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HIV/AIDS and refugees

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I. Introduction and focus of the paper

1. Every year millions of people around the world are affected by humanitarian crises and a significant proportion of these people are living with HIV. Human rights abuses, gender inequalities and other social or structural difficulties in accessing health services are often exacerbated in times of humanitarian crises. It is therefore essential to incorporate HIV interventions into the overall humanitarian response from the onset of an emergency. If not addressed, the impact of HIV will extend beyond the current crisis, influencing the outcome of the response and shaping future prospects for rehabilitation and recovery.

2. UNHCR promotes and supports the development of comprehensive HIV programmes to ensure that persons of concern have universal access to HIV protection, prevention, treatment, care and support interventions. This paper provides an update on UNHCR's HIV and AIDS activities in line with the Office's Strategic Plan for HIV and AIDS 2008-2012. It also reviews specific activities with respect to UNHCR's co-sponsor role in the Joint United Nations Programmes on HIV/AIDS (UNAIDS).

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

3. UNHCR works to ensure that the human rights of persons of concern are protected and that they have access to HIV protection, prevention, treatment, care and support programmes. A key strategy is to ensure that the HIV status of an asylum-seeker does not constitute a bar to accessing asylum procedures, nor constitute grounds for *refoulement*. In 2011, 57 per cent of countries where UNHCR works, had legislation protecting the rights of HIV positive asylum-seekers and 68 per cent had legislation protecting refugees from mandatory HIV testing. Both figures have increased by 6 per cent since 2008, however continuous advocacy is needed to ensure that the rights of refugees and other persons of concern are protected. UNHCR participates in UNAIDS' efforts to encourage countries to remove travel restrictions based on HIV status. Although there has been a significant reduction during the past few years, by the end of 2011, 47 countries, territories and areas continued to impose travel restrictions for people living with HIV, which is one of many forms of discrimination.

4. Scientific progress, reduction of medication costs, advocacy for the inclusion of refugees into national AIDS programmes, improved identification of people in need of treatment and efficient referral to health structures that provide such treatment, have resulted in more access to antiretroviral therapy (ART). In 2011, refugees had access to ART when available to the local population in 88 per cent of countries, compared with 79 per cent in 2008, primarily through government services. As more refugees are enrolled in treatment programmes, UNHCR will need to further strengthen its interventions to ensure patient adherence to and quality of ART. However, recent reductions in overall HIV and AIDS funding will likely disproportionately affect refugees as national programmes favour their own citizens.

5. By the end of 2011, 93 per cent of refugees had access to ART at a level similar than that of the surrounding population. However, many countries still do not mention refugees and internally displaced persons (IDPs) in their national HIV strategic plans. For example, between 1998 and 2008, 50 per cent of African countries with more than 10,000 refugees and/or IDPs did not include these groups in their national HIV strategic plans. Of those countries in Africa which have more than 10,000 refugees and/or IDPs and which have received approval for Global Fund proposals for HIV, 61 per cent did not include these groups in their proposals. UNHCR will work with governments, sister UN agencies and other partners to advocate that refugees and IDPs be included in government national HIV strategic plans as well as in Global Fund proposals. UNHCR will draw lessons from the recent conflict in Côte d'Ivoire, where ART was made available very early on when refugees arrived in Liberia. This approach needs to be replicated in future emergency situations.

6. UNHCR aims to reduce HIV transmission by scaling up effective prevention interventions through culturally appropriate awareness strategies, improved access to voluntary counselling and testing, prevention of mother-to-child transmission (PMTCT), improved access to post-exposure prophylaxis (PEP), and quality care, as well as through strategies targeting populations at higher risk of HIV infection and transmission. Significant progress has been made in these areas through youth initiatives and refugee support groups for people living with HIV. A cross-sectional HIV behavioural surveillance survey among refugees and surrounding communities in Kenya, Uganda and the United Republic of Tanzania (baseline in 2004/05 and follow-up in 2010/11) showed a large decrease in reported risky sexual partnerships.

7. A regional initiative on sex work in humanitarian settings was implemented in East Africa. Interventions involving partners and ministries of health, addressed the special protection and health needs of sex workers, adolescents involved in survival sex and sexual exploitation, and men who have sex with men. Assessments and programmes were developed and/or strengthened through targeted training and support with multi-functional teams in 4 countries (Ethiopia, Kenya, Uganda and Zambia), where HIV and sexual and reproductive health services for sex workers have significantly improved, and where communities have been sensitized and peer-led networks developed.

