees and returnees. RoC's application for the 3rd round of the GFATM, which did not mention refugees, was rejected. HCR and other organisations have an opportunity (and an obligation) to advocate for the inclusion of refugees and returnees when they resubmit the proposal for the 4th round.

The Republic of Congo might also welcome returnees from DRC. Contacts have already been initiated with national officers and financial backers in that country.

RoC HIV/AIDS and related guidelines and policies:

- ◆ Multisectoral strategic plan 2003 - 2005
 - ◆ GFATM proposal for 3rd round
- Other guides and training modules are being designed and/or revised.

The Bamako Initiative (BI)

UNHCR has launched the Bamako initiative since 2000. The sites in Bas-Congo, DRC have progressively implemented it refugee sensitization. For example, the Kimaza site (Oxfam, RoC refugees) introduced the BI in July 2003 and clients pay a nominal fee of 50 Congolese francs (0.14 USD). This amount will be progressively increased up to the ceiling of 200 Congolese francs (0.60 USD) in January 2004. This example is to be followed by the other refugee sites. The said fee is fixed with the agreement of refugee leaders who are supposed to manage the funds through a health committee. Vulnerable people who meet criteria defined by the health committee are exempt from this payment. Since this initiative was brought into operation, Kimaza site has seen a reduction in the number of visits per person to the clinic (from 13 refugee contacts per year to 3 contacts per year). However, previously free materials, such as condoms, needles and syringes, and bandages, now must be paid for. Health personnel also reported a reduction in the number of condoms distributed.

Recommendations:

- a. Follow up of services utilization trends since introduction of the BI: monitoring effects on general attendance to medical services with regard to number of people unable to meet user's fees, mortality rates, incidence of STIs, etc.
- b. Condoms and other HIV/AIDS prevention and care related services (tests, transfusion, VCT, injection and protection materials, etc.) should remain free of charge.

2. Protection

Obligatory HIV testing of refugees or returnees is not practised. Refugees have access to **public services** providing prevention and care services (e.g. VCT, anti-tuberculosis treatment) where they exist. We noticed some worrying discriminatory attitudes among refugees, especially religious leaders regarding HIV/AIDS.

We recommend that sensitization workshops, targeting information-education-communication (IEC) session and testimonies by people living with HIV/AIDS (PLWH/As) be organised with a view to sensitizing and giving positive and correct HIV/AIDS information to the refugee and surrounding host communities.

Sexual and gender-based violence (SGBV) occurs in all communities throughout the world. They are not unique to refugee situations. In Brazzaville, RoC, CEMIR has recorded only 3 cases of sexual violence over the past 5 years. In addition, there is a tendency to limit SGBV solely to cases of rape.

We recommend that UNHCR should, through its on going SGBV programmes, extend and reinforce on all the sites, interventions for preventing and responding to SGBV. Persons who have been trained by UNHCR in SGBV need to effectively disseminate the information to others. Improved coordination between community services, protection, the refugee community and health services is needed. Improved reporting using standardised (and broader) definitions of SGBV is needed.

The site of **Aba, Aru, RoC** is located <20 km from the Sudanese border. Sudanese rebels almost "officially control" the nearest Congolese city to the camp. In 1998, these very rebels attacked the nearby camp of **Dungu** and killed some refugees.

We recommend that UNHCR should be vigilant to the presence of **armed elements** (Sudanese rebels) at Aba and that protection services should be reinforced, notably through the SURGE programme. It is unclear why the camps are allowed to be located at <50km away from a border, which is the accepted standard.

3. Coordination and Supervision

The mission has identified insufficient coordination and supervision at three levels.

Level 1: UNHCR

Coordination meetings are regularly held with IPs present in the capital city (Kinshasa). For various reasons, [namely logistical difficulties such as transportation, insecurity in a few regions (e.g. Aru), the immense size of DRC, the scattering and the isolation of some refugee sites (e.g. Aru), field visits by the health coordinator to the DRC and RoC have been insufficient. One can see it through insufficient and irregular communication, information sharing, and provision of tools and plans to partners. The current situation of one health coordinator for the two countries based in Kinshasa is insufficient.

As regards **the HIV/AIDS UN Thematic Group** and the working meetings, UNHCR participation is consistent. In DRC, however, UNHCR's participation in sub-regional activities and initiatives such as Oubangui-Chari is irregular.

Recommendations:

- i. UNHCR hire a health officer (an International UN Volunteer –Int. UNV) for Aru, DRC as well as a health coordinator for RoC (again, an Int. UNV). The two health professionals should be doctors or nurses with a public health-related competence.
- ii. Planning, follow-up and evaluation meetings with IPs should be more frequent and regular.
- iii. Logistical problems need to be solved in order to make it easier for staff in the capital to visit refugee sites; this may require more funds.:
- iv. UNHCR strongly advocates for the inclusion of refugees and returnees at the UN Theme group and technical meetings; this includes MAP proposals, GFATM, GLIA and Oubangui-Chari).

Level 2: Implementing Partners

The **IPs** do not provide sufficient support or supervision to their staff in the camps. Teams have worked for several months without benefiting from supportive supervision from a senior medical staff who should provide the often junior doctors in the field (who have good will and drive but limited public health and refugee background) with appropriate guidance, support and training.

Recommendations:

- i. each partner should have an experienced health officer to supervise and train their staff in the field. This person needs to work closely and coordinate with UNHCR staff.
- ii. This improved supervision, training, and provision of relevant documentation will require more logistical support to permit consistent and frequent visits to the sites. In some cases, this will require the purchase of motorised canoes and the installation of more radios to facilitate communication between the IPs' base and the camps.

