HIV/AIDS and Internally Displaced Persons in 8 Priority Countries

January 2006

Published by the United Nations High Commissioner for Refugees in collaboration with the Inter-Agency Internal Displacement Division, United Nations Office for the Coordination of Humanitarian Affairs

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Executive Summary:

Little is currently known about HIV among conflict-affected internally displaced persons (IDPs) despite claims that conflict increases HIV among IDPs, that they have high HIV infection rates, and that they lack adequate HIV interventions. An examination of the literature, National HIV Strategic Plans (NSPs) and approved funding proposals among 8 priority countries with large IDP populations was undertaken to improve our understanding of HIV among IDPs and to make recommendations to the United Nations High Commissioner for Refugees (UNHCR), the Office for the Coordination of Humanitarian Affairs (OCHA) and the United Nations Programme on HIV/AIDS (UNAIDS) as well as governments, other UN agencies, and non-governmental organizations (NGOs) working on HIV policies and interventions with IDPs.

This paper is divided into 4 sections: I) Inclusion of IDPs in National Strategic Plans and Proposals; II) HIV/AIDS and IDP Country Profiles; III) Media Coverage of HIV and IDPs; and IV) Essential Factors and Recommendations.

Section I: Inclusion of IDPs in National Strategic Plans and Proposals

A systematic literature review, examination of current NSPs and approved HIV proposals by major donors (World Bank, Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) and the President's Emergency AID Relief (PEPFAR)) for the 8 OCHA priority IDP countries (Burundi, DRC, Columbia, Liberia, Nepal, Somalia, Sudan and Uganda) was undertaken.

Seven (87%) of the 8 NSPs mentioned IDPs while 3 (38%) listed specific HIV interventions. All 8 countries had approved GFATM proposals with an HIV component; 6 (75%) mentioned IDPs and 5 (62%) stated interventions. Three (50%) of the 6 eligible African countries had approved World Bank MAP projects and 1 (33%) mentioned IDPs and specified a need for IDP activities. However, the World Bank funded Great Lakes Initiative on AIDS (GLIA) provides interventions for IDPs and includes 3 of the 8 countries. Of the 8 countries, only Uganda is a PEPFAR country; IDPs are mentioned but no interventions are specified in the approved proposals.

Specific HIV interventions are not included in the majority of the 8 priority IDP countries' NSPs. Similarly, specific HIV interventions for IDPs are not specified in some of the approved HIV proposals for the 8 countries. This lack of specific HIV interventions among NSPs and some HIV-approved proposals from major donors suggests that insufficient HIV programmes are delivered to IDPs in the 8 priority IDP countries. Advocacy at all levels is needed to ensure that IDPs are included in IDP-affected countries' NSPs and HIV proposals. As assessment of HIV interventions for IDPs in those countries that have included them in their approved proposals needs to be undertaken while the possibility of having some funds directed towards IDPs should be sought in those countries that do not have such interventions targeting IDPs.

Section II: HIV/AIDS and IDP Country Profiles

The 8 country profiles in this section contextualise the HIV/AIDS and IDP situations for each country and provide data, if any, about HIV/AIDS among the IDP population. HIV data for the general population came from the 2004 epidemiological update of the UNAIDS and the World Health Organization (WHO), with the exception of Somalia where data was provided by a recent population-based survey led by WHO. The HIV prevalence among the 8 countries with an IDP population estimated from 11.1 to 14.7 million persons ranges from 0.3% to 12.4% with a median of 3.2%; however, there are few data focusing on IDP prevalence. Numerous articles made strong declarations on the effects of HIV among IDPs but most provided little data. Reports claiming twice the HIV prevalence among IDPs in Northern Uganda to the overall population did not examine trends that showed a decrease from 27.0% in 1993 to 11.9% in 2002. We could only find HIV prevalence data for IDPs in Sudan (2002) and DRC (2002). In all other countries, data collected in IDP affected areas were not disaggregated according to displaced and non-displaced persons.

Recent population-based behavioural surveillance surveys (BSS) and/or sentinel surveillance surveys from Burundi, Colombia, DRC, Somalia and Sudan were used to better convey the situation for IDPs in the respective countries. There were almost no data on HIV and IDPs for Liberia and Nepal.

