



Refugees, HIV and AIDS

Fighting HIV/AIDS together with refugees



HIV awareness in Mozambique

Summary of missions in 2004

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HIV/AIDS ASSESSMENT MISSION IN REFUGEE CAMPS IN EL-SHOWAK – SUDAN

Dr. Patterson Njogu, East & Horn of Africa HIV/AIDS Technical Officer

Executive Summary

The first AIDS case in Sudan was diagnosed in 1986 and by Oct-03 10,000 had been reported. In 2002 a community survey estimated the overall HIV prevalence in Sudan at 1.6% and disaggregated by group: commercial sex workers 4.4%, truck drivers 1%, tea sellers 2.5%, prisoners 2%, TB patients 1.6% and refugees 4% (similar to the surrounding population sentinel surveillance in El Gadariff in 1997), among others.

In 2003 UNHCR provided assistance to 110,000 refugees. In 2003 and 2004 UNHCR did not allocate funds for HIV/AIDS activities and local implementing partners hardly had anything set aside. HIV/AIDS co-ordination forums do not exist, most activities were implemented on ad-hoc basis and multi-sectoral coordination has so far not taken off. HIV interventions, especially awareness raising rely on community structures to enhance dialogue and community participation and the absence of community services NGO/IP significantly impede service provision.

Supervision of health services was not adequate and appropriate. COR health unit was strengthened and mandated to provide technical support and ensure adherence to MOH standards. Unfortunately, the unit is confined to the office and conducted only a few supervisory missions in the past year. The number of condoms dispensed was small and the main obstacles appeared to be few outlets and inadequate promotion. In one health unit a prescription was mandatory before condoms were dispensed. In another health unit wooden penis models intended for condom demonstrations were neatly packed and stored.

The supply of essential (syringes, needles) was irregular and the quantities were not adequate. In some inpatient wards used needles were left on lockers, on the floor or were discarded in open boxes yet the health units had stockpiles of approved safety boxes. Of the four health centers only Wad Sharifey possessed a functioning autoclave. All units were also experiencing serious shortages of disinfectants. Reusable equipment such as forceps was not adequately sterilized.

UNFPA supported assessment revealed major RH shortcoming among them: inadequate sterilization, obsolete equipment, shortage disinfectants and restricted referral capacity of obstetric and gynecological emergencies. The report indicates that number of midwives does not meet MOH standards. UNFPA has undertaken to fund and improve RH services selected health centers by providing equipment, fund continuing education, train and deploy midwives as well as procure one ambulance among a host of other interventions. After many years of low investment in health infrastructure, buildings were in poor state. Kilo 26 maternity had a leaking roof and the floor had multiple cracks that were compromising proper hygiene. None of the maternity units had running water.

Sudan is in the early phase of HIV epidemic and authorities and to some extent UNHCR have not garnered "political" and material resources to fight the scourge. UNHCR needs to evaluate its programming and resources allocation with a view of undertaking major adjustments in health, HIV/AIDS and community services sectors. The health programme and community services sector are weak and lack adequate material and financial resources to adequately combat HIV spread among refugees.

Monitoring mission: HIV/AIDS Programmes in Refugee camps in Zambia - 28 January – 19 February 2004

Laurie Bruns, Regional HIV/AIDS Technical Officer, UNHCR Pretoria

Executive Summary

This mission was undertaken by the Regional HIV/AIDS Technical Officer in January and February 2004 to assess the implementation and impact of:

- 1) the 2003 HIV/AIDS programme (03/AB/ZAM/CM/267)
- 2) the actions taken following the Feb/Mar 2003 mission of the Senior HIV/AIDS Technical Officer from UNHCR Geneva
- 3) implementation of conclusions and recommendations from the Regional Workshop on HIV/AIDS and Refugees (Johannesburg, December 2003)
- 4)

Reports and documents related to these points are available through UNHCR Pretoria. In addition, alternative funding opportunities, particularly those under the US President's Emergency Plan for AIDS Relief (PEPFAR), the Global Fund, and the World Bank (MAP programme) were explored. The mission itinerary and list of persons met can be found in Appendix 1.

In Zambia, the strategy for HIV/AIDS programs in the camps hosting Angolan refugees (Mayukwayukwa, Meheba, Nangweshi and Ukwimi1), a great number of whom will repatriate during 2004, is quite different to that employed in the camps in the north, where the Congolese population is unlikely to repatriate in large numbers this year. This pre-VolRep period for the Angolan population is critical, as HIV/AIDS programmes in areas of return in Angola remain weak at best or, in many places, non-existent. As an overall assessment, HIV/AIDS programmes in the camps have improved over the course of 2003, with an integrated multi-sectoral approach and better coordination among IPs evident at the field level.

Project activities funded through 03/ZAM/267, particularly training of clinic based staff, outreach workers, and refugee leaders, and the procurement, development and distribution of information materials have had a positive impact on clinical practices and HIV/AIDS awareness in the refugee community. Partners have already implemented many of the recommendations from the regional workshop on HIV/AIDS held in Johannesburg in December 2003 and demonstrate a sound understanding of UNHCR's priorities and policy related to HIV/AIDS. I was also very encouraged to note the level of interest in and commitment towards combating HIV/AIDS demonstrated by our field based UNHCR colleagues. However, as outlined below, a number of gaps remain. Some of these gaps can and should be filled through existing resources (both human and financial); others will require a boost in funding from UNHCR and other sources.

In the area of coordination, Task Forces on HIV/AIDS would be furthered strengthened through sharing more specific information, particularly on health-related impact indicators (e.g., trends in STIs, teen pregnancy, etc). The large number of outreach workers must work together in order to avoid duplication of efforts. All District Health Management Teams (DHMT) reported good cooperation with IPs; this cooperation is imperative to ensure access to HIV/AIDS related programmes being rolled out at the district level (e.g., strengthening of TB treatment programmes funded through the Global Fund).

With respect to clinical services, universal precautions to prevent transmission of HIV/AIDS in the clinical setting are largely in place, with a few exceptions of incinerators for medical waste that require immediate attention (Mwange; Meheba). Only one clinic, Kala, is dealing with blood transfusion, and proper screening procedures are in place (requires on-going monitoring). Appropriate clinical practices with regard to management of sexually transmitted infections (STIs) and opportunistic infections (OIs) appear to be in place. Monitoring trends in STI and OI incidence should be included in the work plans of the Task Forces.

1 Ukwimi is a small camp in eastern Zambia, population +/-2,500; it was not visited during this mission. Condom distribution in all camps falls far short of the target of one condom per person per month². While numbers are increasing, more emphasis should be placed on increasing the number of "free" distribution sites, promoting acceptance among refugee leaders and overcoming "cultural barriers". Condoms, along with abstinence, remain the front line defense against HIV transmission and should be accorded a priority focus in the programmes. Behavior change communication (BCC) efforts, including materials developed at the camp level in local languages, need to continue. South Africa will continue to source and provide materials in French, Portuguese and Swahili; partners with programmes in other African countries should also be in a position to contribute to this effort. Task Forces should develop a database at the camp level to ensure that all BCC materials are shared. Continued training of refugee leaders and specific groups (e.g., women, youth, religious leaders) will assist in ensuring that correct messages are understood at the community level. Closer supervision of outreach activities must also be instituted to ensure the integrity of messages. UNICEF Lusaka should be approached to provide school based HIV/AIDS materials, in English and/or French as appropriate.

Voluntary counseling and testing (VCT) programmes exist in a number of camps, but all programmes have technical difficulties. VCT programmes must adhere to the national testing protocol and ensure dedicated, confidential counseling and data management. Low awareness in the community of the benefits of VCT and the services available, as well as fear of stigma, most likely account for the low numbers seeking VCT, with the notable exception of Nangweshi³. Anti-retroviral programmes, such as Nevirapine treatment for prevention of mother-to-child transmission, do not exist at the district level for the host population, and therefore would not be indicated for the refugee population at this stage. Similarly, long-term ARV treatment in the public sector is only now being rolled out at the provincial level, and requires a K40, 000 monthly co-payment. Partners are encouraged to monitor district level developments in ARV programmes, with attention to the public health considerations in a VolRep scenario. No ARV programmes currently exist in areas of return in Angola or DRC so it would not be advisable to commence long term therapy in the host country for those repatriating to these countries. Orphans and other vulnerable children (OVC) do not appear on any Task Force work plans. Task Force members should monitor the identification and situation of OVC as part of their on-going activities. Early identification of vulnerable households will ensure appropriate support, family tracing and future planning for children. In order to address the issues outlined above, additional resources will be required. While limited UNHCR funding for HIV/AIDS programmes will continue to be available in 2004, RO Lusaka and implementing partners must urgently pursue the other funding opportunities that exist in Zambia, including the Global Fund, the US President's Emergency Plan for AIDS Relief (PEPFAR), and World Bank MAP funding.

Post-exposure prophylaxis (PEP) for UNHCR staff is available, but it is unclear whether mechanisms are in place to ensure prompt action when required for staff of Sub Office Mongu, Field Office Kaoma and Field Office Solwezi. RO Lusaka should ensure that all staff is aware of the kits and their appropriate use, and that new staff is provided with information on PEP as part of their induction training.

ETAT DE LIEU DES PROGRAMMES VIH SIDA EN FAVEURS DES REFUGIES AU RWANDA ET AU BURUNDI 1-25 Février 2004

Dr Dieudonné T.S. YIWEZA UNHCR Coordinateur Régional VIH/SIDA pour l'Afrique Centrale

RESUME

Il y a dans les deux pays un engagement politique qui crée des opportunités pour la lutte contre le VIH SIDA. Le Rwanda et le Burundi 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. De façon ponctuel, les interventions VIH SIDA organisées par les gouvernements de ces deux pays s'étendent aux réfugiés : distribution des préservatifs, médicaments contre la tuberculose, les dépliants pour l'IEC, les banques de sang et les CDV là où ils existent.

Les attentes des populations réfugiés et celles autochtones à l'égard de l'initiative des pays des grands lacs contre le VIH SIDA (en Anglais : great lakes initiative on HIV AIDS, GLIA) sont croissantes après que le secrétaire Exécutif de la GLIA, le HCR et les points focaux pays ont effectuée cette mission conjointe.

Cependant on note que les points focaux VIH SIDA aussi bien au sein du HCR que des programmes Nationaux de lutte contre le VIH SIDA (PNLS) ont d'autres tâches. Ceci rend incertain leur disponibilité à l'égard de ce projet très demandeur ; surtout en cette phase d'élaboration et implantation.