Level 3: The Refugee Camps/Sites

IPs and UNHCR have good working relationships with the host government's public health services. However, the relationships are mostly limited to the medical referrals of refugee patients to government hospitals. No structured framework of collaboration within health zones exists, such as regular coordination meetings and exchange visits, exchange of various information, assessment tools, etc. IPs working in the same region also do not organise internal visits or exchange visits among themselves. Refugee and host communities are not organised in such a way as to facilitate dialogue and the involvement in the formulation, integration and implementation of strategies to fight HIV/AIDS among the two interacting communities.

Recommendations:

- i. teams in the field improve contacts with national structures (e.g. health zone administrators and health personnel) through meetings and exchange visits. This would facilitate improved integration of HIV/AIDS interventions
- ii. IPs should organise meetings in the field backed up by exchange visits (intra and inter IP visits) in order to improve and standardise interventions.
- iii. Camp/site health committees and multisectoral HIV/AIDS committees should be established in each site; they should include a wide variety of refugee representatives as well as those from the surrounding host community.

4. Prevention

- a. **Blood safety** is assured for refugee populations in most camps/sites. Some sites do transfuse in the camps (e.g. Bas Congo) while most send patients to the local government or mission health facility (e.g. Aru, Impfondu).

Recommendations:

- a. verify the expiry dates of all tests
- b. install reliable cold chain equipment before tests are ordered and monitor temperature of fridge/freezer
- c. when possible, order tests that do not need cold chain (e.g. most 2nd generation HIV rapid tests)
- d. Ensure that laboratories in referral sites are of sufficient quality and have a sufficient supply of non expired tests. This will require visits by UNHCR staff. This would further reinforce collaboration.

- b. **Universal precautions** is not sufficient in most visited camps.

In a few sites, there were shortages of injection materials; this led an IP to re-use the same syringes and needles for one patient over the period of the treatment. Most IP staff had not been trained on universal precautions. “Sharp containers” did not exist in nearly all sites and medical waste management (collection and incineration) was below acceptable standards.

Recommendations:

- i. training and refresher courses for IP staff on universal precautions
- ii. provision and proper usage of “sharp containers” in all sites
- iii. construction of incinerators for all sites that do not have and the repair of those that exist; all incinerators need to have a locking mechanism to ensure that persons cannot open them.
- iv. improvement in the management (supply and use) of surgical and single use materials. We suggest that sites that have launched the BI ensure that injection and surgery materials are not charged to the patient and are kept in the structure and not given to the patient to take home.
- v. Sterilisation methods need to be improved and standardised; some structures use pressure cookers, others boiling water, others only disinfectant. Each structure should have at least one pressure cooker for the sterilisation of materials.

- c. **Condom promotion and distribution**

Condoms are available on all the sites visited. Their distribution is very medicalised; users have to go to the medical centre(s) to get them. Thus, quantities of condoms distributed are far below the UNHCR standards (0.6 condoms by each person per month in emergency stage and 1 condom per month for each person in post-emergency stage). IEC materials are missing everywhere for the promotion of preservatives and how to use them correctly.

Recommendations:

- i. increase distribution points and persons distributing them(e.g. community health agents), social workers, peer educators, kiosks, bars)
- ii. provision of IEC material on sites.
- iii. condoms should not be charged for within the BI framework
- iv. improve recording and reporting mechanisms for condom distribution; ensure consolidation by site.

- d. **Behavioural Change and Communication (BCC) and IEC**

IEC is not a routine structured (or planned) activity on the sites visited. Education materials in appropriate local languages are missing everywhere. The training of peer educators of target groups has not been systematically organised.

Recommendations:

- i. UNHCR HIV AIDS Regional coordinator collects and distributes IEC materials to IPs in languages of refugees.
- ii. IPs should encourage refugee population to develop IEC materials in sites.
- iii. IPs to organise formal HIV/AIDS training session of peer educators and focal points of social groups (e.g. youth, women, religious leaders, teachers, refugees' leaders and local surrounding populations).
- iv. Develop and distribute IEC materials for promotion of preservatives and how to use them correctly.
- v. By training large numbers of refugees on HIV/AIDS, pool of resource persons capable of continuing activities when they repatriate will have been created; provision of incentives such as T-shirts and soft drinks should be sufficient to enhance motivation.
- vi. acquisition of audiovisual equipment (where logistically possible).

e. HIV Voluntary Counselling and Testing

Some partners (i.e. IRC, Oxfam Québec) have initiated VCT in Bas Congo. The training and implementation occurred too quickly in the Oxfam sites; staff were not trained properly, non standardised HIV testing algorithms are used, counselling rooms are not sufficiently private, and community sensitisation was insufficiently undertaken. Thus, use of VCT services is accordingly low.

Recommendations:

- i. VCT services should be established after all minimal interventions required in emergency phase have been established and are functioning properly (annex 1)
- ii. Implementation of national guidelines relating to VCT (and other HIV interventions are followed) and supervision to ensure their use.
- iii. IPs should seek approval from UNHCR prior to the introduction of VCT.
- iv. personnel are properly and sufficiently trained and population is adequately sensitised before VCT services begins.
- v. Standardisation of VCT services at all stages including testing algorithms, and data collection and analysis. The use of three rapid tests are recommended (Annex 5).

f. Prevention of Mother-to-Child Transmission

PMTCT does not exist in DRC or RoC refugee sites. We encourage our partners who have launched VCT to follow Oxfam's example in Bas Congo where they send HIV positive pregnant women to the local public hospital that has a PMTCT programme. However, this needs to be undertaken more systematically by Oxfam.

Recommendations:

- i. PMTCT interventions in refugee sites should only be installed when all required minimal interventions in emergency phase have been implemented and are functioning sufficiently. (Annex 1).
- ii. VCT programmes should be functioning well before PMTCT programmes are implemented.
- iii. UNHCR should be consulted before IPs implement PMTCT programmes.

g. Prophylaxis of opportunistic infections (OIs)

The prophylaxis for OIs does not exist yet in any refugee sites.

