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HIV/AIDS AND REFUGEES

UNHCR's Strategic Plan

2002 - 2004

UNHCR
United Nations High Commissioner for Refugees
Haut Commissariat des Nations Unies pour les réfugiés

This strategic plan (2002-2004) is based on the United Nations High Commissioner for Refugees (UNHCR) policies[1] and technical and normative guidance from UNAIDS and the World Health Organization (WHO)[2].

This paper states UNHCR's objectives and key strategies to combat HIV/AIDS in refugees; these include the continuation and reinforcement of HIV/AIDS programmes in refugee situations and the introduction of comprehensive pilot programmes in selected sites. Lessons learned from the monitoring and evaluation of these pilot projects will be disseminated to other refugee situations.

I. INTRODUCTION

Acquired Immune Deficiency Syndrome (AIDS) has become the most devastating disease humankind has ever faced. In 2001, UNAIDS reported that AIDS has become the leading cause of death in Sub-Saharan Africa and the fourth leading cause of death worldwide. Steep drops in life expectancy in many countries were also reported. Prevention and mitigation of HIV/AIDS must be seen as an essential component of the overall protection of refugees. While data on Human Immunodeficiency Virus (HIV) prevalence in refugee situations are scarce, it is believed that refugees and other displaced populations are at increased risk of contracting the virus during and after displacement due to the following factors: poverty, disruption of family/social structures and health services, increase in sexual violence, and increase in socio-economic vulnerability, particularly of women and youth. However, it is important to combat the stereotypical perception that 'refugees bring AIDS with them to local communities", which may lead to discriminatory practices.

In accordance with the UN Special Session Declaration of Commitment on HIV/AIDS[3] and the international Guidelines on HIV/AIDS and Human Rights,[4] UNHCR adopts a rights-based approach in all its programmes and protection activities related to HIV/AIDS.

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[1] "Refugees and HIV/AIDS" 15 February 2001, EC/51/SC/CRP.7; UNHCR IOM/78/98 FOM/84/98 and its resource package, 1 December 1998; "UNHCR Policy regarding Refugees and Acquired Immune Deficiency Syndrome"; UNHCR IOM/82/92 FOM/81/92, 12 November 1992; "UNHCR Policy and Guidelines regarding Refugees and Acquired Immune Deficiency Syndrome"; and UNHCR IOM/21/88 FOM/20/88 "Policy and Guidelines Regarding Refugee Protection and Assistance and Acquired Immune Deficiency Syndrome", 15 February 1988.

[2] Guidelines for HIV Interventions in Emergency Settings, WHO, UNAIDS, and UNHCR, 1996; Reproductive Health Manual, Inter-agency, 1999; Refugee and AIDS Technical Update, UNAIDS, 1997; Second Generation Surveillance for HIV, WHO and UNAIDS, 2000.

[3] The UN General Assembly at its Special Session called on States, by the year 2003, to enact, strengthen or enforce as appropriate, legislation, regulations and other measures to eliminate all forms of discrimination against, and to ensure the full enjoyment of all human rights and fundamental freedoms by, people living with HIV/AIDS and members of vulnerable groups; in particular, to ensure their access to, *inter alia,* education, inheritance, employment, health care, social and health services, prevention, support, treatment, information and legal protection, while respecting their privacy and confidentiality; to develop strategies to combat stigma and social exclusion connected with the epidemic.

[4] See HIV/AIDS and Human Rights: International Guidelines, UNHCHR/UNAIDS, Geneva, 23-25 September 1996.

II. UNHCR's OBJECTIVES

1. Refugees and asylum-seekers live in dignity, free from discrimination, and their human rights are respected through:

- Ensuring that refugees are not persecuted on the basis of their HIV infection (e.g. preventing restrictions to freedom of movement imposed on the ground of HIV status).
- Ensuring that refugees are not subject to specific measures based on their HIV status, unless these are applied to all residents of the country concerned and are in compliance with international human rights law.
- Promoting and seeking increased access to National AIDS Control Programmes (NACPs) for refugees affected by HIV/AIDS.
- Opposing mandatory testing of asylum-seekers and refugees (for example through registration) since this does not prevent the spread of the virus and is at variance with relevant human rights standards.
- Ensuring that qualified and professional counselling, as well as confidential notification of results accompany individual voluntary testing.
- Seeking automatic waivers where HIV/AIDS constitutes a bar to resettlement or local integration, as this may constitute the only alternative to indefinite orbit or return to persecution.
- Empowering refugee women and girls through basic rights awareness training in order to reduce their vulnerability to HIV/AIDS.[5]
- Ensuring the protection of separated and unaccompanied refugee and children, with a special emphasis on preventing all forms of abuse, including sexual violence, and sexual exploitation.

2. Reduce HIV transmission and improve HIV/AIDS treatment and care by:

A. Improving planning and implementation of HIV/AIDS programmes.

- Undertake standardised situational and theoretical cost analyses to be used as planning tools in the field (documents developed and available upon request).
- Assess existing or new HIV/AIDS programmes and design effective projects based upon results.[6]
- Promote basic HIV/AIDS programmes in all refugee situations based upon various components within the following three broad areas:

[5] For example, harmful traditional practices (widow inheritance, forced marriage, or female genital mutilation) may contribute to the spread of the epidemic. See also "Sexual Violence Against Refugees: Guidelines on Prevention and Response", UNHCR 1995.

[6] UNHCR has initiated assessments of existing HIV/AIDS programmes in Eritrea, Ethiopia and Uganda (conducted by AMREF); Kenya (by an independent consultant); Namibia (by NCA); Guinea and Liberia (by an independent consultant); Rwanda (by AHA); and Zambia (by UNHCR South Africa).

i. Prevention focusing on education and behavioural change: provide essential health information on transmission and prevention of HIV/AIDS and sexually transmitted infections (STIs) [7], including proper condom use, universal precautions in health care facilities, treatment and control of STIs, and access to HIV voluntary counselling and testing.

ii. Treatment and care: ensure proper and appropriate treatment of STIs and opportunistic infections (OIs), prophylaxis of OIs, and implementation of palliative care, including home-based care.

iii. Surveillance, and monitoring and evaluation: strengthen syndromic diagnosis of STIs and monitoring of basic input, process and outcome indicators.

- Improve current knowledge and skills of UNHCR personnel and its partners through training, monitoring and evaluation, programmatic research, and documentation and dissemination of lessons learned.