En effet, il nous faudra renforcer et soutenir les point focaux VIH SIDA du HCR dans les bureaux pays en ce qui concerne la gestion programmatique et la planification stratégique du VIH SIDA : ces personnes sont déjà submergées par les tâches des programmes en cours.

Les partenaires de mise en œuvre du HCR font de leur mieux. Le niveau de mise en œuvre des activités VIH SIDA est de qualité moyenne sur le plan médical et dans les conditions de travail actuelles. Il faudrait cependant améliorer la santé de reproduction, les précautions universelles, l'application des protocoles de prise en charge des Infections sexuellement transmissibles (IST). De même, il y a besoin d'améliorer la communication pour le changement de comportement (CCC) à l'égard du VIH SIDA et l'accompagnement psychosocial que les partenaires opérationnels médicaux font (seuls).

La mise en place des comités multisectoriels de lutte contre le VIH SIDA (CMLS) avec la participation de toutes les couches sociales de la communauté réfugiée, tous les partenaires opérationnels et la communauté autochtone environnante permettrait une meilleure coordination et un partage des responsabilités parmi les différents intervenants selon les compétences de chacun.

Le manque de motivation pour la sensibilisation VIH SIDA dans la communauté est reconnu. Pour ce faire, le staff médical (payé) se charge de la sensibilisation sur tous les problèmes de santé, y compris le VIH SIDA (de façon ad hoc). Ceci rend la CCC et IEC de faible qualité. Nous devrions disposer des équipes formées et motivées pour conduire les activités de CCC. La planification multisectorielle et participative avec les partenaires devrait être améliorée et formalisée.

De plus en plus, ces deux pays mettent en place des ARVs à la disposition des populations autochtones proches des camps des réfugiés. C'est une bonne chose, mais aussi un défi pour le HCR. En effet, avec les pressions, le HCR et ses partenaires devront rester vigilants pour ne pas s'embarquer avec les pressions, dans les ARVs sans une préparation et organisation adéquate. Il nous faut aussi rapidement une politique générale HCR ARVs. Cette politique devrait être connue par nos partenaires, les réfugiés et les gouvernements.

Les supervisions de soutien pour nos partenaires sur terrain méritent une attention particulière. Nous devons pouvoir les organiser avec une personne expérimentée ayant des notions de Santé publique. Plusieurs protocoles thérapeutiques et du matériel d'IEC sont disponibles dans les deux pays. Certains cependant sont en langue locale et les réfugiés ne la maîtrisent assez.

Nous devrions organiser des formations/recyclages réguliers sur les différents aspects de la lutte contre le VIH SIDA pour tout le personnel.

Les conseils pour le Dépistage volontaire (CDV) « partiels » (avec système de référence pour tester le client) sont initiés dans plusieurs camps. A cause de manque de préparation et des contraintes logistiques, il est nécessaire de patienter, résoudre ces problèmes avant de commencer des CDV « complets » dans les camps.

Nous apprécions la participation et disponibilité des points focaux pays, du Secrétaire Exécutif de la GLIA et des bureaux HCR Pays durant la mission.

EXECUTIVE SUMMARY

The High Political commitment to fight HIV AIDS in Rwanda and Burundi is a good opportunity.

Countries have developed various policies in this regards. Although there is no formal action plan for refugees from government institutions, refugees do benefit from national interventions such as free tuberculosis treatment, Information education and communication (IEC) materials, Condoms and safe blood.

Expectations towards GLIA initiative among refugees and surrounding population are growing since we visited the sites with GLIA Executive secretariat, NAC GLIA focal points and provincial HIV Aids committees: people start "believing" in this initiative.

Both UNHCR and National Aids Control GLIA focal points have other duties. This might affect availability to GLIA operations since this project is demanding, especially at the preparation and implementation phases.

UNHCR HIV focal points (in general all country offices) need to be strengthened and supported (capacity/staffing and time): they have already enough tasks with the "normal" operations. There is need for strong and regular coaching in terms of programmatic, policy and "political" and strategic views.

UNHCR IPs is doing well. Level of implementation is quite high on the medical side of HIV Aids battle. However, there is need to improve Universal precautions, reproductive health facilities and proper use of national policies towards management of sexually transmitted infections (STI).

In addition, we need to strengthen the BCC/IEC and psychosocial aspects that often medical IPs (alone) conduct.

Consider multisectoral HIV/AIDS committees as entry point to better coordinating but also task sharing among IPs in the same country and in the same camp.

Lack of motivation for community HIV/AIDS awareness has been reported and need to be addressed. Due to that, medical staff (paid) are requested to conduct general health IEC

including HIV (ad hoc). Thus, BCC on HIV is of poor quality. Need to train specific teams and motivate them for BCC activities.

Multi-sectoral and participatory planning process with beneficiary's involvement need to be improved and structured (through Aids committees).

"ARV train has taken off". This is a good opportunity and at the same times a challenge for us: need to be careful that with pressures, both UNHCR and IPs embark on without proper preparation. UNHCR to develop an ARV policy and communicate it to refugees, IPs and host NACs.

Supportive supervision to our IPs team's in the field need to be addressed. Need of regular visits from senior staff with both HIV Aids and Public health background.

Various Guidelines and IEC material do exist in both countries. This opportunity seems not regularly capitalized. In addition, most IEC materials are in local language that is not always well understood by refugee communities.

Collaboration with existing health system is good. Need to be formalised and structured by including surrounding communities in refuges HIV AIDS multisectoral committees.

Training and refresher courses for STI, Opportunistic Infections, Behavior Change Communication, and Prevention of Mother to child transmission of HIV, etc need be conducted.

Voluntary Counseling and Testing (VCT), with referral to existing local health facilities has started almost everywhere. However, due to lack of proper preparation and follow-ups system and the still existing logistical and stigma constraints, we recommended waiting a bite before considering organizing testing in refugee camps.

GLIA Focal Point from Burundi and Rwanda NAC, GLIA Executive secretariat and UNHCR country offices availability and involvement in the mission were highly appreciated.

HIV/AIDS Programmes in Returnee Areas in Angola: Monitoring and Support Mission 23 March – 03 April 2004

Laurie Bruns, Regional HIV/AIDS Technical Officer, UNHCR Pretoria
Francesca Bonelli, Associate Community Services Officer, UNHCR Luanda

Executive Summary

This mission was undertaken by the UNHCR Regional HIV/AIDS Technical Officer, accompanied by the Associate Community Services Officer from UNHCR Luanda to provide support to UNHCR Angola in:

- Evaluating UNHCR's 2003 intervention in the area of HIV/AIDS
- Defining UNHCR Angola's strategic approach to HIV/AIDS in 2004 and 2005
- Evaluating potential cooperation with other agencies in areas of return and reintegration
- Assessing fundraising possibilities

The mission itinerary and list of persons met can be found in Appendix 1.

In 2003, some 77,000 Angolan refugees returning from neighbouring countries were assisted by UNHCR. As part of the return and reintegration support in areas of return, UNHCR and its implementing partners (IPs), in cooperation with the government of Angola, provided basic health care services and HIV/AIDS awareness programmes for both returnees and local populations. In 2004, these programmes should be further consolidated and strengthened, especially in newly opened areas. While more advanced HIV/AIDS programmes, such as Voluntary Counseling and Testing (VCT) and Prevention of Mother to Child Transmission (PMTCT) are being initiated in Luanda and in other urban areas, UNHCR should work with IPs, UN agencies and government to establish quality primary health care services in areas of return, which would lay the foundation for more advanced HIV/AIDS programmes in the future. This is particularly critical with respect to the Voluntary Repatriation programme for 2004, under which approximately 145,000 Angolan refugees are expected to return¹. However, these activities should be implemented with a view to building the capacity of local organisations and structures, and hand-over of health facilities and related programmes to local authorities.

In 2003, UNHCR Angola supported a number of partners to implement health care and community development programmes in areas of return and reintegration. Many of these programmes included a component on HIV/AIDS prevention, mainly through the provision of primary health care services at health posts and community based awareness activities. Measuring the impact of these programmes is a challenge due to a number of factors, including: the continuous mobility of populations in areas of return; logistics difficulties which regularly interrupted supply of medicines, condoms and other supplies; and the inaccessibility of many areas of return. However, interviews with returnees, UNHCR IPs, other UN agencies, non-governmental organisations and local authorities suggest that while the 2003 HIV/AIDS programmes have succeeded in raising awareness of HIV/AIDS and increasing health seeking behaviours in areas of return, these efforts need to be consolidated and reinforced during 2004. Funding a specialised IP, such as GOAL, focusing on HIV/AIDS prevention in only one province should be avoided; rather the capacity of health and community development partners should be strengthened to integrate HIV/AIDS activities into their current programmes. In order to ensure sustainability, capacity building for and partnerships with local organisations should be promoted.

¹ 90,000 persons under the UNHCR sponsored organized return; 55,000 spontaneous return (UNHCR estimates).

UNHCR field staff have been closely monitoring and appropriately responding to protection related incidents, such as stigma and discrimination against returnees based on real or perceived HIV status. While the number of reported incidents remains low, this should remain a priority activity in 2004 as more refugees will return to more, and newly opened, areas. As mentioned above, UNHCR will continue to fund basic HIV/AIDS prevention programmes in areas of return, but advocacy at the provincial and national level should also form an important pillar of UNHCR's HIV/AIDS programme in 2004, as many agencies and donors are not focusing on areas and provinces of return, but rather on areas with higher population density and those with more established infrastructure. UNHCR should also play a more active coordination role at the provincial level with respect to HIV/AIDS programmes, together with WHO and MINSA.

Post-exposure prophylaxis (PEP) for UNHCR staff is available, but staff are unclear on when and how to access PEP treatment. Each office must identify custodians of the kits and dispensing physicians. BO Luanda should provide all staff with basic training on PEP, and PEP should be included in the induction/ security orientation of all new staff.