Recommendations:

- i. Those persons who have been diagnosed HIV positive by clinical diagnosis or VCT should be checked for active tuberculosis (TB); those with active TB should be treated and those with inactive TB should be provided INH prophylaxis (if government protocol states this should be so).
- ii. Prophylaxis against bacterial infections with trimethoprim-sulpha should be considered in all HIV positive patients that meet the criteria. Government protocols should be followed. Training of IP staff will be required.

h. Post Exposure Prophylaxis (PEP)

After possible accidental exposure to HIV in health structures

These strategies do not exist yet within our health facilities for IPs. Even if antiretroviral medications (ARVs) are not available, UNHCR and its partners should define and put in place simple protocols and reporting mechanisms that can reduce contamination after possible accidental exposure to HIV and record such incidents. According to UN policy, PEP starter kits should be available in all duty stations for UNHCR staff. However, this is not the case in most sub and field offices we visited.

Recommendations:

- i. each IP should clarify its position regarding PEP for its medical staff.
- ii. IPs implement a system to document each incident among their staff
- iii. UNHCR staff should be made aware of PEP and PEP starter kits should be available in all duty stations regardless of locations

PEP for refugees

There is no official policy yet regarding using PEP for refugees in either workplace or cases of rape. Pilot projects for PEP post rape are currently underway in Tanzanian refugee camps.

5. Support, Care and Treatment

I.

II. a. Sexually transmitted infections(STIs)

Care and support of STI exist in all sites but are insufficient.

Recommendations:

- i. training or retraining of staff in syndromic diagnosis and management of STIs; this includes standardisation of therapeutic protocols.
- ii. regular supply of drugs and condoms for STI treatment.
- iii. contact Tracing, treatment and partner follow-up.
- iv. proper surveillance and reporting.

b. OIs including TB

Only Tuberculosis has a standardised (national) protocol. Other current OIs (e.g. skin conditions, candidiasis, certain bacterial infections) have no standard care and support. Care providers staff treat according to their knowledge and (often limited) means.

Recommendations:

- i. standardisation of and training for management of OIS whose treatment is appropriate within refugee context and follows national protocols be implemented.
- ii. Patients with active TB should be encouraged to be tested for HIV.

c. Nutrition

Nutritional support to vulnerable people is organised in most the sites by the IPs' social and community services. Support targets chronically ill patients (e.g. HIV, TB) as well as pregnant and lactating women.

Recommendations:

- i. coordinate with World Food Programme (WFP) to integrate vulnerable people in the WFP's interventions.
- ii. standardise supplementary food rations for those who are chronically ill.
- iii. to reduce stigma, ensure that HIV positive persons are included with those that are chronically ill and not specifically singled out as "HIV/AIDS persons".

d. Home Based Care (HBC)

HBC is not systematically organised. The importance of establishing more comprehensive HBC programmes was not specifically emphasised according to the IPs. Social and community services identify and support those who need HBC in conjunction with health services.

Recommendations:

- i. training and formation of multisectoral teams for HBC among IPs.
- ii. concerns and recommendations regarding stigma, as mentioned in Nutrition section above, should be followed.

e. People living with HIV/AIDS.(PLWH/As)

Although there are chronically ill people living in these sites, many of whom suffer from HIV/AIDS, PLWH/As are not officially recorded due to concerns of stigma, confidentiality, doctors not wishing to make the diagnosis without a laboratory confirmation, and absence of VCT as well as care and support services. In Urban centres (e.g. Brazzaville, Kinshasa, Lubumbashi), IPs follow some refugees who are HIV positive. Access to ARVs does not exist for refugees at present (as well as for the local communities).

Recommendations:

- i. Health staff should be trained in clinical diagnosis of HIV/AIDS according to WHO and host country protocols.
- ii. Sufficient safeguards to ensure confidentiality must be established.
- iii. Proper recording and reporting system should be established that will allow PWH/As to receive nutrition supplementation, prophylaxis and treatment for OIs, and other important services.
- iv. BCC and IEC recommendations above should be followed to reduce stigma and discrimination of PLWH/As.

f. Orphans.

There are some orphans in the sites we visited. For the most part, they live extended families, and rarely with host families. Social and community services deal with nutritional support, schooling and other essential activities for these vulnerable children. Although not yet a significant problem, as the HIV epidemic worsens among these communities, the number of orphans will increase and the ability for the community to absorb them will reduce. The number of Orphans due to HIV/AIDS are not recorded and reported systematically.

Recommendations:

- i. Improved recording and reporting of orphans is needed.
- ii. UNHCR and IPs need to plan for the future, as the HIV epidemic will worsen; this includes a plan for support and care for orphans.

6. Surveillance, Monitoring and Evaluation***a. Behaviour surveillance Surveys(BSS)***

In January 2003 in RoC, IRC undertook a Knowledge, Attitudes and Practices(KAP) survey in Betou. This will serve as a baseline for the future. Other IPs have not undertaken BSS in refugee sites.

Recommendations:

- a. advocacy by HCR and IPs with the host governments to integrate refugees' sites into BSS when organised by national authorities in surrounding host communities
- b. UNHCR is planning to develop a standardised BSS for refugee situations. IP's planning to undertake BSS in their sites should inform UNHCR to help with coordination and technical assistance.

b. Reporting of clinical AIDS cases and deaths due AIDS

Reporting of clinical AIDS cases and deaths due AIDS is neither systematic nor standardised.