In conclusion, there are insufficient data to conclude how conflict and internal displacement affect HIV prevalence. Statements that conflict increases HIV transmission among IDPs or that IDPs consistently have higher HIV infections than the general population are not supported by data. Overall, most of the 8 priority IDP countries have a relatively low HIV prevalence compared to surrounding countries in their respective region. The overall dearth of data on HIV interventions, prevalence and behaviour among IDPs shows that governments, UN agencies and NGOs have not prioritised this area. Comprehensive HIV multi-sectoral assessments among IDPs are needed to provide data to direct programming and to serve as a baseline to allow for the monitoring and evaluating their effectiveness. Serial HIV prevalence and behavioural surveillance studies are needed among IDPs. These surveys should have a sufficient sample size to allow for the disaggregation of results according to displaced and non-displaced populations as well as gender and age.

Section III: Media Coverage of HIV and IDPs

There have been numerous biased and misleading reports by the media on HIV/AIDS and IDPs. Sweeping generalizations are often made with insufficient evidence. Reports make claims about the spread of HIV among IDPs in Burundi, Colombia, Liberia, Nepal, Somalia and Uganda despite the fact that HIV prevalence has never been measured in these populations. News coverage on the HIV situation in Sudan has attempted to provide a more balanced and informed account of the reality of the ground, yet no mention was made that the 1% HIV prevalence among IDPs was the same as the general non-displaced Sudanese population in 2002. Such information could help to quell growing fears that IDPs are responsible for spreading HIV in the country; a claim which remains groundless.

Reporters are held to the Declaration of Principles on the Conduct of Journalists that sets standards for ethical reporting. The media must constantly remember that its words can and will have a direct impact on the lives of IDPs around the world. Incorrect or misleading reporting will increase stigma among an already discriminated and marginalized population. To ensure accurate and unbiased reporting, humanitarian organizations must ensure that the information and data on which they report are valid and clearly explained to reduce the chance of misinterpretation. It would be helpful if journalists increase their knowledge of the HIV epidemic and have HIV/AIDS experts working with displaced populations review their conclusions before articles go to print. Such precautions may ensure less biased and more accurate reporting that may ultimately reduce the unfounded HIV discrimination against IDPs.

Section IV: Overall Essential Factors and Recommendations

The recommendations from this paper are based on **Essential Factors** regarding HIV and displacement and the **10 Objectives** of UNHCR's HIV and Refugees Strategic Plan for 2005-2007.[1]

Essential Factors for HIV and IDPs must be considered when implementing the recommendations. These include:

1. IDPs are a **unique group** often with special needs. Consequently, specific HIV policies and interventions need to be developed that may vary from those for other persons in resource-poor settings. For example:
   - Many IDPs have suffered trauma and violence, including sexual violence, during conflict and flight. In addition, traditional community support structures are often destroyed during displacement. Thus, there are a variety of psycho-social issues in refugee populations which may not exist in more stable communities;
   - Unique opportunities for prevention, support and care may exist in IDP situations that are uncommon in other situations (e.g. information-education-communication materials during food distribution or supplementary feeding programmes, at transits centres during repatriation, and during registration).
   - Some IDPs wish to remain anonymous for a myriad of reasons including security concerns. It is a challenge for them to access HIV interventions and for the humanitarian community to deliver such services in a manner that does not put them or their families into danger. This is particularly true for IDPs living in non-camp situations.

   However, in many ways, IDP communities are similar to other communities worldwide, including the existence of "core" groups that can spread HIV to the broader IDP and surrounding host communities. Therefore, among the IDP population, specific HIV interventions should also be made available for commercial sex workers, intravenous drug users, and men having sex with men in an accessible manner that does not expose them to discrimination.

2. HIV and AIDS constitute not just a health issue but a problem that affects the socio-cultural fabric, human rights and long-term economic well-being of IDPs as well as the local population with which they interact. Thus, well-coordinated **multi-sectoral and multi-partner approaches** are critical to an effective HIV

and AIDS programme. HIV and AIDS interventions must not be implemented in a parallel fashion, but be integrated within and complementary to existing programmes (e.g. health, protection, community services, and education). It is essential to work in close partnership with IDPs and their host communities, and with various national, sub-regional, regional and international actors (e.g. governments, United Nations agencies, international organizations, international and local non-governmental organizations, multilateral and bilateral institutions, religious institutions, and the private sector). All of this must be closely coordinated with the IASC humanitarian reform process that is currently being undertaken.