Sierra Leone HIV/AIDS AND REFUGEES MISSION REPORT - 17-24 MAY 2004

Bilguissa Diallo, HIV/AIDS Coordinator West Africa, UNHCR, Accra
Paul Spiegel, Snr. HIV/AIDS Technical Officer, UNHCR, Geneva

EXECUTIVE SUMMARY

An introductory mission to observe the HIV/AIDS programmes in Sierra Leone was undertaken from 17 to 24 May 2004. The UNHCR Regional Technical Officer for HIV/AIDS for West Africa and the Senior HIV/AIDS Technical Officer from Geneva conducted the mission. The objectives of the mission were to:

1. Introduce and familiarise the Regional Technical Officer for HIV/AIDS with the programmes in the field.
2. Assess the existing policies, practices, prevention programmes, testing, patient care and support activities in Sierra Leone.
3. Identify gaps in services and activities and to make recommendations to improve the overall quality of programs.

An effective coordination and exchange between the different units of UNHCR itself and between UNHCR and Implementing Partners (IP) and Operational Partners (OP) should be established to improve the development, expansion and monitoring and evaluation of HIV/AIDS programmes.

UNHCR in Sierra Leone should become more involved in policy-making meetings such as the UN Theme Group, the Country Coordination Mechanism (CCM) and other national technical committees. Greater participation of UNHCR in national policy making meetings will promote the access of refugees to national and regional services and funds

UNHCR and its partners should concentrate on the Information Education and Communication (IEC) and Behaviour Communication Changes (BCC) components of their HIV/AIDS programmes. UNHCR and its partners should also find avenues for condom provision and distribution, strengthen universal precautions and combat the denial of HIV presence, stigma and discrimination.

UNHCR Sierra Leone is awaiting the stabilisation of the security status in Liberia to organize Voluntary Repatriation of refugees. This time will be ideal to provide refugees with intensive information and Education on HIV/AIDS through sensitisations, trainings, video and audio materials; drama, songs, promotion and distribution of condoms. Once repatriation takes places UNHCR should plan to develop HIV/AIDS awareness packages for the returning refugees.

Standardisation of key programme elements and reporting forms should be established. The host country policies and guidelines should be followed and the HIV/AIDS programmes need to be developed and implemented in line with the national programmes to ensure that quality of services provided to refugees versus the local population are in line. This is also important to avoid fostering a belief that refugees are more infected or are the ones bringing HIV/AIDS in the host population.

UNHCR and its partners should explore the possibilities to include the refugee populations in any forthcoming behavioural and sentinel surveillance studies in the country.

HIV/AIDS AND REFUGEES MISSION REPORT LIBERIA 25 – 31 MAY 2004

Dr Bilguissa Diallo, HIV/AIDS Technical Officer /West Africa/ UNHCR
Dr Dieudonné T.S. YIWEZA, HIV/AIDS Technical Officer Central Africa/ UNHCR
Dr Emmanuel Obura, Health and Nutrition Coordinator/BO Liberia/

EXECUTIVE SUMMARY

An introductory mission to observe the HIV/AIDS programmes in Liberia was undertaken from 25 – 31 May 2004. The UNHCR Regional Technical Officer for HIV/AIDS for West Africa and the UNHCR Regional Technical Officer for HIV/AIDS for Central Africa conducted the mission. The objectives of the mission were to:

- Introduce and familiarize the Regional Technical Officer for HIV/AIDS with the programmes in the field.
- Assess the existing policies, practices, prevention programmes, testing, patient care and support activities in Sierra Leone.
- Identify gaps in services and activities and to make recommendations to improve the overall quality of programs.

UNHCR's assistance to Sierra Leonean refugees is still going on but with a pending plan to stop it by the end of June 2004. The organized voluntary repatriation of some 250,000 Liberian refugees from the neighboring countries will commence in October 2004 when the Disarmament and Demobilization are completed. There are different actors with different approaches in disseminating messages and collecting information related to HIV/AIDS in Liberia. In general, efforts are being made to provide the essential minimum package for HIV/AIDS and other Sexual Transmitted Infections (STIs). Health workers face a lot of problems, ranging from inadequate training, limited equipment and drugs, weak monitoring and supervision. Main constraint is the uncompleted National HIV / AIDS Strategic Plan to focus and co-ordinate efforts. This is compounded by the fact that Liberia is just emerging from 14 years of civil war, which devastated the country and caused massive displacement of the population. Authorities and other actors assume that the prevalence rate is higher than what is officially quoted.

Efforts are made by UNHCR/Liberia and Partners to provide the essential minimum package for HIV/AIDS and other STIs control in Refugee and IDP/returnees Camps: Basic information on HIV/AIDS and STIs prevention is given universal medical precautions are promoted, blood for transfusion is tested in referral clinics, Sexually Transmitted Infections (STIs) are managed using the WHO syndromic approach. At the refugees and Internally Displaced Persons (IDPs) /Returnees health posts, awareness sessions are held ad hoc, condoms are available but its distribution is not wide and the STI management although following the WHO protocol is not well reported. There are some weaknesses in the area of universal precautions.

UNHCR has limited duration of responsibility for returnees. However, since they will be returning over several months, UNHCR presence in the key counties of return will be required. While HIV/AIDS is in the process of maturing in West Africa, UNHCR and its partners will therefore need to focus on to activities that are geared towards awareness rising of the target population and provide means of protection against HIV infection. In designing the action plan for Liberia, UNHCR should be Flexible and Moderate. As the general situation is complex and fragile it will be more practical to concentrate efforts on the counties with considerable number of expected returnees and then extend it to other counties. At this point UNHCR and Partners need to fill the Gaps in information education and communication materials, to find community based distribution points for condoms provision, to continue the training of the staff on STI management and strengthen the universal precautions. All of these activities need to be supported by a good reporting process and a strong coordination. Regular HIV/AIDS inter- agency, multi-sectoral collaborative and coordination meetings between UNHCR, other UN agencies, NGOs and the various Government sectors should be held to discuss HIV/AIDS programming in key Counties of return and Refugee camps and also to look at the future of the residual case load of refugees who continue to stay in the country.

Monitoring Mission: HIV/AIDS Programmes in Refugee Camps in Malawi 14 – 18 June 2004

Laurie Bruns, Regional HIV/AIDS Technical Officer, UNHCR Pretoria

Executive Summary

There are a number of programmes on HIV/AIDS prevention, care, support and treatment in place in Dzaleka and Luwani refugee camps in Malawi. However, through close collaboration between UNHCR, its implementing partners, government and other UN agencies, there is significant potential to strengthen and scale-up these initiatives.

UNHCR should participate in the current review of the National Strategic Framework on HIV/AIDS to ensure that refugees are included as a specific vulnerable group. In addition, through its participation in the UN Theme Group and Technical Working Group on HIV/AIDS, UNHCR should work with UNAIDS and other agencies to contribute to the UN Implementation Support Plan, as well as to explore possibilities for additional funding through Programme Acceleration Funds.

Camp level coordination of HIV/AIDS activities needs to be strengthened. To facilitate information sharing and better oversight of the various programmes, the mission recommends the establishment of HIV/AIDS Task Forces comprised of refugees, implementing partners, camp administration and UNHCR. While clinical preventative practices appear to be sound, clinical staff in both camps would benefit from re-fresher training on universal precautions and syndromic management of STIs. Refugee community members and implementing partner staff would benefit from basic training on HIV/AIDS.

Condom promotion in both camps needs to be drastically scaled up through an increase in the number and types of distribution outlets. Consolidated reporting of the number of condoms distributed per month should also be initiated. Additional educational materials on HIV/AIDS in refugee languages should be ordered through UNHCR Pretoria and other sources. Refugee communities should also be encouraged to develop materials at the camp level. School based programmes would be strengthened through the training of teachers and provision of IEC materials. Community awareness of voluntary counseling and testing programmes needs to be raised through intensive information campaigns in the camps; similar campaigns are needed for PMTCT programmes. VCT and PMTCT programmes, while now available for residents of Dzaleka camp, should also be established in Luwani camp. UNHCR should closely monitor HIV testing in the context of resettlement to ensure that comprehensive services are provided, including pre- and post-test counseling, referral and support.

Nutritional support programmes for chronically ill should be reviewed with the Ministry of Health. Small scale gardening and income generation activities should be more readily available to households and individuals affected by AIDS. Contacts with community based programmes, such as the FHI home based care and orphan support programmes, should be initiated with a view to extending these programmes to the refugee camps.

In order to effectively improve and build upon existing HIV/AIDS programmes in the camps, additional funding will be required. UNHCR should assist implementing partners to apply for funding through the National AIDS Commission and other funding opportunities, of which there are many in Malawi. In the short term, limited additional funds are available through UNHCR's regionally administered HIV/AIDS programme.

ETAT DES LIEUX SOINS DE SANTE PRIMAIRES & VIH SIDA - Province équateur Nord, RDC - JULLIET 2004

Dr YIWEZA T.S. Dieudonné, Régional HIV AIDS Technical Officer, UNHCR
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RESUME

Le HCR a organisé une mission d'identification au nord équateur du 1er au 5 juillet 2004 pour préparer le retour des populations congolaises de RDC qui s'étaient réfugiées en République Centrafricaine (+/- 10.000 personnes) et en République du Congo (+/- 60.000 personnes). Cette mission avait deux volets: les besoins généraux en matière de Soins de santé Primaire (SSP) des zones de santé qui accueilleront les retournés et l'intégration du VIH/SIDA dans les activités de ces Zones de Santé.

Le mandat du **HCR** étant très précis en terme d'appui ponctuel aux **rapatriés volontaires (Volrep)**, la mission s'est élargie à AHA (Action Humanitaire Africaine) et à la CRB (Croix-Rouge de Belgique) dans le but d'intéresser d'autres acteurs à poursuivre les actions initiées par le HCR dans le cadre précis d'appui aux rapatriés volontaires.

La Province de équateur a été **retenue** pour la mise en oeuvre de l'initiative de lutte contre le VIH SIDA dans les pays des grands lacs (**GLIA**, Great lakes Initiatives on AIDS).

Le HCR et le PNMLS sont entrain de conclure un partenariat dans la lutte contre le VIH SIDA en milieu réfugiés, rapatriés et éventuellement déplacés internes dans le cadre du **projet MAP** (multi country AIDS programme) financé par la Banque Mondiale.

Cette mission a donc aussi permis de définir des plans d'action en faveur des rapatriés et populations des zones de retour pour un appui du MAP ou de la GLIA. Ce plan d'action font partie des documents séparés qui seront soumis à la GLIA et au PNMLS dans le cadre des projets respectifs.

Les Zones de Santé visitées étaient Zongo, Libenge, Bwamanda et Bokonzi.