- Promote refugee participation at all stages of HIV/AIDS programmes and empower refugees to take responsibility themselves for HIV prevention.

B. Reinforcing surveillance, and monitoring and evaluation of HIV/AIDS programmes.

- Strengthen biannual reporting for all refugee populations with a UNHCR presence using the basic HIV/AIDS programme summary form (Appendix 1).

- Apply second generation surveillance systems for HIV/AIDS and its related diseases using qualitative and quantitative surveillance methodologies (e.g. conduct serial behavioural change surveys, examine mortality and morbidity trends, and establish sentinel surveillance systems).

- Based on existing tools, develop and implement a practical and informative monitoring and evaluation tool for HIV/AIDS refugee programmes using input, process and outcome indicators.

- Ensure dissemination of results of evaluations within and between regions together with regular feedback to those involved in the programme.

[7] UNHCR has produced a manual on HIV/AIDS education for refugee youth entitled *Window of Hope* that is being field-tested in numerous countries. Lessons-learned from HIV/AIDS prevention programmes in some refugee situations are being documented and disseminated for use in other situations. In addition, UNHCR provides country operations with various information materials on issues related to HIV/AIDS and other STIs.

III. IMPORTANT FACTORS FOR CONSIDERATION

1. The linkage between the protection of human rights and effective HIV/AIDS programmes is apparent as people will not seek HIV-related counselling, testing, treatment and care if lack of confidentiality, discrimination, refoulement, restrictions to freedom of movement, or other negative consequences exist. For these reasons, an essential component of a comprehensive response is the facilitation and creation of a legal and ethical environment which is protective of human rights.

2. HIV/AIDS is not just a health issue but a problem that affects the socio-cultural fabric, human rights and long-term economic well-being of refugees. Thus, it is fundamental to develop multi-sectoral and multi-partner approaches. It is essential to work in close partnership with various national, regional and international actors, including the refugees themselves, to establish effective programmes.

3. Implementation of HIV/AIDS programmes in emergency situations is essential. However, donors and partners must recognise that HIV/AIDS is primarily a development issue that requires long-term commitment to improve the health and well-being of individuals and their communities.

4. Women, in particular adolescent girls, as well as young people are vulnerable groups at high risk of infection and special attention must be focused upon them when designing programmes. Other high-risk groups that facilitate the infection to the broader community, such as commercial sex workers and intravenous drug users, also need to be targeted. Programmes targeting AIDS orphans are also necessary.

5. In strengthening existing or creating new HIV/AIDS programmes for refugees, it is crucial to recognise the limited technical and financial resources of most asylum countries, which generally cannot meet the needs of their own population let alone contribute to refugee programmes.

6. The introduction of Prevention of Mother to Child Transmission (PMTCT) and Anti-retroviral (ARV) treatment programmes pose significant challenges, and consideration must be given to the related technical and financial factors before implementation of such programmes.

IV. MAIN STRATEGIES (2002-2004)

1. Ensure the effective implementation of UNHCR's protection policy and standards at field level.

- Actively monitor and intervene if any discriminatory practices arise because of refugees' HIV status.
- Report (as a minimum Situational reports, Annual Protection Report) any HIV protection related issues (including admission, registration, freedom of movement, standard of treatment, etc.).
- Promote the UNHCHR/UNAIDS 1996 international guidelines on Human Rights and HIV/AIDS with government counterparts and other humanitarian actors.
- Develop and implement HIV/AIDS protection training and awareness programmes for field staff and UNHCR's partners.
- Expand basic rights awareness training for refugees.
- Establish or reinforce UNHCR's links with Office of the High Commissioner for Human Rights (OHCHR) and other relevant human rights partners in order to implement and promote the 1996 international guidelines by OHCHR and UNAIDS.

2. Further consolidate UNHCR's commitment to combat HIV/AIDS in refugee situations at all levels of the organisation.

- Regional Bureaux/Country Representatives will have primary responsibility to operationalise the present strategic plan both in strengthening existing programmes and in implementing the pilot projects. They should also, with support as needed from the Division of Operational Support (DOS), macro-monitor progress on a biannual basis using the HIV/AIDS Programme Summary form (see Appendix 1).
- DOS will re-invigorate UNHCR's internal HIV/AIDS task force.
- Division of Resource Management (DRM) and DOS should further develop and implement HIV/AIDS training and awareness programmes for UNHCR staff at headquarters and in the field, and for partners.

3. Reinforce access to qualified technical resources and strengthen institutional capacity building through partnerships.

- Regional Bureaux and DOS will identify and establish HIV/AIDS focal points in various countries. In addition, regional technical consultants will be identified in each of the three broad HIV/AIDS categories (outlined in section B.1, 3rd bullet) and put at the disposal of the pilot sites, as well as other countries with existing HIV/AIDS programmes (see Organisational Structure chart -Appendix 2). Both

HIV/AIDS focal points and consultants may be employed by UNHCR or its partners.

- The HIV/AIDS ExCom Advisory Group (see Appendix 3) will serve as an advocacy and support group, while the Inter-Agency Working Group on Reproductive Health (some 25 NGOs and UN agencies), as well as other partners, will provide access to technical support at the regional and country level.

- The Inter-Agency HIV/AIDS working group in Emergency Settings, chaired by WHO, will provide technical assistance to UNHCR and its partners. An expert group on HIV/AIDS and Refugees will be created to help UNHCR in planning for its HIV/AIDS programmes and to provide technical advice.

- UNHCR will establish close links with UN Theme Groups and NACPs to encourage them to include refugees in their mandates. UNHCR will follow the policies of NACPs in their respective countries. Where available, UNHCR will use NACPs' technical resources and, where needed, will assist in their technical capacity building efforts.

- UNHCR will further enter into partnership, when feasible and as needed, with UNAIDS and its co-sponsors (UNFPA, UNICEF, World Bank, UNESCO, UNDP, ILO, UNDCP and WHO), bi-lateral donors at central, regional and local levels, regional bodies (e.g. African Union, ECOWAS), and UNHCR's partners.[8]

- Major emphasis will be placed on building the capacity of local partners and refugees. Successful implementation of HIV/AIDS programmes will help to strengthen other existing programmes and enable the creation of new programmes.[9]

4. Continue to support current HIV/AIDS programmes.

- Many refugee situations currently have various elements of HIV/AIDS programmes in situ but their coverage is not comprehensive, in part due to limited access to technical and financial resources (Summary by region - Appendix 4).[10]

- After further evaluation, programmes will continue to be provided with financial and technical support (Timeline –Appendix 5).