Recommendations:

- i. institute mortality register in each refugee site and ensure column for 'direct cause' and 'underlying' cause of death (Annex 7).
- ii. follow recommendations in PLWH/As section.

c. Blood donors

Data on blood donors are incomplete, not standardised, and often not disaggregated by refugee and local persons.

Recommendations:

- i. IPs follow and record results of refugee blood donors who go to referral hospitals to donate bloods; this could serve as a 'proxy indicator' of HIV prevalence. Data must be disaggregated into refugees and locals.
- ii. However, IPs must refrain from using such data to declare an estimate of HIV prevalence among the refugee populations they serve due to the biases of this estimate. Other data need to be combined with these data to make an estimate.

d. Syphilis testing at Antenatal Care (ANC) clinics

The testing of Syphilis during the ANC sessions is not systematic in all sites. Where it exists, it is often of unreliable quality.

Recommendations:

- i. All refugee sites should organise syphilis testing in ANC clinics. If cold chain is not available in camps, (e.g. many sites in RoC along the river), a mobile strategy with transportation of vaccines and reagents in cool boxes on the day ANC services are offered; RPR testing for syphilis is dependent upon a cold chain.
- ii. Like HIV data among blood donors, these data can be used as a proxy indicator of HIV prevalence.
- iii. Syphilis testing in ANC clinics is also a precursor to HIV ANC sentinel surveillance.

e. Syndrome approach of STIs

Most sites do not use the STI syndromic approach.

Recommendations: see STI section 5. a.

f. OI + TB

Only cases of Tuberculosis are notified

Recommendations: see STI section 4. g. and 5. b.

g. VCT

Where they exist (i.e. Bas Congo, DRC), it is necessary to review the system of the collection of data and post test follow up. See also recommendations in section 4. e.

h. PMTCT

PMTCT does not exist in refugee sites. Where possible, we encourage our partners to collaborate with local structures that offer PMTCT. See also recommendations in section 4. f.

i. Sentinel surveillance

Apart from IRC in Bas Congo, DRC, HIV sentinel surveillance among ANC attendees has not been organised elsewhere. The results of this study undertaken between June to October 2002 showed a prevalence of 3.2%. This prevalence was similar to the local population where ANC has been undertaken at a local hospital.

Recommendations:

- i. After ANC syphilis has been established in refugee sites (see section 6. f.), ANC HIV sentinel surveillance should be considered to be implemented. Consultation with UNHCR and local authorities must occur. Whenever, possible, ANC sentinel surveillance among refugees should occur during the same time as that undertaken in the surrounding communities.
- ii. UNHCR and IPs should advocate to include refugee sites within government's sentinel surveillance programmes.

RESUME

1. politique generale

La République Démocratique du Congo (RDC) et la République du Congo (RC) ont développé chacun en ce qui le concerne des documents normatifs de politique de lutte contre le Sida, des protocoles et guidelines spécifiques (module de formations pour les infections sexuellement transmissibles (IST), le conseil pour le dépistage volontaire (CDV), etc.) et des plans stratégiques multisectoriels.

Dans ces documents, « les réfugiés », au même titre que « les déplacés », sont considérés comme populations vulnérables. Cependant, cela ne ressort pas dans la formulation des plans d'actions : il n'existe pas d'action clairement définies et visant spécialement les populations réfugiés.

En RDC, les projets de financement de la Banque Mondiale « MAP » (Multi country aids Programme) et du Fonds Mondial ont tenu compte du contexte réfugié. De même, les initiatives sous-régionales comme la Great Lakes Initiative for HIV/AIDS (GLIA) et l'Oubangui Chari considèrent la population réfugiée comme population à haut risque. Des interventions spécifiques en faveur des réfugiés sont en cours d'élaboration.

Pour ce qui est du MAP (130, 000,000 dollars US) qui est en phase d'évaluation, un plan d'action spécifique pour les réfugiés est en cours d'élaboration.

En ce qui concerne le fonds mondial contre la tuberculose, la malaria et le VIH Sida (FM) (113, 000,000 dollars US), la RDC a été retenue au troisième tour. Des actions spécifiques pour les réfugiés seront envisagées dès signature des accords.

La RDC pourra accueillir dans un futur proche des rapatriés du Congo Brazza, de la République centrafricaine, de la Zambie, Tanzanie, etc.

Ces groupes ont été retenus dans les différents plans de financement en cours d'élaboration.

Différents guidelines et documents normatifs sont disponibles :

- ◆ Cadre stratégique HIV Sida
- ◆ Plan stratégique 1999 2008
- ◆ Plan intermédiaire 2001-2003
- ◆ Module de formation en conseil de dépistage volontaire (CDV)
- ◆ Module de formation en prise en charge des infections opportunistes (2002)
- ◆ Guide de traitement antirétroviraux
- ◆ Normes et directives sur les CDV (2002)
- ◆ Guide pratique du CDV (2002)
- ◆ Normes et directives sur la prévention de la transmission mère et enfants (PTME) (2001)
- ◆ Guide pratique de prise en charge des infections sexuellement transmissibles (IST) (2001)

En République du Congo, le HCR devra suivre également les différents plans de financement en cours d'élaboration (Oubangui Chari, MAP, FM) et continuer les plaidoyers initiés par l'équipe afin que le réfugié y soit bien pris en compte. En effet, dans la requête de financement pour le FM de mai 2003, rejetée, les réfugiés et les déplacés ne sont pas mentionnés. La République du Congo pourra aussi accueillir des rapatriés de la RDC. Des contacts ont été initiés avec les responsables nationaux et les bailleurs de fonds dans ce sens.

Différents modules de formations et documents normatifs (voir supra) ont été élaborés en RC.