Concernant l'état sanitaire général, les Zones de santé de Zongo et Libenge ne reçoivent pas d'appui global. La Zone de Santé de Bokonzi est appuyée par Memisa mais ne répond pas à tous les besoins de la Zone de santé

Les Hôpitaux Généraux de Référence sont en relatif bon état, mais manquent de système d'évacuation des déchets et source d'énergie. Leurs problèmes principaux se résument en :

- ◆ **Gestion** : le recouvrement des coûts, supervisions, capacitation et motivation du personnel
- ◆ **Logistique** : approvisionnement en médicaments, réactifs et consommables, chaîne du froid

Les Centres de Santé visités sont délabrés, manquent de matériel et de médicaments. Leurs problèmes rejoignent out naturellement ceux des hôpitaux et zones de santé : **gestion et approvisionnement**.

L'hôpital de Bwamanda est soutenu par plusieurs partenaires et fonctionne correctement. Son problème principal est le taux d'occupation des lits trop élevé (probablement du au long séjour des cas de trypanosomiase).

Concernant l'intégration des activités de prévention et de lutte contre le VIH/SIDA, la situation est quasi vierge dans toutes les zones visitées. Beaucoup de militaires sont présents dans ces zones de santé et toutes déclarent que les IST font parties des 5 maladies les plus fréquemment rencontrées, ce qui laisse présager un risque élevé en matière de VIH SIDA. Il n'y avait nulle part de comité de lutte contre le VIH/SIDA, les connaissances du personnel de santé étaient souvent lacunaire, les précautions universelles non respectées et les préservatifs peu répandus. Partout, le personnel de santé était conscient de l'importance de s'engager davantage dans ce domaine.

→ **Recommandations :**

La Province de équateur, comme les autres provinces en RDC se trouve dans une phase d'urgence post conflit, aggravée par plus de 25 ans d'une politique sanitaire non fonctionnelle. L'appui du HCR dans le cadre du rapatriement volontaire des réfugiés congolais de la RDC a partir la RCA et RoC devra s'inscrire dans le cadre **d'un appui global a la zone de santé** sélectionnée avec comme cible toute la population vivant dans les zones de retour sélectionnées. Pour avoir un impact raisonnable, les interventions devront s'étendre au delà du mandat classique de quelques mois d'appui aux rapatriés. Pour ce faire, le HCR devrait opérer avec un partenaire capable de continuer l'action après le désengagement du HCR pour une période minimale de 2 -3 ans.

De même, les projets MAP ou GLIA devront tenir compte de ce contexte de total collapsus du système de santé dans les zones choisies : des interventions verticales axées sur le VIH SIDA et ne tenant pas compte de l'approche SSP seront a la fois inutiles et néfastes : **tout est a refaire dans les zones visitées.**

De façon plus pragmatique, nous recommandons l'appui aux hôpitaux généraux de référence, le Bureau central de la Zone de santé et 1 ou 2 grands centres de santé des zones de retour. Cet appui s'articulera au tour de thèmes de **la gestion des services de santé et approvisionnement. Une étroite collaboration avec et implication des les structures et institutions existantes est aussi recommandée**

EXECUTIVE SUMMARY

From 1st to July 5, 2004, UNHCR organized an assessment mission in the north of the Equator province to prepare the **voluntary repatriation (Volrep)** of return of the Congolese (DRC) refugees from Central African Republic (CAR, (+ / - 10.000 people) and in Republic of Congo (RoC: + / - 60.000 people). This mission had two shutters: looking at the general Primary Health Care (PHC) situation in return areas (District health) and the **integration of the HIV/AIDS** activities in the PHC package in the return areas.

UNHCR's mandate and support towards **returnees** being very precise in terms of time and package, the mission was enlarged to AHA (African Humanitarian Action) and to the CRB (Cross-red of Belgium) in order to involve actors pursuing actions initiated by UNHCR after its withdrawal.

Equator province has been selected as a **GLIA (Great Lakes Initiatives on AIDS)**: one health district should be chosen to benefit funds from this regional initiative on HIV AIDS.

In addition, UNHCR and the DRC national AIDS council (PNMLS) are liveliness to conclude a partnership in the struggle against VIH AIDS among refugees, repatriates and possibly Internally displace people (IDPs) under **the World Bank HIV AIDS funded MAP** (multi country AIDS programme).

Therefore, this mission allowed defining plans of action in favor of returnees and host communities in return areas under the MAP or the GLIA projects. These Action Plans are presented in separate documents and will be submitted to PNMLS (MAP) and GLIA accordingly.

The mission visited Zongo, Libenge, Bwamanda and Bokonzi District Health.

As to **the general health situation**, Zongo and Libenge District health don't receive a global support. Bokonzi health District is supported by Memisa but this support doesn't cover the needs of the entire area.

The Referrals Hospitals have relatively good infrastructure, medical waste management system, water supply and energy are missing.

Their main problems can be summarized as following:

- ◆ **Management:** cost recovery strategy, supervisions tools, coordination capacity building and incentive of health personnel
- ◆ **Logistics:** supply chain and provision of medicines, reagents, material and equipments and cold Chain.

Visited Health Centers are ruined and miss materials and medicines. Their problems are indeed similar to those of Hospitals and District management teams: **management and supply**.

The Bwamanda referral hospital has support from several partners and its function is quite good. Its main problem is the high occupation rate (probably due to the long stay of sleeping sickness cases).

Concerning HIV AIDS, the situation is just at the infancy in all visited zones. A lot of soldieries are present in these areas. Sexually transmitted infections (STI) are reported to be among the five top diseases, what lets foretell an elevated risk for VIH AIDS in the areas. HIV/AIDS Multisectoral committees (Task forces) are not established, health workers' knowledge on HIV/AIDS are limited, universal precautions no respected and condoms promotion/distribution inexistent. Everywhere, the health personnel and leaders are conscious of the magnitude of HIV AIDS in the area and the need of improving interventions against the pandemic.

→ **Recommendations:**

The Equator Province, as other provinces in DRC, is in an emergency post conflict phase, worsened by more than 25 years of non-operational health system. UNHCR's health support under the repatriation framework of Congolese (DRC) refugees from CAR and RoC should be in line with a global **support to a health District approach**, targeting returnees as well as host communities in return areas.

Interventions should be extended beyond the classic mandate of few months support to returnees if we want reasonable impact. Therefore, UNHCR should operate with partners capable to continue the action after UNHCR's disengagement for at least 2 -3 years.

In the same way, the MAP or GLIA projects should take into account this context of total collapse of the health system in selected areas: vertical approach focused only on HIV AIDS and not considering Primary health care (PHC) as whole will be at a time useless and ominous: **all is to do from scratch in the visited zones**.

Practically, we do recommend an approach that supports general hospitals, District health management offices, and 1 or 2 big health centers in a selected health district. Such a support should focus on **improving basic health services delivery and supplies**. Partnership with and involvement of existing health facilities is essential.

LES PROGRAMMES DE LUTTE CONTRE LE SIDA EN MILIEU REFUGIE Embarcadère sur le fleuve Cavaly, frontière Ivoirio-Liberienne - Tabou, Cote d'ivoire, 12 – 24 juillet 2004

Dr. Bilguissa Diallo, Conseillère Technique VIH/SIDA Afrique de l'ouest

Résumé

La Côte d'ivoire est le pays le plus touché par l'épidémie du VIH/SIDA en Afrique Occidentale. Elle héberge environ 10% des cas de SIDA notifiés par l'ensemble des pays africains à l'OMS et à l'ONU SIDA. En 2000, l'on estimait à 1.000.000 le nombre de personnes vivant avec le VIH en Côte ivoire. La prévalence du VIH dans la population générale a été estimée à 10,51% en 2001, (plan stratégique, Côte ivoire). Dans la cadre de la lutte contre le SIDA, Le pays possède un cadre stratégique National et des directives nationales concernant la transfusion sanguine, la prise en charge syndromique des Infections Sexuellement Transmissibles (IST), la Prévention de la Transmission Mère Enfant (PTME). Il a aussi disponibilité de directive sur le Conseil et Des pistage Volontaire (CDV), la prise charge des infections opportunistes (IO) , les accidents exposant au sang et présence d'un pool de prescripteurs d'Anti Rétroviraux (ARV) soutenu par l'existence d'un guide de soins à domicile.

Il est clair que la crise qui secoue le pays a un impact négatif sur les Services générales et c'est ce qui fait qu'il a été enregistré un ralenti considérable dans l'expansion à l'intérieur du pays des différentes activités de lutte contre le SIDA .

Les fonds reçus de Fond Global, du PEPFAR, MAP et Autres Organisations de Coopération ou Organisations Non Gouvernementales avoisines les 75 millions de Dollars et ont considérablement boostée la réponse Ivoirienne à l'épidémie. Dans le Plan Stratégique National de lutte contre le VIH Sida, les réfugiés sont considérés comme groupes vulnérable et à risque. Face a la gravité et l'agressivité de ce fléau, l'appui offert par les programmes actuels du HCR/CI aux réfugiés en général , aux femmes et adolescents en particulier est très insuffisant.

En Cote ivoire, il n'existe pas de programme proprement dit de lutte contre le Sida en milieu réfugié :

- Il n'y a pas de matériel d'éducation et de sensibilisation sur le VIH/SIDA.
- Les précautions universelles (PU) dans les structures sanitaires sont très volages. Aucun des centres de santé visités n'est doté d'incinérateur ou de puits pour brûler ou enfouir les déchets médicaux.
- Les Infections Sexuellement Transmissibles (IST) qui se taillent une part importante dans la morbidité ne sont pas soignées correctement.
- Il y a pas de préservatif, la disponibilité de préservatif dans la communauté réfugiée est inférieure a 1% des besoins mensuels réels.
- Il n'existe pas de programme de planification familiale dans les localités visitées et ce depuis deux ans.
- Le commerce du sexe est un fait notoire et un nombre non négligeable de femmes réfugiées en pratique. De jeunes Garçons réfugiés s'adonnerait de plus en plus au commerce du sexe surtout dans les zones portuaires international.

La progression de VIH en Afrique de l'ouest prend de l'ampleur cela mérite que des efforts soutenus, des ressources appropriées, et des stratégies de communication soient mises à profit pour freiner son expansion. Pour ce faire le Bureau du HCR en Cote ivoire devrait :

- introduire dans son programme d'assistance aux réfugiés un volet complet de lutte contre le Sida. Avec des partenaires opérationnels chargés de la prévention du VIH

dans les communautés de réfugié étendu dans la mesure du possible à leurs populations hôtes.