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[8] UNHCR, along with UNAIDS, UNICEF, WFP and the World Bank, is a member of the sub-regional Mano River Union Initiative (covering Guinea, Liberia and Sierra Leone) working to address HIV/AIDS in a co-ordinated manner in the region.

[9] For example, HIV voluntary counselling and testing programmes will improve local laboratory capabilities by improving the skills of lab personnel and by providing equipment.

[10] HIV/AIDS projects, although not comprehensive and mainly supported with resources from the UNHCR Annual Programme Budget and United Nations Foundation Funds exist in the following countries: Central African Republic, Democratic Republic of Congo, Eritrea, Ethiopia, Ghana, Guinea, Kenya, Kyrgyzstan, Liberia, Moldova, Namibia, Nepal, Nigeria, Pakistan, Republic of Congo, Rwanda, South Africa, Sudan, Tanzania and Thailand.

- Lessons learned from these programmes will continue to be documented and disseminated to other sites and partners.

5. Develop comprehensive HIV/AIDS pilot projects in refugee situations through a phased approach targeting specific sites.

- In its initial phase, HIV/AIDS programmes will focus primarily on refugee situations.
  - Specific refugee sites will be chosen according to selection criteria (see Appendix 6). The proposed clusters for the pilot projects are: East Africa - Kenya, Tanzania and Uganda; West Africa – Guinea, Liberia; Southern Africa – South Africa and Zambia; and Asia – Thailand and Nepal (Regions and countries as shown in Appendix 7). Regional planning meetings will begin during the first semester of 2002 (Timeline for pilot projects is shown in Appendix 8).

- Pilot site projects will undergo regular monitoring and evaluation including human rights and protection-related issues; lessons learned will be documented and disseminated. Partners will be encouraged to implement successful parts of pilot projects in their other sites.

- Making HIV/AIDS prevention comprehensive implicitly requires UNHCR to work with governments through their NACPs. Where possible, UNHCR will support HIV/AIDS services made available to local populations in refugee hosting areas through national governments and other actors such as UNAIDS and its co-sponsors.

6. Limited scope of UNHCR activities in returnee situations.

HIV/AIDS prevention and care programmes for returnees are primarily the responsibility of the Government of the country of origin, supported by UNAIDS and its co-sponsors. Thus, UNHCR's activities in these situations will mainly focus on:

- Sharing information with the country of origin's NACP about the status of HIV/AIDS programmes for refugees in the country of asylum.

- Sharing information with refugees about the status of HIV/AIDS programmes for nationals in their country of origin.

- Providing specific inputs as the need arises and based upon the available resources of UNHCR and the country of origin's NACP.

7. Access additional financial resources.

- Develop a specific section for HIV/AIDS activities in UNHCR's Annual Programme Budget for 2003 and beyond to identify more accurately activity and funding needs.

- This plan identifies the need for additional funds to complement what UNHCR already has included in the various sectors of its Annual Programme Budget, such as health, community services, education, protection, water/sanitation, shelter, child protection, and gender programmes, to help combat HIV/AIDS. We have estimated the additional cost between USD 2.50 to 3.60 per refugee/year to implement comprehensive HIV/AIDS programmes in stable, post-emergency refugee situations with 5% HIV prevalence (see Pilot site budgets -Appendix 9a and 9b). This estimate will rise as the prevalence of HIV increases and anti-retroviral drugs are introduced. These additional costs rely upon secured funding of HIV/ AIDS programmes in UNHCR's Annual Programme Budget, which is the largest financial component of such programmes in refugee situations. UNHCR, with the support of the HIV/AIDS ExCom Advisory Group, will adopt a combination of the following approaches to seek the additional funds needed (see Budget -Appendix 10):

  i. Secure interim funding for 2002 from the Annual Programme resources, namely the Operational Reserve.

  ii. Include budgetary requirements in the Annual Programme Budgets for 2003 and 2004.

  iii. Seek access to the Global Fund to Fight AIDS, Tuberculosis and Malaria with partners, governments and private organisations.

  iv. Promote bilateral funding by donors to UNHCR's partners.

Appendix 1 a: HIV/AIDS Protection, Prevention and Care Activities in Refugee Settings Form

Location :_____ **Population:** _____
(name of settlement, country) (size)

Score Guide: 0 = no activities being implemented
1 = small amount of activities
2 = moderate amount of activities
3 = comprehensive activity/ program in place
4 = not applicable