Plan stratégique multisectoriel 2003-2005

Plan de requête pour financement aux fonds mondiaux

Les autres guides et modules de formations sont en cours d'élaboration/révision

Initiative de Bamako (IB)

Le HCR a lancé l'initiative de Bamako (IB) depuis début 2000. Les sites dans le Bas Congo l'ont progressivement instauré après sensibilisation des réfugiés. Par exemple, le site de Kimanza (Oxfam, réfugiés de la République du Congo) a introduit en juillet 2003 le paiement d'un montant forfaitaire

de 50 Francs Congolais (0,14 USD). Ce montant sera progressivement augmenté pour atteindre le plafond de 200 FC (0,6 USD) en janvier 2004. Cet exemple devrait être suivi par les autres sites de réfugiés. La tarification est fixée avec l'accord des leaders des réfugiés sensés gérer les fonds à travers un comité de santé.

Les vulnérables qui remplissent les critères définis par le comité de santé ne paient pas.

Depuis cette initiative, on est passé en 3 mois de 13 contacts par réfugié par an (avant l'IB) à 3 contacts par an dans le même site.

Nous recommandons de

- a. Suivre la tendance de l'utilisation des services après l'IB, et voir comment cela affecte les consultations curatives : % des personnes ne pouvant payer les frais de consultations, taux de mortalité, incidence des IST après l'IB, etc.
- b. S'assurer que les préservatifs et autres services liés à la prévention du VIH (test, transfusions, CDV, RPR, matériel injectables et de protection, etc.) restent gratuits dans le cadre de l'IB

2. Protection

La **discrimination, les tests obligatoires ou la stigmatisation** du réfugié ou rapatrié à cause du statut VIH **ne sont pas connus**.

Les réfugiés ont **accès aux services publics** en rapport avec la prise en charge du VIH (par exemple le CDV, le traitement anti-tuberculeux, etc.) là où ils existent.

Cependant nous avons rencontré des attitudes négatives et préoccupantes parmi les réfugiés, plus spécialement les responsables des groupes religieux par rapport au VIH Sida

Nous recommandons que des ateliers de sensibilisation, des séances IEC (Information, Education et communication) ciblées et des témoignages par des PVV (personnes vivant avec le VIH Sida) soient organisés pour sensibiliser et donner à ces groupes une information positivement correcte sur le VIH Sida.

Des **cas de violence sexuelle** ont été signalés un peu partout. Mais cela n'est pas spécifique au milieu réfugié. A Brazzaville, la CEMIR a enregistré 3 cas de violence sexuelle en 5 ans. On a l'impression dans les deux pays que les SGBV ne sont pas tous notifiés. En plus, la tendance est de considérer et limiter les SGBV aux rares cas de « viol » médicalement prouvés.

Le HCR devra, au travers de son programme SGBV en cours, devra étendre et renforcer dans tous les sites les interventions pour prévenir et répondre aux violences sexuelles.

Nous recommandons que les personnes que le HCR aura formées en SGBV disséminent réellement l'information à toute la population au niveau des sites.

Aussi, nous recommandons une meilleure coordination entre les services sociocommunautaires, la protection, la communauté et les services médicaux.

Sites à Aru : le site de **ABA** est situé à moins de 20 Km de la frontière soudanaise. La cité la plus proche du camp est presque officiellement gardée par les rebelles sud soudanais. En 1998, ces mêmes rebelles ont attaqué le camp de **Dungu**.

Nous recommandons que le HCR soit vigilant avec la présence des **éléments armés** non contrôlés (rebelles soudanais) à **ABA** et que le service de protection soit renforcé notamment à travers le programme SURGE.

3. Coordination et supervision

La mission a noté une insuffisance de coordination et supervision à 3 niveaux :

Niveau 1 : HCR (coordination médicale) et partenaires opérationnels

Des réunions de coordinations sont régulièrement organisées avec les partenaires opérationnels présents dans la capitale (Kinshasa). Pour plusieurs raisons, [notamment des difficultés logistiques (transport), la sécurité dans certaines régions (Aru) et l'étendue de la RDC, la dispersion et l'isolement de certains sites de réfugiés (Aru, Congo B)] les visites de terrain de la coordination médicale pour les 2 pays sont insuffisantes. Ceci se traduit par une communication, échanges

d'informations, la provision des outils et plans de travail et supervisions de soutien aux équipes des partenaires insuffisantes et irréguliers. Une coordination médicale pour deux pays basée seulement à Kinshasa (RDC) n'est pas à notre avis suffisante.

Nous suggérons le recrutement des médecins (e.g. volontaires des Nations Unies ; VNU) pour Aru et la République du Congo. Ces deux médecins devront avoir des compétences santé publique afin de mieux secondar la coordination médicale à organiser et coordonner au mieux les différents aspects de l'assistance médico-sanitaire. Des séances de planifications, suivi et évaluation avec nos partenaires devraient être plus fréquentes et régulières. **Aussi, il y est nécessaire** de résoudre les problèmes logistiques afin de faciliter le personnel de la capitale de visiter le terrain ; cela impliquera des fonds supplémentaires.

Pour ce qui concerne les réunions du Groupe Thématique et du Groupe de travail, le HCR y participe. En RDC cependant, on a noté que les participations du HCR aux activités des initiatives sous régionales (comme « Oubangui Chari ») étaient irrégulières à cause de la non inclusion systématique du HCR sur la liste d'invités.

Nous recommandons que le HCR s'assure de sa participation aux réunions du Groupe thématique et groupe de travail afin de garantir l'inclusion des réfugiés dans les différents plans stratégiques nationaux et plans de financement et initiatives encourus (exemple : Banque Mondiale, Fonds Mondial, Oubangui Chari)

Niveau 2 : Au sein de l'équipe médicale des partenaires Opérationnels

On note aussi une insuffisance sinon absence de supervision. Les équipes ont fonctionné durant plusieurs mois sans bénéficier d'une supervision de soutien de la part d'un personnel médical expérimenté pouvant apporter aux (jeunes) médecins sur terrain (pour la plupart de très bonne volonté et bien dynamiques mais avec une expérience en santé publique et du contexte réfugié limitée) la guidance, le soutien et la formation nécessaires pour assister efficacement les communautés réfugiées à leur disposition.