- Etablir une structure de coordination des activités de lutte contre le SIDA avec les partenaires mais aussi renforcer sa collaboration avec les organes Etatiques ou non, qui Accentuer le plaidoyer auprès des autorités Nationales, les leaders communautaires, oeuvrent dans la lutte contre le SIDA. religieux et traditionnels en faveur des activités de lutte contre le Sida en milieu réfugié.
- Renforcer la capacité du staff médical des partenaires à la prise en charge des IST, la gestion des déchets médicaux et leur adhésion aux précautions universelles. de connaissances, le changement d'attitude et l'adoption de pratiques sûres par les membres
- Etablir une bonne stratégie de sensibilisation communautaire sur le VIH pour l'acquisition de la communauté bénéficiaire.
- Adopter une approche binaire dans l'implantation des activités éducatives pour que la communauté s'approprie du programme mais aussi assurer une certaine pérennisation des activités.
- Renforcer le programme de soins de santé primaires dans la Zone d'accueil des Réfugiés (ZAR) en terme de structure de centre de santé, recyclage du personnel, la collecte et l'interprétation des données épidémiologiques.
- Offrir des possibilités d'apprentissages professionnels aux adolescents qui ne vont pas à l'école. en d'autres termes une orientation de ce que devrait être l'éducation pour les Offrir l'opportunité aux femmes et adolescentes réfugiées de renforcer leurs capacités et réfugiés en Cote ivoire doit être définie. aptitudes à prendre leur vie en main (une alternative au commerce du sexe).
- Développer des activités complètes de la santé de la reproduction qui tient comptes des besoins des femmes et des adolescents.
- Etablir un service effectif et affectif de planification familiale dans chaque site réfugié.
- Développer des activités spéciales de prévention du VIH/SIDA pour les plus vulnérables : les jeunes, les femmes et les professionnelles du sexe.
- Avoir un suivi rapproché de l'avancé des différentes composantes de la lutte contre le Sida dans le Pays pour en assurer l'accès aux réfugiés.
- Prendre activement part à la révision de plan stratégique National prévu en Novembre 2004 afin d'obtenir des rectificatifs sur l'ancien cadre et faire refléter le besoin des réfugiés dans le nouveau.
- Faire le suivi de la démarche entamée par la mission VIH auprès de FNUAP/CI pour l'obtention des kits Santé Reproductive.

Executive summary

Cote d'Ivoire is the country most affected by the HIV/AIDS epidemic in West Africa. It is home to about 10% of AIDS cases in all African countries known to the WHO and UNAIDS. In 2000, it was estimated that 1,000,000 people were living with HIV in Cote d'Ivoire. HIV/AIDS prevalence within the overall population was estimated at 10, 51% in 2001 (Strategic Plan, Cote d'Ivoire). Within the framework of the fight against HIV/AIDS, the country has elaborated a National Strategic Plan, National guidelines on blood transfusion, treatment of Sexually Transmitted Infections (STI) and the Prevention of the Mother to Child Transmission (PMTCT). There are also guidelines on voluntary counseling and testing VCT, medical treatment for opportunistic infections, management of Post exposure accidents and a pool of Anti Retro Viral (ARV) prescriptions.

The Ivorian civil crisis had serious negatives impact on the general delivery of services in the country and has slowed down the country's capacity and its commitment in the struggle against AIDS more specifically in rural areas. Funds received from Global Fund, PEPFAR, MAP and other non-governmental and cooperation organizations is approximately 75 millions USD and have considerably boosted the Ivorian response to the epidemic. Within, the National Strategic Plan for HIV/AIDS, refugees are considered as vulnerable and at risk group.

Faced with the gravity and aggressiveness of this epidemic, the support offered by the

current programs of UNHCR/CI to refugees in general, women and adolescents in particular is insufficient. There are no HIV/AIDS programmes in refugee settings.

- Lack of Information, education and communication IEC materials on HIV/AIDS
- Universal precautions in the health structures are sporadic. None of the health posts has an incinerator or a proper waste pit for medical waste management.
- Sexually Transmitted Infections (STI), which are an important factor in the morbidity, are not properly treated.
- There are generally no condoms available in refugee settings. Where condoms are available for the refugee community, the supply is less than 1% of the actual monthly needs.
- There has been no family planning services provided in the localities for the past two years.
- Globally, reproductive health is very badly managed. Commercial Sex work is widespread and many refugee women are engaged in the practice. Young refugee boys are more and more involved in the commercial sex work especially around the international seaports.

The spread of HIV in West Africa is increasing and there a call for sustained efforts, adequate resources and communication strategies to be implemented to stop the spread.

Recommendations for UNHCR Cote d'Ivoire:

- To introduce as part of its humanitarian assistance to refugees, a complete HIV/AIDS program along with Implementing Partners (IP) developing activities of HIV prevention for refugee as well as their immediate host communities.
- Establish a structure of coordination of HIV/AIDS activities with IP's and reinforce collaboration with Governmental Organizations, UN agencies and other partners involved in the struggle against AIDS.
- Increase advocacy with national authorities, community leaders, religious and traditional leaders in support of activities aimed at the fight against AIDS in refugee settlements.
- Reinforce the capacity of IP's medical staff in terms of the management of STI, medical waste and an adherence to universal precautions.
- Establish an efficient community-based sensitization strategy on HIV for behaviors changes and adoption of safe sex practices by members of the beneficiary community.
- In all educational activities, adopt a peer approach in order to encourage community participation in programs and to ensure that these activities have continuity.
- Reinforce the primary health care program in the zone of refugee settlement ZAR (building, staffing, practices, epidemiological data collection and interpretation).
- Provide opportunities of professional/vocational training for teenagers not attending school. In an order word, a comprehensive assessment of the educational needs of refugees in Cote d'Ivoire is required.
- Offer opportunity to women and teenagers to reinforce their capacity and ability in order to take control of their own lives (alternatives to prostitution and protection against AIDS).
- Develop reproductive health activities, taking into consideration the needs of women and adolescent.
- Establish for each of the refugee sites an effective and a friendly Family planning service.
- Establish an HIV/AIDS programme targeting vulnerable group such as youth, women and commercial sex workers.
- Closely monitor the development of different components of the fight against HIV/AIDS in the country to ensure that the programme is accessible to refugees: VCT, PMTCT, and ARV.
- Actively participate in the upcoming revision of the National Strategic Plan in November 2004 in order to obtain some modification on the first version so that refugee needs are reflected and strategies are developed for them in the new Plan.
- Follow up of the HIV/AIDS mission negotiation with FNUAP for provision of R/H kits in refugee settings.

LES PROGRAMMES DE LUTTE CONTRE LE SIDA DANS LES CAMPS DE REFUGIE EN GUINEE - 26 Juillet au 9 Août 2004

Dr Bilguissa Diallo, Conseillère Technique VIH/SIDA Afrique de l'ouest

Resume

Face à l'avancé de la pandémie, la Guinée a réagi par un engagement des autorités politiques et sanitaires qui a facilité la création du cadre stratégique, des documents normatifs, des protocoles et guides de prise en charge et le développement d'un multi partenariat pour une réponse multisectorielle.

Le taux de séroprévalence au niveau national qui était évalué à 2,8% en 2001(enquête nationale de prévalence) est actuellement estimée par projection de l'OMS/ONUSIDA à 3,2% (ONUSIDA -GUINEE).

Les fonds estimés à près de 60 millions de Dollars US sont disponibles pour la lutte contre le SIDA et proviennent du Fond global, le Projet Multisectoriel de lutte contre le SIDA (MAP 2), PAF, du Gouvernement, des Agences Onusiennes, la coopération internationales et les ONGs.

Les acteurs et intervenants dans la lutte contre le VIH SIDA en Guinée ont reconnu que l'épidémie est aujourd'hui au seuil d'une nouvelle phase, que la réponse est faible et qu'il convient de vite et mieux agir. Certaines insuffisances, notamment au niveau de la coordination dans les activités et les difficultés socio-politiques et économique que traverse le pays depuis près d'une décennie, ont fait que la Guinée soit assez en retard dans la mise en place des activités complètes de lutte contre le Sida. Les zones urbaines à l'intérieur du pays sont faiblement couvertes. Le matériel d'Information d'Education et de Communication (IEC) utilisé date des premières heures du Programme National et n'est pas disponible à large échelle. La prise en charge syndromique des Infections Sexuellement Transmissibles (IST) est adoptée mais ne couvre pas l'ensemble du territoire national et la rupture en molécule de traitement des IST est fréquente. La promotion du préservatif à faible coût était le fort du Programme National mais à ce jour sa promotion connaît quelques difficultés du fait des ruptures comme Albadariah (Kissidougou). Le sang quand il est disponible il est sécurisé, mais de plus en plus d'hôpitaux de référence habilités à faire des transfusions ont du mal à subvenir aux besoins de leurs banques sanguines (poches, tests sérologiques). Le Conseil et Dépistage Volontaire (CDV) et la Prévention de la Transmission Mère Enfant (PTME) sont en phase pilote dans le pays.

Les tests VIH/SIDA sont pratiqués dans la plus part des hôpitaux de référence sans conseil préalable ou d'accompagnement et la confidentialité autour du dépistage est très volage.

Les Anti Rétroviraux (ARVs) sont disponibles en pharmacies privées, le prix élevé, la constance dans l'approvisionnement assez critique et le nombre de prescripteurs est réduit.

Les réfugiés sont reconnus dans le cadre stratégique comme groupe vulnérable, mais aucune stratégie de lutte contre le Sida n'est développée pour eux. Ils sont aussi omis dans les propositions faites par la Guinée au Fond Global et au MAP.

Le programme National de lutte contre le SIDA n'a d'activités dans aucun des camps de réfugiés du pays. Il ya un malaise perceptible au niveau de la communauté locale de la Guinée Forestière (zone d'accueil des réfugiés) quand à l'avancé de la pandémie et la paupérisation. Pour des esprits mal avertis les réfugiés sont responsables de cette situation (Voir Annexe 1).

Dans la Région de la Guinée forestière, **la lutte contre le SIDA est nettement mieux organisée en milieu réfugié.**

Le HCR et ses partenaires ont mis sur place (dans les camps de Kissidougou et de Nzerekoré) :

- Des programmes de sensibilisation et d'éducation de la communauté avec un accent particulier pour les jeunes.
- La prise en charge des IST est syndromique et le préservatif gratuitement distribué au niveau de la communauté.