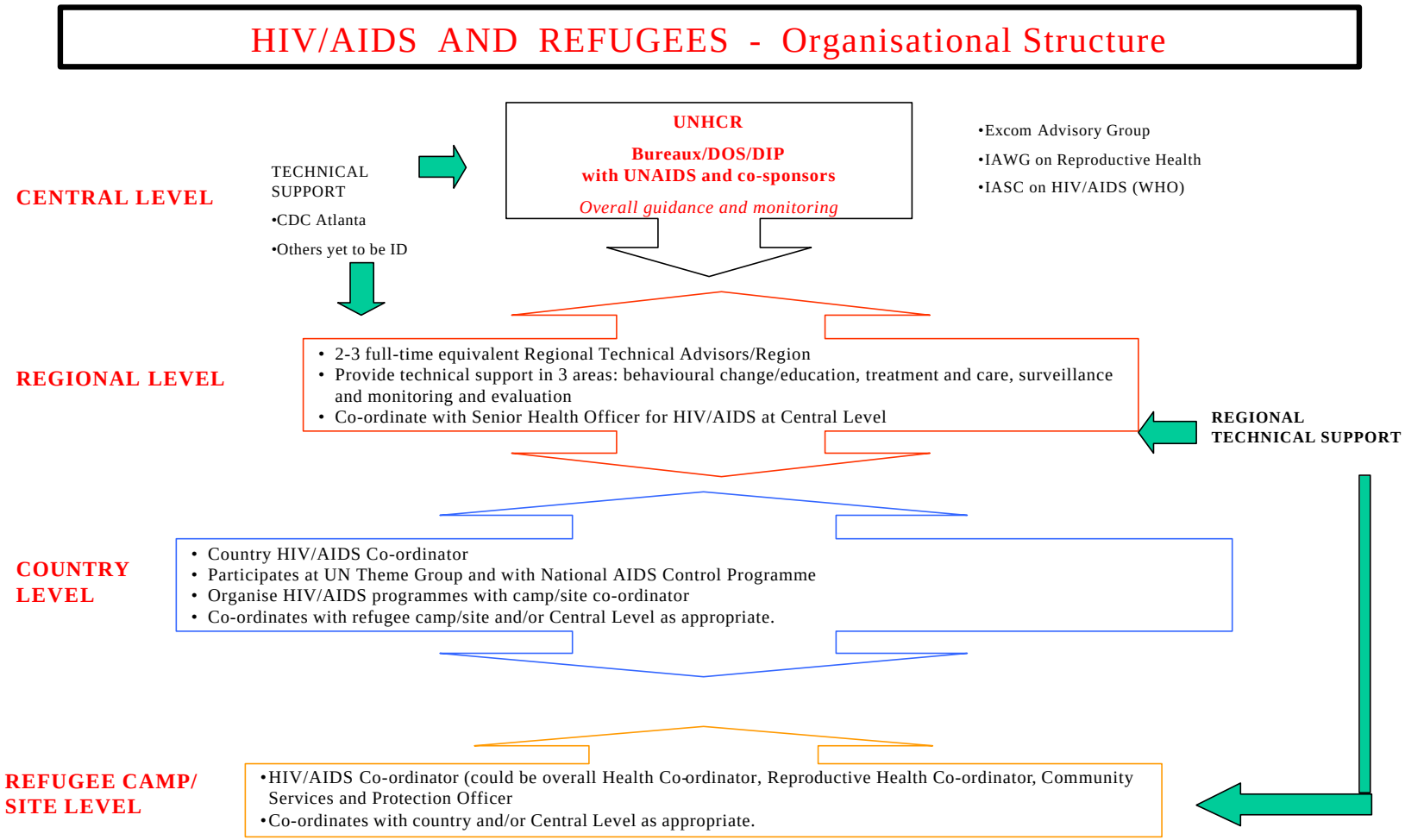
-use 0 to 3 guide unless otherwise stated
Y / N /UNK = yes / no / unknown

III. ACTIVITIES	Current Situation	Plan for 2002	Plan for 2003
A. Basic Information			
1. Prevalence of HIV in country of asylum (% or UNK)			
2. Prevalence of HIV in country of origin (% or UNK)			
3. National Policies on HIV exist and are available? (Y/N/UNK)			
B. Human Rights Issues			
4. Human rights of People Living with AIDS in jeopardy? (Y/N/UNK)			
5. HIV testing confidentiality ensured? (Y/N/UNK)			
6. Mandatory HIV testing prohibited? (Y/N/UNK)			
C. Prevention of HIV			
7. HIV blood safety (testing of blood for transfusion)			
8. Universal precautions			
9. Condom promotion and distribution			
10. HIV/AIDS awareness campaigns			
11. Behavioural change programmes			
12. Youth-specific programmes			
13. STI case management and control			
14. HIV/AIDS integrated in school curriculum			
15. Programmes targeting commercial sex workers			
16. Programmes targeting intravenous drug users			
17. Voluntary counselling and testing			
18. Prophylaxis for opportunistic infections			
D. Care of HIV/AIDS			
19. Treatment of opportunistic infections			
20. Home-based care			
21. Counselling and support of people with HIV			
22. Mother to child transmission (MTCT)			
23. Anti-retroviral treatment (other than MTCT) for host population			
24. Anti-retroviral treatment (other than MTCT) for refugees			
E. Surveillance and Monitoring of HIV and Related Diseases			
25. Sentinel HIV surveillance systems			
26. Surveillance of AIDS-related mortality			
27. STD incidence			
28. Pulmonary Tuberculosis (PTB) Incidence			
F. Co-ordination			
29. UNHCR active member in UN Theme Group			
30. National AIDS Control Programme			

Appendix 1 b: Instructions to fill out HIV/AIDS Protection, Prevention and Care Activities in Refugee Settings Form