3. Implementation of HIV and AIDS programmes in **emergency situations** is essential. Policies and interventions must begin at the onset of a crisis and continue throughout the displacement cycle; such HIV programmes in emergency settings will be guided by the strategies and priorities set forth in the IASC guidelines.[2]

4. IDPs and their host communities generally interact closely and HIV programmes should be established that take into account this interaction. Thus, **integrated HIV programmes** that follow host government protocols, guidelines, and strategic plans should be implemented while parallel programmes should be avoided.

5. **Women and girls** are more susceptible to HIV due to gender discrimination and violence, biology, insufficient access to HIV prevention information and services, inability to negotiate safer sex, and lack of female-controlled HIV prevention methods. AIDS is affecting women most severely in places where heterosexual sex is a dominant mode of HIV transmission, as is the case in sub-Saharan Africa and the Caribbean. Adult women in sub-Saharan Africa are up to 1.3 times more likely to be infected with HIV than their male counterparts; this inequality is greatest among young women aged 15–24 years, who are approximately three times more likely to be infected than young men of the same age. Furthermore, women are more likely to take in orphans, provide home-based care, cultivate crops and seek other forms of income to sustain their families. The above factors may be more pronounced among IDP women and girls due to their vulnerability to sexual exploitation and violence throughout the displacement cycle. Policies and programmes must be prioritised and tailored to their needs as well as to the elderly who also have an increased burden.

6. **Young people**, aged 10-14 years, are at the centre of the epidemic. They are vulnerable to contracting HIV when they become sexually active due to socio-cultural, psycho-social and emotional factors. They may have insufficient information and understanding about HIV, they may display risky behaviour such as having consecutive and short-term sexual relationships, and they may lack access to the means to protect themselves. In some regions, intravenous drug use is spreading at an alarming rate among young people. These factors are enhanced among young IDPs who have been exposed to situations of conflict and displacement.

7. **Unaccompanied children, orphans and other children affected by HIV and AIDS** may experience economic hardship and psychosocial distress, suffer from increased malnutrition and illnesses, and may have a higher withdrawal rate from school than other children. These factors are enhanced among IDP children who have often fled from war, and may have lost one or both parents or been sexually exploited or violated. Early identification of IDP children made vulnerable by HIV and AIDS is critical in order to provide necessary support and to initiate family tracing and family reunification processes.

8. Policies and HIV interventions for **urban IDPs** can be more complicated because they are diverse groups who often live in widely dispersed areas, making them difficult to locate and access. Unlike IDPs living in camps, the type, level and cost of services provided to urban IDPs are not standardised and may vary considerably. HIV-related support and services for those who are not yet self-reliant should be provided through support, where necessary, to national health and education services and not by the creation of parallel structures and special services for IDPs. However, as mentioned above, some IDPs may wish to remain anonymous and thus providing services to this group is complicated and must be done in a confidential and subtle manner, possibly without government support.

9. IDPs returning to their homes may have lower, higher, or equal HIV prevalence to those who never left. For those IDPs who have been exposed to HIV programmes supported by NGOs and UN agencies, their knowledge of HIV may be higher and their behaviour less risky than those who were non-displaced. Furthermore, IDPs may have acquired important and valuable HIV-related skills that can be used when they return home (e.g. those involved in providing camp-based health care and education). UNHCR and OCHA should play a key role in ensuring continuity between IDPs who return home and those who never left. Overall, HIV policies and programmes need to be directed towards all persons in the area of return and not solely for returnees in order to avoid stigma and discrimination and to have a broader effect.

The **10 Objectives** of the strategy, which relate to refugees and other persons of concern to UNHCR, are:

1. **Protection -** to ensure that refugees, asylum-seekers and other persons of concern who are affected by HIV and AIDS can live in dignity, free from discrimination, and that their human rights are respected, including their non-discriminatory enjoyment of the highest attainable standard of physical and mental health.
2. **Coordination and Mainstreaming -** to ensure that HIV policies and interventions for refugees are coordinated, mainstreamed and integrated with those at the international, regional, subregional, country and organizational levels.
3. **Durable Solutions -** to develop and incorporate HIV policies and interventions into UNHCR's programmes for durable solutions, including voluntary repatriation, local integration and resettlement, in order to mitigate the long term effects of HIV.
4. **Advocacy -** to advocate for HIV-related protection, policy and programme integration, and subregional initiatives for refugees, and other persons of concern in a consistent and sustained manner at all levels.