- Le personnel médical a été formé sur les précautions universelles et La gestion des ordures médicales est globalement remarquable.
- La formation des paires éducateurs parmi les jeunes est organisé et assure ainsi une pérennisation et appropriation du programme.
- Le système de référence dans la gestion des violences sexuelles est bien établi et fonctionnel.
- Les composante des soins de santé primaires sont développées et offertes gratuitement aux réfugiés et Population environnante.

La mission a entre autre noté :

- Un manque de coordination et d'intégration des activités de lutte contre le sida avec les autres activités de santé des réfugiés ainsi que le programme National ou local.
- Une certaine faiblesse dans la sensibilisation des femmes et des adolescents non scolarisés des camps sur le SIDA en particulier.
- Une disparité dans la méthode de promotion et de distribution de préservatif d'un camp à l'autre.
- Les avortement provoqués sont en hausse et les services de planification familiale sont globalement faibles (connaissance et disponibilité de méthode contraceptives)
- Non interprétation des données épidémiologiques disponibles (Santé Curative et Reproductive).

Pour améliorer des programmes de lutte contre le Sida, la mission conseille entre autres les activités suivantes (lire le rapport pour plus de détails) :

1. La Représentation à Conakry et les bureaux de terrain du HCR doivent maintenir leur participation active aux réunions : le groupe thématique et technique mais aussi les réunions programmatiques qui se tiennent au niveau National et locale.
2. Faire figurer le VIH/SIDA sur l'agenda des Réunions de Coordination Santé Nutrition (Santé/Nutrition/VIH) et Nommer des Points focaux VIH/SIDA au niveau des Bureaux HCR à travers le Pays.
3. Que le HCR et Partenaires approvisionne au plus vite les bureaux et les partenaires en matériel IEC : Vidéo, Posters, livret éducatif, dépliants.
4. Uniformiser et vulgariser les programmes de lutte contre le Sida dans les camps à savoir le Camp de Boreah, de Inainé et de Nonah.
5. Améliorer la sensibilisation communautaire par :
 - i. La stratégie : utiliser des moyens audio visuels (les vidéo clubs bcaux), groupe théâtral, compétitions sportives.
 - ii. les groupes cibles : en plus des jeunes, prendre en compte les besoins des femmes et des adolescentes.
 - iii. Promouvoir les méthodes de prévention de seconde génération (CDV, PTME).
6. Formation et recyclage des pairs éducateurs de VIH et Animateurs de santé communautaire sur les techniques d'IEC /Communication pour le Changement de Comportement (CCC).
7. Former et équiper en Matériel IEC des pairs éducateurs volontaires parmi les femmes et les adolescents non scolarisés sur la prévention du SIDA dans chaque Camps
8. Améliorer la stratégie de distribution des préservatifs : renforcer la distribution Communautaire, harmoniser le nombre de préservatif distribués suivi d'un bon rapportage.
9. Recyclage du personnel de santé sur :
 - les précautions universelles et les techniques de désinfection et stérilisation.
 - la prise en charge des IST, la prise en charge des Infections Opportunistes.
 - La gestion des accidents d'exposition au sang et autres dérivées.
 - Le Gestion médicale des cas de violences sexuelles.

10. Améliorer les services de Planification Familiale en organisant une promotion du service mais aussi diversifier les méthodes de PF tout en assurant la continuité du service.
11. Organisation de Campagne de sensibilisation sur les méfaits de l'avortement provoqués dans les camps de réfugiés (projection Vidéo, scénettes, formation de Paires éducateurs volontaires).
12. Améliorer la gestion des déchets médicaux à Lainé et à Kouankan.
13. Nécessité de réactualiser pour le staff les connaissances et procédures de la gestion médicale des viols plus particulièrement les procédures visant à minimiser les risques d'infection au VIH.

Executive summary

In response to spread of the pandemic of HIV/AIDS, Guinea adopted a political engagement that facilitated the creation of the National Strategic Plan, the development of normative documents, protocols and guidelines for care and treatment and adoption of a multi-sectoral approach for an effective response to AIDS and mitigates its impact.

The National Seroprevalence is currently estimated by UNAIDS to be at 3, 2%, but the National Seroprevalence survey conducted three years before, in 2001 found it to be at 2,8%.

Around 60 millions US Dollars are available for activities to fight HIV/AIDS. These come from the Global Fund, the Multisectoral Accelerated Programme (MAP 2), the Programme Accelerated Fund (PAF), the Government, UN Agencies, International Cooperation and Non-Governmental Organisations.

The actors and intervening parties in the struggle against HIV/AIDS in Guinea recognized that the epidemic has now reached the doorstep of a new phase, and that the current response to the epidemic is weak. There is a need for a quick and better action.

Socio-political and economic difficulties of the country over the past decade have made Guinea a latecomer in setting up a comprehensive activities in the fight against HIV/AIDS.

The urban zones of the country are poorly covered by the National AIDS Control Program and the material of Information, Education and Communication (IEC) are those from the beginning of the Program and are not available at a large scale. The syndromic management of Sexually Transmitted Infections (STI) has been adopted but is not used in health facilities all over the country. STI drugs are not available in all state-health structures.

One of the strong points of Guinea's programme against AIDS was the social marketing of condoms and their availability at a very low price. Currently, however social marketing of condoms has become very infrequent and inexistent in rural areas such as Albadariah (Kissidougou). Blood for transfusion when available is secured by a series of tests. Note that more and more referral hospitals have difficulty to meet their blood bank needs (pockets, serological tests). The Voluntary Counselling and Testing (VCT) and the Prevention of Mother to Child Transmission (PTME) are at a pilot phase. The HIV/AIDS tests are practiced in most of the referral hospitals without pre and post counselling, and confidentiality around the testing is very low. Anti Retroviral treatment (ART) is available in private pharmacies, the high price, the inconsistency of provision and the reduced number of trained prescribers limits the access for the patients.

Refugees are recognized in the strategic plan as vulnerable group, but no strategy of struggle against AIDS is developed for them. They are also omitted in the propositions made by Guinea to donors such as the Global fund and MAP. The National AIDS control program doesn't have activity in none of the refugee camps of the country.

There is a vocal uneasiness of the local community of the Forest Region of Guinea (area of refugee settings) when faced with the advancement of the pandemic and pauperization.

Many believe that refugees are responsible of the spread of HIV AIDS (See Annex 1).

In the Forest Region, the struggle against AIDS is distinctly better organized in refugee settings.

UNHCR and its partners have developed activities in Kissidougou and Nzérékoré Refugee Camps:

- Development of a program of sensitization of the community with a particular accent for the youth.
- Syndromic approach in STI case management is adopted; free condoms are promoted and distributed at the community level.
- Medical staff has been trained on universal precautions and the management of medical waste is generally very good.
- Training of peer educators among the youth is organised to assure the perpetuation and appropriation of the program.
- The channel of sexual violence case referral and management is established and functional.
- Components of primary health cares are developed and offered free of charge to the refugees and their surrounding population.

The mission noted among others:

- A lack of coordination and integration of the HIV/AIDS with health activities for refugees, as well as the National or local health program.
- A certain weakness in the sensitization of women and non schooled teenagers on HIV/AIDS in particular.
- A disparity in the method of promotion and distribution of condoms.
- Criminal Abortions are on the increase and the services of Reproductive Health/ Family Planning are globally weak (community knowledge and availability of contraceptive method)
- Non interpretation of the available epidemiological data (Curative and Reproductive Health).

To improve AIDS control programs for refugees, the mission recommends the following activities among others (read the report for more of details):

1. UNHCR BO in Conakry and Field offices must maintain their active involvement to the meetings such as UN Theme Group, technical groups but also to programmatic meetings holds at National and local level. Proceed to the Nomination of HIV/AIDS Focal Points in all UNHCR's Offices.
2. HIV/AIDS should figure on the agenda of the Health and Nutrition Coordination Meetings as Health/Nutrition/HIV.
3. UNHCR and its partners to supply workers with IEC materials such as: Videos, Posters, booklets.
4. To standardize and expand the HIV/AIDS activities to all camps such as Boreah, Nonah and Lainé.
5. Improve the community sensitization by:
 - i. Sharpening the strategy: use of audio visual (the local video clubs), drama group, sport events and others.
 - ii. Beneficiaries: in addition to the youth, consider the needs of women and unschooled teenagers.
 - iii. Promotion of second generation prevention methods (VCT, PMTCT).
6. Training and/or refresher training of pair's educators and Community Health Animators on IEC / Behavioural Change Communication (BCC) techniques.
7. Train and equip peer educators among camps women and the no schooled teenagers on HIV/AIDS transmission and prevention.
8. Improve the strategy of Condom distribution: reinforce the Community based distribution, harmonize the number of condom distributed and data collection related to the activity.
9. Refresher training of the health staff on:
 - i. Universal precautions and the techniques of disinfection and sterilization.
 - ii. Management of STI and Opportunist Infections.
 - iii. Post Exposure Prophylaxis.
10. To improve the services of Family planning (FP) by organizing a promotion of the service but also by offering a Variety of FP methods and assuring a continuity of the service.

11. Organization of sensitization Campaign on the consequences of criminal abortions by using video projection, Drama, training of peer educators.
12. Improve the management of the medical waste in Lainé and Kouankan.
13. Re-actualize for the medical staff at all level, their knowledge and procedures to follow in the management of Sexual assault cases more especially procedures aiming to minimize the risks of infection in the VIH.

Monitoring Mission: HIV/AIDS Programmes in Osire Refugee Camp, Namibia 2 – 6 August 2004

Laurie Bruns, Regional HIV/AIDS Technical Officer, UNHCR Pretoria

Executive Summary

This mission was undertaken to review the HIV/AIDS programmes in Osire refugee camp, and to follow up on issues identified during 2003 missions undertaken by the Regional HIV/AIDS Technical Officer, the Senior HIV/AIDS Technical Officer and UNHCR intern².