A. Basic Information	How to fill in the HIV/AIDS Activities Form
1. Prevalence of HIV in Country of Asylum	Write in prevalence of HIV in country of asylum. If unknown put UNK, and seek out data and complete section later.
2. Prevalence of HIV in Country of Origin	Write in prevalence of HIV in country of origin. If unknown put UNK, and seek out data and complete section later.
3. National Policies on HIV exist and are available?	If national policies exist, and you have copies, mark Yes. If not, state whether they exist and try and obtain copies for use as a guide to developing HIV/AIDS programmes in your situation.
B. Human Rights Issues	
4. Human rights of People Living with AIDS in jeopardy?	If there are known problems of human rights abuses of people with HIV/AIDS - then mark yes. If unknown, look into this issue in more detail.
5. HIV testing confidentiality ensured?	If testing for HIV is done for refugees at your site or referral hospital, check to see if confidentiality is ensured. Examine whole process from start to finish.
6. Mandatory HIV testing prohibited?	HIV testing must be completely voluntary. Pay special attention to mandatory HIV testing for resettlement or before marriage.
C. Prevention of HIV	
7. HIV blood safety (testing of blood)	All blood should be for HIV tested before transfusion. Visit the hospitals, check registers and ask about HIV test kits.
8. Universal Precautions	Protective gloves, masks and other materials, proper disposal of infectious material and sharps should be strictly adhered to in health facilities. Visit health services to ensure health workers protect themselves and the patients.
9. Condom promotion and distribution	Adequate number of quality condoms that are easily available to population. Check number of condoms distributed and number of places where they are available.
10. HIV/AIDS awareness campaigns	Are there information/education materials available in local language of the refugees, radio programmes and other media available for disseminating HIV/AIDS messages on routine basis.
11. Behavioural Change Programmes	Programmes are intensive activities that aim to build skills and attitudes for safe sex and responsible behaviours. Should be targeted at specific population groups.
12. Youth-specific programmes	Include sports, youth centres, skills building and peer education programmes.
13. STI case management and control	Health facilities that have special services for treatment of STIs for both men and women. Contact tracing of partners is imperative. Antenatal clinics should screen pregnant women for STIs. Check that sufficient and proper drugs are available, clinical staff appropriately trained and using host-country treatment protocols.
14. HIV/AIDS integrated in school curriculum	Is there a specific curriculum for HIV/AIDS integrated in the schools? Is this training in the language of the refugees? Does it include action-oriented learning activities?
15. Programmes targeting commercial sex workers	If known areas of prostitution in/around the camps, are there programmes specifically targeting sex workers?
16. Programmes targeting intravenous drug use	If there are known areas or groups of intravenous drug users in/around the camps, are there programmes specifically targeting them?
17. Voluntary Counselling and Testing	Is service available where refugees can receive pre- and post-test counselling and then have HIV test undertaken in confidential manner?
18. Prophylaxis for opportunistic infections	Do HIV/AIDS patients receive INH for tuberculosis prophylaxis, antibiotics for bacterial prophylaxis, other medicines for prophylaxis of other diseases? Are drugs available, do treatment protocols exist, and are staff trained?
D. Care of HIV/AIDS	
19. Treatment of opportunistic infections	Does health service care for people with HIV/AIDS by treating illness associated with AIDS? Are drugs available, do treatment protocols exist, and are staff trained?
20. Home-based care	Is there support for people with AIDS to go home and be cared for there? Is there support to families caring for people suffering at home? Is there appropriate pain management, nutritional or psychological support available?
21. Counselling/support of people with HIV	Is there a counselling service available for people who are HIV +?
22. Mother To Child Transmission (MTCT)	Are programmes available to provide proper VCT and MTCT to mothers testing HIV+? Is confidentiality ensured? Do discussions regarding safe breast versus bottle feeding occur?
23. Anti-retroviral (ARV) treatment (other than MTCT) for host population	Does host-country have policy regarding ARV treatment for people with AIDS? Is this service subsidised by the Government?
24. Anti-retroviral (ARV) treatment (other than MTCT) for refugees	Do refugees receive ARV treatment either as part of host-gov't programme or other programme? Is confidentiality ensured? Are there sufficient medications? Have staff and laboratory personnel received sufficient training?
E. Surveillance and Monitoring of HIV and Related Diseases	
25. Sentinel Surveillance	Does sentinel surveillance occur in refugee population? If yes, state which population (e.g. pregnant women at prenatal clinic, people giving blood for transfusion, etc). Assess quality of system, including confidentiality, lab etc.
26. Surveillance of AIDS-related mortality	Does health information system (HIS) report deaths due to AIDS? Is there a case-definition for defining AIDS? Has training been done for health personnel?
27. STI Incidence	Does HIS report incidence of STIs? Do they report according to syndrome, if use syndromic diagnosis? Do they follow trends over time?
28. Pulmonary Tuberculosis (PTB) Incidence	Does HIS report incidence of PTB? Is the laboratory diagnosis done properly? Has proper training of health and lab personnel occurred? Do they follow trends over time?
F. Co-ordination and Networks	
29. UNHCR active member in UN Theme Group	Does UNHCR (in the capital/BO) participate routinely at UN Theme Group Meetings? Is UNHCR an official member of the Group?
30. National AIDS Control Programme(NACP)	Does UNHCR coordinate/have contact with host country's NACP?

Appendix 2:
HIV/AIDS and Refugees- Organisational Structure



Appendix 3:
Excom Advisory Group

Permanent Missions	NGOs / IGOs	UN Agencies
Australia Mr. Kerry Kutch Counsellor (Development)	**AHA** Dr. Dawit Zawde President	**ILO** No name as yet
Finland Kristina Häikiö Counsellor	**ICMC** Mr. Dale Buscher **Director of Operations**	**IOM** Ms. Mary Haour-Knipe HIV/AIDS Focal Point
Ghana No name as yet	**IFRC** Dr. Hakan Sandbladh Snr Health Officer for Relief Health	**UNAIDS** Marika Fahlen Director, Dept Social Mobilisation & Information
Greece (Hellenic Center) Dr. Theodore Papadimitriou	**MSF-Int** Ms. Isabelle Andrieux-Meyer Director Med Dept	**UNESCO** Mr. H. Oussedik Chief ED/PEQ/PES
Iran No name as yet	**NCA** Rev. Atle Sommerfeldt General Secretary	**UNHCHR** Ms. Lisa Oldring HIV/AIDS Focal Point
Italy Ms. Maria Grazia Trozzi Humanitarian Affairs		**UNICEF** Mr. Stephen Woodhouse Regional Director
South Africa No name as yet		**UNFPA** Mr. Alphonse MacDonald Director
Switzerland No name as yet		**WFP** Mr. Werner Schleiffer Director Geneva LO
Uganda Mr. Arthur Gakwandi Counsellor		**WHO** Dr. T. Turmen Executive Director Family & Community Health
USA Ms. Linda Thomas-Greenfield Counsellor		
Zambia No name as yet		

** Permanent Mission of Canada declined to participate due to the limited number of staff in Geneva. However, Canada reiterated its full support to UNHCR on this initiative.

Appendix 4:
Compilation of Self Assessments of HIV/AIDS Programmes in Refugee Settings, Grouped by Region as of December 2001

The following compilation of HIV/AIDS simple monitoring forms, based on self-assessments at the country level, have been completed by UNHCR and its partners in the field by the end of 2001. These forms are not meant to be comprehensive. Their purpose is to improve co-ordination, communication and feedback within the field and between field and headquarters on HIV/AIDS and related issues. Detailed and standardised HIV/AIDS programme assessments have been or will be completed in numerous countries where UNHCR is present.

Overall interpretation of forms:
Many country programmes did not complete and return the forms to UNHCR headquarters. There was a large variation in the completeness of the forms from those countries that did return them. Many country programmes were unaware of HIV prevalence in the refugees' countries of asylum and origin. HIV prevention programmes comprised the largest component of UNHCR and its partners programme. However, programmes targeting groups such as youth and commercial sex workers and those integrating HIV/AIDS education in school curricula, two important prevention strategies, appeared to be insufficient in many countries. Voluntary counselling and testing is not available in most countries. Reporting on care and treatment of HIV/AIDS patients as well as monitoring and co-ordination of HIV/AIDS programmes clearly indicate the need for further reinforcement.