Nous recommandons que chaque partenaire ait un personnel médical expérimenté pour coordonner et superviser les équipes sur terrain et aussi garder un niveau adéquat de programmation avec la coordination médicale HCR.

Ceci implique des formations/recyclages du personnel, une documentation adaptée et bien fournie, plus de moyen logistiques pour permettre les visites sur terrain. Dans certains cas ceci impliquera l'achat des pirogues motorisées supplémentaires et l'installation de plus de radios pour faciliter la communication entre la base du partenaire et les centres de santé.

Niveau 3 : Sur terrain

Les équipes entretiennent de bonnes relations de travail avec les services médicaux publics. Cependant on a noté que ces rapports sont quasi limités aux seules références médicales de nos patients. En effet, il n'existe pas de cadre structuré de collaboration avec les Zones de Santé : réunions de coordination et échanges des outils de travail, visites réciproques. Les équipes des partenaires évoluant dans la même région n'ont ni de réunions internes ni de visites d'échanges entre elles. Les communautés réfugiés et autochtones ne sont pas assez organisées pour faciliter le dialogue et leur implication dans la définition et implantation des stratégies de lutte contre le Sida.

Nous suggérons que les équipes terrain améliorent les contacts avec les structures nationales (Zones de santé) à travers des réunions et visites d'échange. Ceci faciliterait une meilleure intégration de nos interventions sur terrain dans le cadre de l'action globale de lutte contre le Sida dans les plans et stratégies nationaux. De même, les partenaires opérationnels devraient pouvoir organiser sur terrain des réunions et visites pour améliorer les interventions et standardiser les approches. Enfin, des comités de santé et comités multisectoriels de lutte contre le Sida devraient être formés dans chaque site et les autochtones vivant dans les alentours immédiats des camps de réfugiés devraient y siéger.

4. Prévention

a. La sécurité transfusionnelle est en générale assurée. Certains sites transfusent les patients sur place (Bas Congo) et d'autres les réfèrent vers une structure publique locale (Aru, Impfondo).

Nous recommandons que nos équipes

- a. Vérifient les dates d'expirations des tests :
- b. la mise en place d'une bonne chaîne de froid avant de commander les tests qui exigent une chaîne de froid
- c. l'utilisation au tant que possible des tests rapides VIH pouvant être conservés à une température ambiante

Et quand les tests sont faits dans des structures de référence, **nous recommandons** que nos équipes sur terrain s'assurent que les structures de référence appliquent les recommandations nationales (ou à défaut ceux de l'OMS) relatives à la sécurité transfusionnelle. Nos équipes devraient pouvoir s'assurer également du stock suffisant des intrants de laboratoire des structures de référence et au besoin, coordonner avec les bureaux HCR terrain pour les assister dans le processus d'approvisionnement de ces intrants (test HIV, vaccins, test de la syphilis RPR) ce qui renforcerait la collaboration.

b. Le respect des **précautions universelles** n'est pas satisfaisant dans la plus part des camps visités. On note des ruptures de stocks en matériel d'injection (ce qui a poussé 1 Partenaire Opérationnel (P.O) à réutiliser des seringues et aiguilles pour la même personne), la formation du personnel n'a pas été faite. Les « sharp containers » n'existent pas et la gestion des déchets médicaux (collection, incinération) est en dessous des normes acceptables. **Nous recommandons** la formation et recyclage de tout le personnel des structures de santé, l'approvisionnement en « Sharp containers » la fabrication des incinérateurs métalliques que l'on peut fermer pour les sites sur les axes fluviaux et axes routiers au Congo B et la réparation et protection des incinérateurs déjà existant (bas Congo, Aru)

La gestion (approvisionnement et utilisation) du matériel de chirurgie de base et celui à usage unique devrait être par ailleurs améliorée.

La stérilisation n'est pas standardisée : certains utilisent les casseroles à pression, d'autres utilisent la technique de flambage ou l'eau bouillie ou seulement le désinfectant.

Nous recommandons que chaque structure de soins aient au moins une casserole à pression pour la stérilisation du matériel.

Aussi, **nous suggérons** que les structures qui ont lancé la stratégie de l'initiative de Bamako veillent à ce que les matériels d'injection et de chirurgie ne soient pas facturés directement au patient afin de prévenir tout risque de réutilisation.

c. La promotion et distribution du préservatif

Globalement parlant, les préservatifs sont disponibles dans tous les sites visités. Leur distribution est très médicalisées : les utilisateurs doivent se rendre au poste du centre de santé pour s'en procurer. Il manque partout le matériel IEC pour la promotion des préservatifs. Ainsi, les quantités de préservatifs distribués sont de loin inférieures aux normes du HCR (0,6 préservatifs par personne par mois en phase d'urgence et 1 préservatif par mois par personne en phase post urgence en se référant à la population totale).

Nous recommandons l'augmentation des points de distributions des préservatifs (agents de santé communautaires (ASC), agents sociaux, pairs éducateurs, kiosques, etc. et la mise à disposition des sites du matériel IEC pour la promotion du préservatif. Enfin, les préservatifs ne devraient pas être l'objet d'une tarification spéciale dans le cadre de l'initiative de Bamako : ils devront rester absolument gratuits et accessibles à tous.