The 2004/ 2005 refugee programme in Namibia presents a critical window of opportunity to combat the transmission of HIV as the programme enters the final stages of the voluntary repatriation operation to Angola. The mission noted the positive impact of UNHCR's 2003 supplemental HIV/AIDS funding, as well as the Southern African HIV/AIDS and Refugees workshop (December 2003), on HIV/AIDS prevention, care and treatment programmes in Osire camp, although momentum seems to have slowed in 2004. Budgetary provisions to ensure supplies for universal precautions and STI medications at the camp clinic appear inadequate, and the resignation of AHA's HIV/AIDS Coordinator in July 2004 has caused a break in on-going prevention activities. Condom supplies must be guaranteed at the camp level through intervention with MOHSS and central medical supplies in Windhoek. Partnerships with UNICEF, UNFPA and, with UNHCR's recent co-sponsorship, UNAIDS, should be strengthened so that national HIV/AIDS programmes supported by government and these UN agencies can be extended to Osire camp. School based and youth focused programmes need additional support in terms of training and supervision. With the departure of the previous focal point on HIV/AIDS at UNHCR Namibia earlier this year, a designation of a new UNHCR focal point would greatly facilitate monitoring and follow up on HIV/AIDS related issues, as well as inter-agency collaboration. However, the mission recognises that BON staff are somewhat over-stretched due to the VolRep programme.

Care and support programmes for chronically ill, including nutritional support, should be reviewed by UNHCR, AHA and WFP. Access by refugees to public sector anti-retroviral treatment programmes must be closely coordinated by MOHSS, UNHCR and AHA, with attention to the implications of VolRep and other movement. Linkages with local support groups for people living with HIV/AIDS should be promoted.

UNHCR staff should receive an orientation on PEP treatment, and kits should be supplied by BON to FO Osire and Rundu.

² For further information, please see reports: "Assessment of HIV/AIDS Programs among Refugees in South Africa, Namibia and Zambia", by Bruns, L. and Spiegel, P., Feb/Mar 2003; "HIV/AIDS Activities in Osire Refugee Camp, Namibia", by Bruns, L., June 2003; "Coordination, Monitoring and Evaluation of HIV/AIDS Programs, Osire Refugee Camp, Namibia", by Ariyaprakaj, V., June-August 2003.

UNHCR AND UNAIDS JOINT MISSION : HIV/AIDS ASSESSMENT MISSION IN REFUGEE SETTING IN YEMEN September 2004

Patterson M. Njogu: UNHCR: - HIV/AIDS Regional Technical Officer
**Iris Semini: UNAIDS Inter Country Team for the Middle East and North Africa: -
Programme Development Advisor**
**Iman Mortay: UNAIDS Inter Country Team for the Middle East and North Africa:
- Technical Officer**

Executive Summary

This report summarizes the findings and recommendations of a joint assessment mission that UNHCR and UNAIDS undertook to Yemen on 26 August – 3 September 2004. The paper is based on discussions and interviews with a wide-range of partners, including TG members (UNICEF, UNFPA, and WHO), UNHCR in Sana'a and Aden, and NGOs, as well as relevant available documentation.

Data on HIV/AIDS in Yemen, while extremely limited, indicate a low prevalence (0.01%). By the end of 2003 WHO/UNAIDS estimated that 12,000 adults and children were living with HIV/AIDS. Most refugees come from Somalia where little is known about HIV/AIDS epidemic and Ethiopia where HIV/AIDS epidemic is advanced and mature. Annually, approximately 10-15 refugees infected with HIV/AIDS are identified; these cases heighten fear and fuel stigma and discrimination. Mainly due to lack of knowledge regarding the nature of HIV/AIDS and methods of transmission, strong stigma and discrimination prevail against people living with HIV/AIDS. HIV/AIDS is strongly perceived as a "foreign" disease, leading to high prejudice towards refugees among health care workers and across society. In Yemen, refugees are often subjected to mandatory HIV testing, detention on the basis HIV serostatus, disclosure of serostatus to third parties, threatened with deportation, relocated to Kharaz camp from urban centers and a number have been voluntarily repatriated because they were HIV positive. These basic human rights violation has gone on unchallenged and not clearly documented by UNHCR, NGOs and UN community.

National HIV/AIDS prevention, care, treatment and support programmes are at developmental stage in Yemen. NAP has launched training programmes on syndromic management of STIs, basic counseling skills and development of IEC materials among others. In the refugee programme, HIV/AIDS interventions were at infancy, were not adequately orientated and appear to be developing parallel to national efforts. Because of stigma, discrimination and violations of basic human rights against refugees, the programme was "secretive" and does not benefit from national initiatives such as training, policy development and advocacy. Denial, discrimination and violations of basic human rights were pronounced. Yemenis infected with HIV/AIDS are not spared. The refugee programme should proceed cautiously and only implement prevention, care, treatment and support programmes that NAP is actively pursuing. There is no room for unilateral programming. Ideally programming should take into account the level of programme development of the surrounding population. The mission does not recommend proactive development of VCT, PMTCT, Sentinel Surveillance and introduction of ARVs ahead of national efforts. However, UNHCR may advocate for and catalyze their development.

Recommendations

- Orientate UNHCR/GOY and IP staff members about HIV/AIDS and human rights violation that are often associated with HIV/AIDS.
- Monitor, investigate and document prevalent forms of stigma, discrimination, basic human rights violations. Discuss these violations with the Theme Group on HIV/AIDS.
- Interact with the Minister of Human Rights and the National AIDS Programme, and bring to their attention human rights violation and possible ways to address them.
- Integrate HIV/AIDS prevention, care, treatment and support programmes in all aspects of UNHCR programme and implementing partners. Follow national guidelines and protocols.

Incorporate surrounding populations and the local MOPHP in refugee HIV/AIDS programme.

- Strengthen the capacities of UNHCR, the implementing partners and national programmes to programme and implement HIV/AIDS prevention and care strategies, with a particular focus on vulnerable populations.
- Pre-entry medical screening, which could result in refolements, should be approached with caution, clear objectives, goals and the actions to be taken.
- There should be consistently rejection of use of mandatory screening as a method of control. UNAIDS and UHNCR do not recommend mandatory screening neither on public health nor on humanitarian ground, unless for blood safety.
- The mission does not recommend proactive development of VCT, PMTCT, Sentinel Surveillance and introduction of ARVs ahead of national efforts however.
- UNHCR may however, advocate for and catalyze their development.
- Development of a UNAIDS Programme Acceleration Fund proposal for 2004-2005 with a focus on HIV programmes among refugees. Action: MENA-ICT and UNHCR
- Provide HIV/AIDS prevention messages, information and communication materials in Arabic and Somalis from neighboring countries to the implementing partners.

HIV /AIDS ACTIVITIES FOR REFUGEE IN GHANA – October 2004

Dr Bilguissa Diallo - Regional HIV/AIDS Technical Officer

Executive Summary

In October 2004, an assessment mission was undertaken in Ghana to assess HIV/AIDS related programs for the 48,034 refugee population registered in the country.

The mission was fielded in order to:

- Familiarize the Regional HIV/AIDS coordinator with camp based HIV/AIDS programs in Ghana.
- To identify existing HIV/AIDS programs and activities in the Country.
- Make recommendations for Refugee programmes improvement where necessary.

Ghana has in place a National HIV/AIDS Strategic Framework 2001-2005 which is supported by donor funding. It does not mention directly refugee needs and therefore has no programmes specifically addressing refugee needs. The Framework will be reviewed for the period 2006-2010 this provides an opportunity for lobbying for the inclusion of refugee needs in the frame work so programmes specific to addressing the HIV/AIDS of refugees.

The incidence of HIV/AIDS has been increasing steadily over the years; at the end of 2002 the median prevalence of HIV in Ghana for adult was 3.4%.

Though refugees have no mention in the National Strategic Framework, many organizations are active and developing and implementing HIV/AIDS prevention programmes for the Refuge communities. These include government funded organizations and ministries, NGOs, CBOs and some International agencies. This situation clearly demonstrates a willingness to address what is now widely accepted as a serious issue, HIV/AIDS in refugee settings. However, there is a need for coordination to synergize efforts such as would bring maximum benefits to targeted beneficiaries in the camps but also avoid overlapping and duplication of provided services.

In the camps IEC would need to be supplied in adequate quantities and in the relevant languages of the refugees to achieve maximum impact. Every effort needs to be made in securing, promoting and distribution of adequate supplies of condoms in the refugee settlements. The recurrence of condom shortages in the camps is an issue of concern and should be solved with high priority.

IP with strong capacity in battling HIV/AIDS with openness to address all issue related to the matter should be identified to forestall all component of a good response to the advance of the epidemic.

Refugee women and girl in reproductive age need more specifically have to be targeted for STI education.

Finally in order to bring HIV/AIDS and management practices in the camp up to the required standards more in-service and retraining of health workers on HIV/AIDS and other health related services would be very necessary.

Mission de Suivi et Evaluation VIH/SIDA République du Congo 12- 22 Novembre 2004

Dr YIWEZA T.S. Dieudonné - UNHCR Coordinateur Régional VIH/SIDA Afrique Centrale

Résumé

En novembre 2004, nous avons conduit une mission dans les sites de réfugiés de la République du Congo.

Cette mission avait 3 buts :

- le suivi des activités VIH SIDA en faveur des réfugiés congolais de la DRC
- la tenue de la première réunion médicale
- le lancement de la formation sur les conversations communautaires
- et la prise de contact avec les cadres de l'initiative des pays riverains de fleuves Congo, Oubangui et Chari (IFCOC).

Il n'y a pas eu beaucoup d'amélioration depuis la dernière visite de novembre 2003 :

Les comités multisectoriels de lutte contre VIH/SIDA ne sont pas installés. Cela est dû entre autre au grand éparpillement des sites des réfugiés le long du fleuve. Pour cela, on opte pour la stratégie de la formation des points focaux communautaires pour mener les **conversations communautaires** (voir annexe 1). Ces formations vont se dérouler dans toutes les 3 agglomérations et vont concerner les réfugiés hommes et femmes.

Les réunions de **coordination** médicales avec le HCR et les partenaires médicaux (cemir, GTZ, IRC) ne sont pas tenues. La première a été tenue au cours de notre visite. Au cours de cette réunion, nous sommes parvenus à un consensus sur les grands défis et stratégies de la prise en charge des réfugiés notamment en ce qui concerne les formations, les approvisionnements et les rapports épidémiologiques.

Les matériels audiovisuels commandés pour les **IEC** et communication pour le changement de comportement (**CCC**) ne sont pas encore disponibles sur terrain.

La prise en charge des Infections sexuellement Transmissibles (IST) pose encore problème. **La formation sur les approches syndromiques** n'a pas encore lieu. L'approvisionnement en intrants **pour les précautions universelles est erratique** : on connaît des ruptures de stock dus au retard de livraison des commandes mais aussi aux difficultés de transport dans cette zone enclavée.