Appendix 4 cont:
Compilation of Self Assessments of HIV/AIDS Activities in Refugee Settings in West Africa
End of 2001

Score Guide: 0 = no activities being implemented; 1 = small amount of activities; NI = No information available; 2 = moderate amount of activities; 3 = comprehensive activity/ program in place; Y/N = yes or no

Activities/Situation	**CAR**		**GAM**	**GHA**	**GUI**		**BEN**	**SEN**
Number of beneficiaries	35'000	2'300	10'000	3'000	13'500	57'373	4'700	3'000
Setting	camp	urban	camp	camp	camp	camp	urban	urban
A. Basic Information								
Prevalence of HIV in Country of Asylum	NI	14%	NI	Y	NI	1,5-2,5%	4%	NI
Prevalence of HIV in Country of Origin	NI	NI	NI	NI	NI	2,50-2,99%	NI	NI
Policies on HIV available?	NI	NI	N	Y	NI	Y	Y	Y
B. Human Rights Issues								
Human rights of PWAs in jeopardy?	N	N	N	Y	NI	NI	N	N
Confidentiality ensured?	Y	Y	Y	Y	1	N	Y	Y
Mandatory testing prohibited?	Y	Y	Y	Y	0	Y	Y	Y
C. Prevention of HIV								
HIV blood safety (testing blood)	1	0	O	Y	2	Y	Y	Y
Universal Precautions	1	1	O		1	1	Y	O
Condom promotion and distribution	1	1	Y	3	1	3	Y	Y
HIV/AIDS awareness campaigns	1	1	Y	3	0	2	Y	Y
Behavioural Change Programmes	1	1	O	2	0	3	Y	Y
Youth-specific programmes	0	0	O	3	0	1	Y	O
STI case management and control	2	2	O		2	2	N	O
HIV/AIDS integrated in school curriculum	1	1	NI	0	NI	3	N	NI
Programmes for commercial sex workers	0	0	O	0	NI	0	N	O
Voluntary Counselling and Testing	0	0	O	2	0	0	Y	O
D. Care of HIV/AIDS								
Treatment of opportunistic infections	1	1	O	2	2	0	N	O
Home-based care	0	0	O	3	0	0	0	O
Counselling & support of people with HIV	0	0	O	2	0	0	0	O
Mother To Child Transmission	0	0	O	Y	0	0	1	O
ARV treatments	0	0	O		0	0	0	O
E. Monitoring of HIV								
Sentinel Surveillance (pregnant women)	2	2	O	Y	0	0	1	O
Surveillance of HIV/AIDS-related mortality	1	1	O	Y	0	0	Y	O
STD Incidence (within expected range)	NI	2.5%	O		1	2	NI	O
F. Co-ordination and Networking								
Active member in UN Theme Group	1	2	O	2	NI	0	Y	0
Other networks?	0	0	O		NI	2	NI	0

Appendix 4 cont:
Compilation of Self Assessments of HIV/AIDS Activities in Refugee Settings in the East and Horn of Africa
End of 2001

Score Guide: 0 = no activities being implemented; 1 = small amount of activities; NI = No information available; 2 = moderate amount of activities; 3 = comprehensive activity/ program in place; Y/N = yes or no

Activities/Situation	SUD	ERT*	ETH*	KEN*	SOM*	DJB*	UGA
Number of beneficiaries	160'000						172'700
Setting	camp						camp
A. Basic Information							
Prevalence of HIV in Country of Asylum	0.99% - WHO,1999						6.1/100 MOH-2000
Prevalence of HIV in Country of Origin	2.87% - WHO,1999						NI
Policies on HIV available?	Y						Y
B. Human Rights Issues							
Human rights of PWAs in jeopardy?	N						N
Confidentiality ensured?	Y						Y
Mandatory testing prohibited?	Y						Y
C. Prevention of HIV							
HIV blood safety (testing blood)	2	1	1	3	NI	0	3
Universal Precautions	2	1	2	3	NI	1	3
Condom promotion and distribution	1	2	2	2	NI	1	2
HIV/AIDS awareness campaigns	2	3	2	2	NI	1	3
Behavioural Change Programmes	2	1	1	1	NI	0	2
Youth-specific programmes	1	2	2	2	NI	0	2
STI case management and control	3	2	2	3	NI	2	3
HIV/AIDS integrated in school curriculum	0						1
Programmes for commercial sex workers	0	0	0	2	NI	0	0
Voluntary Counselling and Testing	0	0	0	0	NI	0	1
D. Care of HIV/AIDS							
Treatment of opportunistic infections	1	1	1	2	NI	0	2
Home-based care	0	0	0	0	NI	0	1
Counselling & support of people with HIV	0						1
Mother To Child Transmission	0	0	0	1	NI	0	0
ARV treatments	0						0
E. Monitoring of HIV							
Sentinel Surveillance (pregnant women)	0	0	0	0	NI	NI	0
Surveillance of HIV/AIDS-related mortality	1						2
STD Incidence (within expected range)	0.4/1000/ Nov.'01						43 new / 1000/year
F. Co-ordination and Networking							
Active member in UN Theme Group	2						y
Other networks?	2						y

* information gathered from Regional Health Co-ordinator; not sent by country

Appendix 4 cont:
Compilation of Self Assessments of HIV/AIDS Activities in Refugee Settings in Southern Africa
End of 2001

Score Guide: 0 = no activities being implemented; 1 = small amount of activities; NI = No information available; 2 = moderate amount of activities; 3 = comprehensive activity/ program in place; Y/N = yes or no

Activities/Situation	
Number of beneficiaries	
Setting	
A. Basic Information	
Prevalence of HIV in Country of Asylum	
Prevalence of HIV in Country of Origin	
Policies on HIV available?	
B. Human Rights Issues	
Human rights of PWAs in jeopardy?	
Confidentiality ensured?	
Mandatory testing prohibited?	
C. Prevention of HIV	
HIV blood safety (testing blood)	
Universal Precautions	
Condom promotion and distribution	
HIV/AIDS awareness campaigns	
Behavioural Change Programmes	
Youth-specific programmes	
STI case management and control	
HIV/AIDS integrated in school curriculum	
Programmes for commercial sex workers	
Voluntary Counselling and Testing	
D. Care of HIV/AIDS	
Treatment of opportunistic infections	
Home-based care	
Counselling & support of people with HIV	
Mother To Child Transmission	
ARV treatments	
E. Monitoring of HIV	
Sentinel Surveillance (pregnant women)	
Surveillance of HIV/AIDS-related mortality	
STD Incidence (within expected range)	
F. Co-ordination and Networking	
Active member in UN Theme Group	
Other networks?	