8. The provision of PEP to rape survivors has increased in UNHCR programmes. For the past two years, most countries showed sustained improvement in coverage (e.g. Bangladesh: 71% in 2009 to 93% in 2011, and the United Republic of Tanzania 49% in 2009 to 68% in 2011). However, countries are still struggling to reach the standard of 100 per cent of rape survivors receiving PEP within 72 hours of the incident. UNHCR will continue to identify the bottlenecks to ensure the timely and adequate clinical management of rape survivors.

9. In 2011, the percentage of women having access to PMTCT programmes increased, even though only 39 per cent of operations meet the 100 per cent coverage standard, an 8 per cent increase since 2008; great improvements were observed in countries such as Djibouti (51% to 98%) and Chad (2% to 55%). To reach the objective of no new infant born with the virus, UNHCR will scale up targeted activities to prevent primary infections of women, to identify HIV-positive pregnant women, and to provide treatment and care to those women and their infants.

10. In operations with return or reintegration programmes, UNHCR works to incorporate HIV strategies and interventions into policies and programmes for durable solutions to mitigate the long-term effects of HIV and AIDS. A key strategy is to advocate for and establish local integration and repatriation policies and programmes that include appropriate prevention and treatment interventions for HIV and AIDS. Approximately 75 per cent of operations in 2011 had integrated HIV strategies, including the continuation of ART into their exit strategies, an 18 per cent increase since 2008.

III. UNHCR and UNAIDS

11. Based on the revised UNAIDS Division of Labour in 2010, UNHCR and the World Food Programme (WFP) were designated co-conveners in the area, "*Addressing HIV in humanitarian emergencies*", in partnership with the World Health Organization (WHO), the United Nations Office on Drugs and Crime (UNODC), the United Nations Population Fund (UNFPA), the United Nations Children's Fund (UNICEF), and the United Nations Development Programme (UNDP), with the support of the UNAIDS Secretariat. This Division of Labour area lays the foundation for ensuring that issues related to HIV in humanitarian settings are addressed.

12. The global coordination of HIV in humanitarian settings is now carried out through the Inter-Agency Task Team (IATT), which succeeded the Inter-agency Standing Committee (IASC) Task Force on HIV in Humanitarian Situations. Apart from relevant UN partners, the IATT has expanded its membership to include international organizations such as the International Organization for Migration and the International Federation of Red Cross and Red Crescent Societies (IFRC), as well as representatives of civil society and academia. The aim is to establish a bridge between humanitarian and

development actors, to improve effectiveness in HIV preparedness and response, and to strengthen coordination of HIV response along the humanitarian continuum. As a part of the IATT, in November 2011, UNHCR and WFP hosted a non-governmental organization (NGO) forum, including NGO members from the UNAIDS' Programme Coordinating Board, and revived the web platform "*AIDS and Emergencies*".

13. The capacities of national counterparts have been supported to ensure the integration of HIV into preparedness plans in disaster-prone areas. Training, in-depth guidance, and awareness-raising in Africa, Asia, the Middle East and North Africa, Europe and the Americas, on the principles of HIV programming in emergency settings were conducted in coordination with United Nations country teams, UN joint teams on AIDS, representatives from national AIDS commissions, government disaster management units, the IFRC, and various civil society organizations.

14. Guidance at the global, regional and field levels for the integration of HIV as a cross-cutting issue in all clusters has been provided through the IASC Guidelines for Addressing HIV in Humanitarian Settings.[1] When appropriate (e.g. during the Côte d'Ivoire post-election violence), human resources were deployed to support initial inter-agency assessments and the design of response plans and humanitarian funding proposals.

IV. Conclusion

15. Significant progress has been made in ensuring access to HIV protection, prevention, treatment, care and support for refugees and other persons of concern. The continuity of treatment was ensured during the recent crisis in Côte d'Ivoire, and the coverage and quality of HIV interventions are steadily increasing in emergency as well as protracted situations. UNHCR will continue to advocate for the inclusion of refugees and IDPs in national HIV strategic plans and programmes. As co-convener in the UNAIDS Division of Labour, "*Addressing HIV in Emergencies*", UNHCR and its partners will continue its advocacy work with governments, donors, and humanitarian partners to create and build upon environments that mitigate the impact of HIV, and that reduce the stigma and discrimination of those affected by HIV.

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[1] http://www.humanitarianinfo.org/iasc/pageloader.aspx?page=content-products-products&productcatid=9