Les contacts avec le nouveau **Secrétaire exécutif de l'IFCOC** nous a permis de renouer contact avec cette initiative sous régionale. Le HCR est perçu comme un futur partenaire de première importance dans cette initiative contre le VIH SIDA financée par la **Banque Africaine de Développement (BAD)**.

Ce rapport donne une analyse sommaire des constats par grand chapitre. En annexe se trouvent les documents et rapports de réunions et formations effectuées.

Nous remercions la représentation HCR République du Congo (ROC) et les collègues sur terrain pour leur soutien au cours de cette mission.

HIV/AIDS Training and Monitoring Mission: Mozambique

HIV/AIDS awareness session, Marratane refugee camp 21-28 November 2004

**Laurie Bruns, Regional HIV/AIDS Technical Officer, UNHCR Pretoria
Jean-Pierre Kalala, Refugee Life Skills Programme,
Planned Parenthood Association of South Africa**

Executive Summary

This mission was undertaken by the UNHCR Regional HIV/AIDS Technical Officer and PPASA Life Skills Programme Manager to provide support to UNHCR Mozambique in:

- Evaluating current camp -based HIV/AIDS interventions
- Supporting and strengthening on-going HIV/AIDS awareness training in the refugee community
- Exploring potential cooperation with other agencies and organisations, including the Ministry of Health, bilaterals and non-governmental organisations

The mission itinerary and list of persons met can be found in Annex 1.

Marratane refugee camp, located in Nampula province in northern Mozambique, currently hosts some 4,600 refugees, the majority of whom originate from the Democratic Republic of the Congo. While there are basic HIV/AIDS prevention, care and support programmes in the camp, there is an urgent need to scale up and expand these programmes. The identification of a competent community services implementing partner for Marratane, with expertise in HIV/AIDS, would greatly enhance these efforts and would provide much needed supervision and support to refugee initiatives in the camp.

There are many local HIV/AIDS programmes being initiated in Nampula City and throughout Nampula province through the Ministry of Health, with the support of international NGOs and bilateral organisations. UNHCR should actively pursue linkages with these programmes with a view to extending relevant services to Marratane and to promote the inclusion of refugees in programmes conducted outside of the camp . Some of the initiatives to be explored include: behavioural surveillance surveys; peer education training and support; information, education and communication materials in French and Portuguese language; community based condom promotion; voluntary counseling and testing; prevention of mother to child transmission; support groups for people living with HIV and AIDS; anti-retroviral treatment; and home based care. A list of relevant organizations and areas for potential interagency collaboration is included at the end of this report.

UNHCR and INAR staff should monitor supplies of condoms in the camp to ensure sufficient stock is available, as well as checking clinic supplies to ensure universal precautions (disposable needles, syringes, gloves, hand washing supplies). The medical waste disposal pit should be enclosed by a secure fence. Additional outlets for condom distribution should be explored in cooperation with community leaders, women, youth and other refugee groups. As part of this mission, the Refugee Life Skills Programme Manager from PPASA provided two days of training to refugee community members and leaders. The training built upon previous support provided to the community in 2003, and included re-fresher information and new skills for peer educators as well as a clarification of roles and responsibilities of refugee HIV/AIDS organizations in Marratane. New IEC materials were shared with the peer educators in order to support their on-going education and awareness activities in the camp. Post-exposure prophylaxis (PEP) for UNHCR staff is available, but staff were unclear on when and how to access PEP treatment. Training on PEP was provided by the mission to staff at OCM Maputo and FO Nampula. Each office must identify custodians of the kits and dispensing physicians. OCM Maputo should ensure that all staff have received an orientation on PEP, and are aware of the protocol to be followed in case of a sexual assault or occupational exposure to HIV. PEP training should be included in the induction orientation of all new staff.

HIV/AIDS Monitoring Mission: Kala and Mwange Refugee Camps Zambia - 06-11 December 2004

Laurie Bruns, Regional HIV/AIDS Technical Officer (Southern Africa)
Dieudonne T.S. Yiweza, Regional HIV/AIDS Technical Officer (Central Africa)

Executive Summary

This mission was undertaken by UNHCR Regional HIV/AIDS Technical Officers from Southern and Central Africa to provide support to UNHCR Zambia in monitoring and evaluating current camp-based HIV/AIDS interventions.

The mission itinerary and list of persons met can be found in Annex 1.

For background on Mwange and Kala camps, please see HIV/AIDS mission report of February/March 2004.

The mission noted an overall improvement in coordination and service delivery in both camps. Inter-agency Task Forces on HIV/AIDS have been established at the camp level and are meeting regularly. Relationships with the District Health Management Teams are good, but closer cooperation on reporting and supply management is required. When interruptions in supplies, such as condoms or test kits, result at the Lusaka level, ZRCS and AAH Head offices, together with UNHCR Lusaka, should be requested to intervene. Training for clinical staff on universal precautions, syndromic management of STIs, and other related protocols has been provided by the DHMT for both camp clinics. However, there is an urgent need to train laboratory technicians on the national HIV testing protocol.

Clinical staffing levels of both ZRCS and AAH should be rationalised with respect to posts and designations, particularly in light of funding constraints.

Behaviour change and communication efforts have been strengthened; however, there is a need to reinforce programmes targeting youth and those combating stigma and discrimination against people living with HIV and AIDS. The implications of the reduced food rations experienced in late 2004 should be closely monitored, as community members reported a resultant increase in risk taking behaviours, including transactional sex. Refugees have access to the government anti-retroviral treatment programme, including PMTCT, but UNHCR and partners must explore the possibility of fee waivers. Partnering with CDC and UTH on sentinel surveillance surveys in both camps should be pursued as a matter of priority in 2005.

The mission fielded many questions from the refugee community on health and HIV/AIDS programmes in areas of return in the DRC. Refugees were encouraged to take full advantage of the programmes offered in Kala and Mwange, as such programmes are nascent, if existing at all, in the DRC. Certificates should be issued for all training, as well as letters of recommendation outlining experience acquired in the camps, to enable refugees returning to DRC to utilize their skills and knowledge.

Post-exposure prophylaxis (PEP) for UNHCR staff is available, but staff were unclear on when and how to access PEP treatment. Training on PEP was provided by the mission to staff at SO Kawambwa. SO Kawambwa and FO Mporokoso must identify custodians of the kits and dispensing physicians. RO Lusaka should ensure that all staff have received an orientation on PEP, and are aware of the protocol to be followed in case of a sexual assault or occupational exposure to HIV. PEP training should be included in the induction orientation of all new staff.

Follow Up Mission of HIV/AIDS Programmes In Liberia and Sierra Leone - December 7th to 24th 2004

Dr Bilguissa Diallo, HIV/AIDS Technical Officer West Africa

Executive Summary

The missions conducted by the regional Technical officer to Liberia and Sierra Leone in December 2004 were essentially follow ups to the earlier missions to these countries in May 2004. The present report is divided in two and compiles findings and recommendations from the two countries.

The objectives of the mission in the two countries were to

- a. Review the progress in the implementation of the recommendations for programme improvement made after the first mission. Evaluate the impact of VAR funds in addressing the programme improvement.
- b. Draft a Work plan for 2005 activities with UNHCR and its partners HIV/AIDS focal persons
- c. Review the repatriation processes and its HIV/AIDS component in order to make relevant recommendations.

Field visits were undertaken to refugee camps and transit centers. Working sessions were also organized between the mission and the relevant organizations (UNHCR Implementing partners, UNMIL, UNFPA, MRU and the National AIDS control programmes). Group discussions were also held with members of the refugee communities, health workers, teachers and refugee community leaders.

Programme implementation is at varying levels of progress and success in the two countries. This derives from the varying priorities determined by the offices after the assessment mission but also dictated by the field realities. For the two Countries like the other West African countries benefiting from this initial phase of UNHCR programme in West Africa, the scarcity of Information, education and communication material was a real challenge. This Gap is about to be filled with the provision and distribution of IEC Material including booklets, leaflets, Videos, posters and other for programme usage. However UNHCR and IP have to focus on development and distribution of culturally and linguistically appropriate material for the beneficiaries; due to their low literacy rate.

The Branch Office (BO) in Liberia assumed the role of a spending authority over the VAR funds released by UNHCR Headquarters. The funds were used to provide capacity building materials (training material) for IPs and to organize a training of trainers' workshop for HIV/AIDS focal persons. The Branch office benefited from a second release of funds which is being used to strengthen the Universal precautions and to provide STI drugs to health centers along the frontiers with Cote d'Ivoire.

Difficulties of condom supply has been resolved within the last four months, however STI drugs availability remains a major concern for health workers and patients.

A good network of HIV/AIDS focal persons is being developed in the country with the support and the commitment of UNHCR BO and SOs. This process need to be supported by the BO HIV/AIDS focal person, through field visits and holding regular coordination meeting with IPs and HIV/AIDS Focal persons.

Sierra Leone benefited from the VAR and had its awareness programme strengthened. The community outreach sessions are more regular and the number of HIV animators was increased. Female and male Condoms were provided; their promotion and distribution avenues were widened. A significant improvement regarding the Universal precaution was made in Largo refugee camps with the construction of a waste management area and the training of the health staff.

STI cases management has improved but its syndromic notification is still below standard.

This also goes for the condoms distribution records, were the breakdown by age range and sex is not yet consistent and not consolidated by the Health coordinators.

A VCT consultant hired by UNHCR will arrive in a few days in Sierra Leone to work with UNHCR health staff, BO and Kenema districts hospitals to strengthen their VCT services.

In term of coordination, the Health coordinators still need to ensure that HIV/AIDS is a regular theme at the UNHCR health Coordination meetings in Sierra Leone.

There is a need from the health Coordinators for a closer follow up with IPs to ensure integration of HIV/AIDS mission recommendation in the various areas.

HIV/AIDS integration in the repatriation process has to be strengthened by emphasizing on the awareness sessions and the condom distribution. More specific recommendations will be done after consultations are held with the health Partners and other involved units in the repatriation exercise.

The Main constrains in the programme activities is late programme commencement and the long process in the reception of VAR funds. This resulted in a late submission and/or conclusion of Sub agreement between UNHCR and Implementing partners.

Additionally there are different levels of understanding of the HIV/AIDS programme and its strategies as well as the priorities globally defined by UNHCR in battling HIV/AIDS.

There is a real need of bringing the involved staff together and share understanding and provide a short training on HIV/AIDS programme related issues.