Appendix 4 cont:
Compilation of Self Assessments of HIV/AIDS Activities in Refugee Settings in the Great Lakes Region
End of 2001

Score Guide: 0 = no activities being implemented; 1 = small amount of activities; NI = No information available; 2 = moderate amount of activities; 3 = comprehensive activity/ program in place; Y/N = yes or no

Activities/Situation	RWA*	TAN	BDI*	DRC	COB
Number of beneficiaries		530'000		364'700	110'000
Setting		Camp			
A. Basic Information					
Prevalence of HIV in Country of Asylum		Tan:8.09 %		5,1% *	7% *
Prevalence of HIV in Country of Origin		Bdi: 11.3% DRC: 5.% Rwa: 11.2%		NI	NI
Policies on HIV available?		Y		Y	Y
B. Human Rights Issues					
Human rights of PWAs in jeopardy?		N			
Confidentiality ensured?		Y		Y	Y
Mandatory testing prohibited?		Y		Y	Y
C. Prevention of HIV					
HIV blood safety (testing blood)	1	3	0	2	2
Universal Precautions	2	3	2	2	2
Condom promotion and distribution	2	3	2	2	2
HIV/AIDS awareness campaigns	2	2	1	2	2
Behavioural Change Programmes	1	2	0	2	2
Youth-specific programmes	1	2	0	0	0
STI case management and control	2	3	2	2	2
HIV/AIDS integrated in school curriculum		2		0	0
Programmes for commercial sex workers	0	1	0	0	0
Voluntary Counselling and Testing	0	1	1	0	0
D. Care of HIV/AIDS					
Treatment of opportunistic infections	1	2	1	2	2
Home-based care	0	2	0	0	0
Counselling & support of people with HIV		2		0	0
Mother To Child Transmission	1	0	1	0	0
ARV treatments		0		0	0
E. Monitoring of HIV					
Sentinel Surveillance (pregnant women)	0	2	0	0	0
Surveillance of HIV/AIDS-related mortality		1		0	0
STD Incidence (within expected range)		3		NI	NI
F. Co-ordination and Networking					
Active member in UN Theme Group		Yes		Y	Y
Other networks?		No		Y	Y

* information gathered from Regional Health Co-ordinator; not sent by country

Appendix 4 cont:
Compilation of Self Assessments of HIV/AIDS Activities in Refugee Settings in Asia
End of 2001

Score Guide: 0 = no activities being implemented; 1 = small amount of activities; NI = No information available; 2 = moderate amount of activities; 3 = comprehensive activity/ program in place; Y/N = yes or no

Activities/Situation	NEP
Number of beneficiaries	100'000
Setting	Camp
A. Basic Information	
Prevalence of HIV in Country of Asylum	0.29% WHO,'99
Prevalence of HIV in Country of Origin	NI
Policies on HIV available?	Y
B. Human Rights Issues	
Human rights of PWAs in jeopardy?	NI
Confidentiality ensured?	Y
Mandatory testing prohibited?	N
C. Prevention of HIV	
HIV blood safety (testing blood)	3
Universal Precautions	3
Condom promotion and distribution	3
HIV/AIDS awareness campaigns	2
Behavioural Change Programmes	0
Youth-specific programmes	0
STI case management and control	2
HIV/AIDS integrated in school curriculum	NI
Programmes for commercial sex workers	0
Voluntary Counselling and Testing	0
D. Care of HIV/AIDS	
Treatment of opportunistic infections	0
Home-based care	0
Counselling & support of people with HIV	1
Mother To Child Transmission	0
ARV treatments	0
E. Monitoring of HIV	
Sentinel Surveillance (pregnant women)	0
Surveillance of HIV/AIDS-related mortality	3
STD Incidence (within expected range)	2.77/1000, Sept,2001
F. Co-ordination and Networking	
Active member in UN Theme Group	
Other networks?	

Appendix 4 cont:
Compilation of Self Assessments of HIV/AIDS Activities in Refugee Settings in Caswaname
End of 2001

Score Guide: 0 = no activities being implemented; 1 = small amount of activities; NI = No information available; 2 = moderate amount of activities; 3 = comprehensive activity/ program in place; Y/N = yes or no

Activities/Situation	PAK
Number of beneficiaries	
Setting	
A. Basic Information	
Prevalence of HIV in Country of Asylum	0.07%
Prevalence of HIV in Country of Origin	NI
Policies on HIV available?	1
B. Human Rights Issues	
Human rights of PWAs in jeopardy?	NI
Confidentiality ensured?	Y
Mandatory testing prohibited?	Y
C. Prevention of HIV	
HIV blood safety (testing blood)	1
Universal Precautions	1
Condom promotion and distribution	Y
HIV/AIDS awareness campaigns	2
Behavioural Change Programmes	2
Youth-specific programmes	1
STI case management and control	2
HIV/AIDS integrated in school curriculum	0
Programmes for commercial sex workers	0
Voluntary Counselling and Testing	0
D. Care of HIV/AIDS	0
Treatment of opportunistic infections	
Home-based care	
Counselling & support of people with HIV	
Mother To Child Transmission	
ARV treatments	
E. Monitoring of HIV	
Sentinel Surveillance (pregnant women)	0
Surveillance of HIV/AIDS-related mortality	
STD Incidence (within expected range)	NI
F. Co-ordination and Networking	
Active member in UN Theme Group	Y
Other networks?	Y

Appendix 4 cont:
Compilation of Self Assessments of HIV/AIDS Activities in Refugee Settings in Europe
End of 2001

Score Guide: 0 = no activities being implemented; 1 = small amount of activities; NI = No information available; 2 = moderate amount of activities; 3 = comprehensive activity/ program in place; Y/N = yes or no

Activities/Situation	CROATIA
Number of beneficiaries	
Setting	
A. Basic Information	
Prevalence of HIV in Country of Asylum	288 HIV/AIDS cases 1985-2000
Prevalence of HIV in Country of Origin	713 cases by end 98
Policies on HIV available?	Y
B. Human Rights Issues	
Human rights of PWAs in jeopardy?	N
Confidentiality ensured?	Y
Mandatory testing prohibited?	Y
C. Prevention of HIV	
HIV blood safety (testing blood)	3
Universal Precautions	2
Condom promotion and distribution	1
HIV/AIDS awareness campaigns	1
Behavioural Change Programmes	1
Youth-specific programmes	2
STI case management and control	2
HIV/AIDS integrated in school curriculum	2
Programmes for commercial sex workers	2
Voluntary Counselling and Testing	3
D. Care of HIV/AIDS	
Treatment of opportunistic infections	3
Home-based care	1
Counselling & support of people with HIV	2
Mother To Child Transmission	2
ARV treatments	3
E. Monitoring of HIV	
Sentinel Surveillance (pregnant women)	NI
Surveillance of HIV/AIDS-related mortality	3
STD Incidence (within expected range)	3
F. Co-ordination and Networking	
Active member in UN Theme Group	Y
Other networks?	N