Il est important que chaque partenaire du HCR améliore le suivi et la notification des préservatifs distribués.

d. Communication pour le changement de comportement (CCC) et IEC

L'IEC n'est pas une activité structurée (ou planifiée) routine dans les sites visités. Le matériel d'éducation fait énormément défaut partout. La formation des pairs éducateurs des groupes cibles n'a pas été organisée de façon systématique. **Nous recommandons** que l'équipe VIH/Sida HCR sélectionne, collecte et distribue les matériels IEC autant que possible dans les langues des réfugiés.

Les partenaires devraient organiser des formations classiques et systématiques des pairs éducateurs et points focaux des groupes sociaux (e.g. jeunes, femmes, leaders religieux, enseignants, leaders réfugiés et autochtones). **Nous recommandons** qu'un accent particulier soit mis sur le recrutement actif et la formation des réfugiés à cette fin. En effet, il est démontré qu'après le rapatriement, les réfugiés rentrent souvent dans des zones où il n'existe pas des ressources pour mener certaines interventions de lutte contre le Sida. En formant le plus grand nombre possible de réfugiés pendant leur séjours sur les sites, on aura ainsi créé un pool des personnes ressources capables de continuer certaines activités dans leur propre pays. La provision des incentives comme T-shirts, boisson sucrée pendant les rencontres devraient suffire pour les motiver.

Enfin **nous recommandons** l'acquisition de matériels audio visuels (là où son utilisation est logistiquement possible) pour organiser et améliorer la routine de CCC.

e. Conseil pour le dépistage volontaire du VIH (CDV)

Certains partenaires (International Rescue Comitee (IRC), Oxfam Québec) on initié dans le Bas Congo des CDV. Il faudra reconnaître que l'implantation était précoce surtout pour les sites de Oxfam : le personnel n'était pas adéquatement formé, les algorithmes de dépistage du VIH non standardisés, la salle de conseil pas convenable. L'utilisation de ces services est faible par manque de bonne préparation et sensibilisation des utilisateurs. **Nous recommandons** que les algorithmes et le système de collecte et traitement des données soient standardisés, que le personnel soit formé et que la population sensibilisée. L'usage de 3 test rapides est ici recommandé (Voir annexe 5) toujours s'assurer du respect des directives de conservation de chaque test. Quand et autant que possible, utiliser les tests qui n'exigent pas de chaîne de froid.

Dans tous les cas, **Nous recommandons** le respect des directives nationales relatives aux CDV. Pour les autres sites (Aru, Congo B) les CDV ne pourront être instaurées que si toutes les interventions minimales requises en phase d'urgence (*voir annexe 1*) sont mises en place et consolidées. Le HCR devra être consulté avant introduction de telles activités.

f. La Prévention de la transmission Mère enfant du VIH (PTME) n'existe pas encore en tant que telle dans les sites.

Nous encourageons nos partenaires ayant lancé les PTME à suivre l'exemple de Oxfam qui a organisé avec un hôpital public local une PTME pour une réfugiée et son enfant. Dans tous les cas, les PTME ne pourront être instaurées que si toutes les interventions minimales requises en phase d'urgence (*voir annexe 1*) soient mises en place et consolidées. Le HCR devra être consulté avant introduction de telles activités.

g. Prophylaxie des infections opportunistes

Il n'existe pas encore de prophylaxie pour les infections opportunistes pour les Personnes vivant avec le VIH/Sida (PVV). Nous suggérons que les partenaires maîtrisent d'abord les interventions de base pour la lutte contre le VIH/Sida dans le contexte d'urgences complexes et suivent les initiatives et protocoles nationaux avant d'initier de telles interventions.

h. Post exposure prophylaxie (PEP)

1. Après exposition accidentelle au VIH dans les structures de soins

Ces stratégies en faveur du personnel n'existent pas. Même si les Anti rétroviraux (ARV) ne sont pas disponibles, le HCR et ses partenaires devraient définir et mettre en place des protocoles simples pouvant diminuer considérablement la contamination après exposition accidentelle au VIH. **Nous suggérons** aussi qu'un système de notification de tels accidents soit instauré afin d'en suivre la tendance et la fréquence.

Les nations unies ont une politique concernant le PEP (*voir annexe 6*). Cependant, nous avons noté que la plus part des sous délégations et bureaux de terrain ne disposaient pas de kit PEP pour le personnel des nations unies. **Nous recommandons** que le staff HCR soit sensibilisé et informé sur le PEP comme il se doit.

Pour ce qui est de nos partenaires opérationnels, chacun devrait pouvoir clarifier sa position vis-à-vis du PEP avec son staff soignant.

2. PEP pour les réfugiés

Il n'existe pas encore de politique officielle en regards du PEP pour les réfugiés que ça soit dans le cadre d'accident de travail ni après un viol.

Des études en faveur de l'utilisation du PEP après un viol sont en cours en Tanzanie

a. Infections Sexuellement Transmissibles (IST)

La prise en charge des IST existe mais devrait partout être amélioré :

1. Formation du personnel
2. Utilisation de l'approche syndromique
3. Standardisation des protocoles thérapeutiques
4. Approvisionnement régulier en médicaments et autres intrants contre les IST
5. recherche, traitement et suivi du partenaire
6. surveillance et reportage

b. Infections Opportunistes (IO) + Tuberculose (TB)

Seule la Tuberculose bénéficie de prise en charge standardisée en fonction du protocole national en vigueur. Les autres infections opportunistes courantes (dermatoses, candidose, etc.) n'ont pas de prise en charge standard. Les médecins et personnel soignant réagissent en fonction de leurs connaissances et moyens (souvent limités). **Nous recommandons** une standardisation de la prise en charge des IO courantes et dont le traitement est accessible dans le contexte réfugié, en même temps une formation du personnel soignant.