Appendix 5:
Timeline for Ongoing and New Projects by year from 2002-2004

Plan of Action for Ongoing and New Projects: 2002-2004												
2002	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**
Create HIV/AID refugee plan												
HCR Advisory Group meeting												
Continue ongoing and implement new projects												
HCR internal task force meeting												
HIV Refugee Expert Technical Meeting												
HCR's HIV/AIDS Refugee Update Publication												
Programmatic Research												
2003	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**
Continue ongoing and implement new projects												
HCR Advisory group meeting												
HCR IntraAgency task force meeting												
HIV Refugee Expert Technical Meeting												
HCR's HIV/AIDS Refugee Update Pub												
Continue programmatic research												
2004	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**
Continue ongoing and implement new projects												
HCR Advisory group meeting												
HCR IntraAgency task force meeting												
HIV Refugee Expert Technical Meeting												
HCR's HIV/AIDS Refugee Update Pub												
Continue programmatic research												
Joint meeting-all Regions												

Note:

-meetings in Geneva

-meetings in Regions

Appendix 6:
Criteria for Selection of Pilot Project Sites for Implementation of Comprehensive HIV/AIDS Programmes

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1) Population

- Refugees
  - Camps and urban populations
- Repatriated persons will not be included in pilot sites
  - UNHCR will provide details of HIV/AIDS programmes returnees had as refugees to NACPs

2) Geography and Size

- *Sites* defined by refugee populations surrounding UNHCR Sub-Office (e.g. Ngara, Tanzania)
- *Clusters* constitute sites defined by region (e.g. East Africa)
- Approximately 50,000 - 100,000 persons

3) Prevalence of HIV

- Mixture of low, concentrated and generalised-level epidemic

4) Partners

- Range of implementing and operational partners (international and national)
- Health and non-health organisations
- Interest in HIV/AIDS programmes in refugee situations
- Institutional impact: have presence in other refugee situations so lessons-learned can be implemented elsewhere

Appendix 7:
Possible Pilot Sites and Clusters

Cluster/Sites	Situation	Est. Pop. in Camps (except S Africa)	Est. Prevalence *	Ethnic Group	Health Partners	Non-Health Partners
East Africa						
Ethiopia	East	140,000	G	Somali	ARRA	SCF
Ethiopia	West	80,000	G	Sudanese	ARRA	Radda Barnen
Kenya	Dadaab	130,000	G	Somali	MSF-B	CARE, NCCK
Kenya	Kakuma	75,000	G	Sudanese	IRC	NCCK, JRS
Tanzania	Ngara	120,000	G	Burundi	NPA	
Tanzania	Kibondo	100,000	G	Burundi	IRC	UMATI, DRA
Tanzania	Kasulu	150,000	G	DRC/Burundi	TRCS	CORD
Sudan	El Showak	70,000	Unknown	Eritrea	COR	
Uganda	Arua	80,000	G	Sudanese		
Central Africa						
Rwanda		28,000	G	Burundian	AHA	PSI
West Africa						
Guinea		100,000	C/G	S. Leone	IRC, MSF	ARC, RHG
Liberia	Sinje	25,000	Unknown	S. Leone	Mercy	IRC
Southern Africa						
Namibia	Osiere	20,000	G	Angola	AHA, NRC	NCA
South Africa	Urban refugees	50,000	G	many	National	
Zambia		115,000	G	Angolan	CARE	
Asia						
Nepal		95,000	L	Burmese	AMDA	
Pakistan	Punjab	50,000	L	Afghan	MCI, MSF	SCF
Pakistan	Balochistan	150,000	L	Afghan	MCI, MSF	SCF
Pakistan	NWFP	1,000,000	L	Afghan	CAR,IRC	GTZ,
Thailand	North	110,000	C/G	Burmese	IRC, MSF	

* Using data from rural areas in host country among low risk groups (pregnant women, blood donors) from US census bureau, June 2001

L= low-level epidemic (HIV prevalence not consistently exceeded 5% in any defined subpopulation

C= concentrated epidemic (consistently >5% in at least one defined subpopulation and is <1% in pregnant women in urban areas)

G= generalised epidemic (consistently >1 % in pregnant women)

Appendix 8:
Timeline for Pilot Site Project Implementation by year from 2002-2004

Plan of Action for Pilot Sites: 2002-2004												
2002	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**
Create HIV/AID refugee plan	+11&12/01											
Meeting in E Africa												
Preparation for implementation in E Africa												
HIV assessments in E Africa												
Implementation in target sites in E Africa												
Monitoring and Evaluation (M&E) in E Africa												
Meeting in W Africa												
Preparation for implementation in W Africa												
HIV assessments in W Africa												
Implementation in target sites in W Africa												
Programmatic Research												
2003	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**
Meeting in S Africa												
Preparation for implementation in S Africa												
HIV assessments in S Africa												
Implementation in target sites in S Africa												
M&E in S Africa												
Meeting in SE Asia												
Preparation for implementation in SE Asia												
HIV assessments in SE Asia												
Implementation in target sites in SE Asia												
Meeting in E Africa												
Add other sites in E Africa												
Continue w current sites in E Africa												
M&E in E Africa												
Meeting in W Africa												
Add other sites in W Africa												
Continue w current sites in W Africa												
M&E in W Africa												
Continue programmatic research												
2004	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**
Meeting in S Africa												
Add other sites in S Africa												
Continue w current sites in S Africa												
M&E in S Africa												
Meeting in SE Asia												
Add other sites in SE Asia												
Continue w current sites in SE Asia												
M&E in SE Asia												
Meeting in E Africa												
Continue w sites in E Africa												
M&E in E Africa												
Meeting in W Africa												
Continue w sites in W Africa												
M&E in W Africa												
Continue programmatic research												
Joint meeting-all Regions												

Note:

-2nd meeting for region occurs 4-6 months after implementation

-addition of sites to region occurs 1 yr after initial implementation and coincides w 3rd meeting

-meetings in Regions

-1st month of implementation in Region