c. Nutrition

L'appui nutritionnel aux personnes vulnérables est organisé presque dans tous les sites à travers le service social et communautaire du partenaire et avec le budget alloué directement par le HCR. Le soutien intéresse particulièrement les malades chroniques, les tuberculeux, parfois les femmes enceintes et allaitantes. Dans certains sites (comme au Bas Congo) le Programme alimentaire Mondial (PAM) apporte un supplément alimentaire à ces groupes vulnérables et non spécifiquement aux PVV. **Nous recommandons** de coordonner avec le PAM là où c'est possible pour intégrer les personnes vulnérables dans les interventions du PAM et de standardiser la ration nutritionnelle supplémentaire en faveur des personnes chroniquement malades.

d. Soins à domicile

Les Soins à domicile ne sont pas systématiquement organisés. Les besoins ne se font pas vraiment sentir selon les partenaires rencontrés. Les quelques cas identifiés sont pris en charge par le service social et communautaires et les agents de santé communautaires. **Nous recommandons** la formation/recyclage des équipes multisectorielles pour assurer les soins à domicile

e. Personnes vivants avec le VIH (PVV)

Il existe dans les sites des personnes chroniquement malades. Les personnes vivant avec le VIH/Sida ne sont pas officiellement répertoriées (à cause du stigma, de la confidentialité, de l'absence (ou récente création) des CDV).

Dans les centres urbains (Brazzaville, Kinshasa, Lubumbashi) les partenaires suivent quelques réfugiés connus HIV+. Il n'existe pas d'accès aux ARVs pour les réfugiés.

Nous recommandons de coordonner avec le PAM là où c'est possible pour intégrer les personnes vulnérables dans les interventions du PAM et de standardiser la ration nutritionnelle supplémentaire en faveur des personnes chroniquement malades.

f. Orphelins

De même, on trouve des orphelins dans les sites. Ceux-ci sont en général absorbés dans les familles élargies ou les familles d'accueil. Le service communautaire s'en occupe (appui nutritionnel, scolarisation, etc.). Les orphelins du Sida ne sont pas systématiquement répertoriés.

6. surveillances, suivi et évaluation

a. Enquête pour le changement de comportement

République du Congo : IRC a fait une étude connaissances, attitudes et pratiques (CAP) dans le milieu réfugié à Betou en janvier 2003. Même si on ne peut pas les comparer aux autres études dans le milieu réfugié, les résultats de cette enquête CAP constituent de données de base intéressantes pour le futur. **Nous suggérons** de lancer un plaidoyer pour intégrer les sites de réfugiés dans les enquêtes sur le comportement organisées par les instances nationales.

Dans le même sens, le HCR planifie de développer un outil standardisé des ECC. Les partenaires voulant entreprendre des ECC devront en informer le HCR bien avant.

b. la Notification des cas cliniques et de décès du Sida n'est pas systématique ni standardisée. Il est important que les services médicaux et sociaux communautaires aient les éléments de définition des cas probables de Sida lors de la déclaration des causes de décès. Nous recommandons d'instaurer un registre de mortalité dans les sites de réfugiés avec une colonne « cause directe » et une autre « cause sous jacente) (Voir annexe 7)

c. Donneurs de sang

Les données épidémiologiques sur les donneurs de sang sont incomplètes et peu standardisés pour que l'on en tire des conclusions scientifiquement plausibles. **Nous suggérons** à nos partenaires de suivre aussi les données sur les transfusions sanguines effectuées dans les hôpitaux de référence et dont les donneurs sont des réfugiés. Ceci pourrait contribuer à cerner un « proxy indicator » sur la prévalence du VIH dans le milieu réfugiés. **Nous recommandons aussi** à nos partenaires de ne pas utiliser de telles données pour estimer la prévalence du VIH dans leurs zones.

d. Dépistage de la syphilis à la CPN (consultation prénatale)

Le dépistage de la syphilis durant les séances de CPN n'est pas systématique.

Nous suggérons que tous les sites organisent le dépistage de la syphilis. Si la chaîne de froid ne peut être mise en place (sites de la République du Congo sur l'axe fluvial), nous recommandons une stratégie mobile avec transport des vaccins et réactifs dans des boîtes isothermes le jour de CPN.

Ces données sont utiles pour définir un « proxy indicator ». Il faut cependant assurer une chaîne de froid adéquate et le suivi du partenaire.

e. Approche syndromique des IST

La plupart des sites n'utilisent pas l'approche syndromique. Il nous faudra organiser des formations du personnel et standardiser les la récolte données épidémiologiques. Le suivi des contacts des patients souffrant des IST devrait être amélioré. Nous recommandons une surveillance adéquate des IST et une notification en fonction du syndrome.

f. IO+ TB

Seuls les cas de TB pulmonaire sont notifiés. Nous recommandons d'encourager ces cas de TB de se faire tester. De même, il est nécessaire d'améliorer le suivi et reportage des TB.

g. CDV

Là où ils existent (Bas Congo, RDC), il est indispensable de revoir les système de récolte des données et suivi post test.

h. PTME

La PTME n'existe pas sur les sites de réfugiés. Là où cela est possible, nous encourageons nos partenaires à collaborer avec les structures locales.

i. Surveillance sentinelle

En dehors de IRC au Bas Congo, RDC, elle n'est pas encore organisée ailleurs. Les résultats de l'étude effectuée entre juin et octobre 2002 ont montré une prévalence de 3,21 %.

Les centres de santé des sites qui auront mis en place les activités élémentaires de lutte contre le VIH/Sida en milieu réfugié et un dépistage systématique de la syphilis pourront, après concertations avec le HCR, envisager l'organisation des surveillances sentinelles.

Quand c'est possible, le HCR fera un plaidoyer pour inclure les sites dans les surveillances sentinelles organisées par le gouvernement.