5. **Quality HIV Programming -** to ensure appropriate, integrated HIV interventions for refugees, IDPs, returnees and other persons of concern, in concert with national programmes in host countries and countries of return.
6. **Prevention -** to reduce HIV transmission and HIV morbidity through the implementation of culturally and linguistically appropriate health and community-based interventions.
7. **Support, Care and Treatment -** to reduce HIV morbidity and mortality; this includes access to antiretroviral therapy when available to surrounding host populations when appropriate.
8. **Assessment, Surveillance, Monitoring and Evaluation -** to improve programme implementation and evaluation.
9. **Training and Capacity Building -** to improve HIV related skills and capacities of UNHCR, its partners, refugees, and other persons of concern.
10. **Resource Mobilisation -** to increase funds and move beyond traditional donors to ensure the objectives stated in this strategic plan are achieved.

The recommendations from this paper are based on the 10 objectives of UNHCR's HIV and Refugees Strategic Plan for 2005-2007. They are based on UNHCR's mandate and role as cluster lead for protection, shelter, and camp coordination and management among conflict-affected population according to the recent IASC humanitarian reform process. The recommendations are also based on OCHA's mandate to coordinate humanitarian response, policy development and humanitarian advocacy.

1. Protection

IDPs are often an oppressed minority group within a country who lack security and protection. HIV/AIDS is fundamentally linked to protection; UNHCR should include an HIV component in all of its protection policies and programmes at the global, regional and country levels. In its coordinating role, OCHA should ensure that no gaps regarding HIV/AIDS and protection occur and that such programmes are implemented in a complementary fashion.

2. Coordination and Mainstreaming

OCHA will have a major role in coordinating the various HIV programmes in IDP situations. This coordination must occur in close collaboration with UNHCR and other UN agencies, governments and NGOs.

3. Durable Solutions

IDPs should be able to return home and live in peace and dignity. Strong coordination and communication among all agencies providing HIV/AIDS programmes to IDPs need to occur when IDPs return to their area of origin. Issues such as continuation of antiretroviral treatment (ART), utilisation of HIV skills that IDPs may have learned while being displaced, and other important matters must be coordinated. Local integration is another possibility.

4. Advocacy

As this paper clearly shows, advocacy is needed at the global, regional and country level to ensure that IDPs are included in their countries' HIV national strategic plans and proposals. Since UNHCR became a cosponsor of UNAIDS in June 2004, refugees and IDPs have systematically been included in new global

policies, such as UNAIDS prevention policy paper and the new HIV and EDUCAIDS - The Global Initiative on Education and HIV/AIDS. However, a concerted effort at the country level, through the HIV/AIDS UN Theme groups needs to be undertaken. Countries who have specifically received HIV funds for IDPs (see section I of the paper) need to report on what has actually been implemented; priority countries that have not included IDPs in their proposals must see if some funds can be redirected to IDPs. All future HIV proposals (as well as other proposals from countries with IDPs) should include a specific component for IDPs. A campaign to advocate for inclusion of IDPs in country HIV programmes must also be directed at major donors. As section III shows, the media has published biased and discriminatory reports in some IDP situations. UN country theme groups as well as UNHCR and OCHA should monitor HIV and IDP media articles to ensure accurate and unbiased reporting occurs; they should respond accordingly when it does not. The same concept applies when UN agencies, governments and NGOs release reports on HIV and IDPs. Finally, as is currently done by UNHCR with media articles relating to HIV and refugees, a group of individuals or organizations should be established to monitor how the media reports on HIV and IDPs and to respond accordingly.

5. **Quality HIV Programming**
   UNHCR and other UN cosponsors must ensure appropriate and integrated HIV interventions for IDPs occur in concert with national programmes. Minimum essential services as outlined in the IASC guidelines for HIV/AIDS interventions in emergency settings must be implemented. A similar level and quality of services as those received by surrounding host communities must be assured. Section II, clearly illustrates that there is insufficient information on IDP and HIV programmes to provide a clear picture of their needs and the gaps. A recent report in Northern Uganda reports that basic HIV services are lacking for IDPs. A comprehensive HIV/AIDS needs assessment, combined with assessments from other sectors in a multi-sectoral fashion, is needed in all 8 IDP priority countries.

6. **Prevention**
   The same points as for recommendation 5.

7. **Support, Care and Treatment**
   The same points as for recommendation 5. As antiretroviral therapy (ART) becomes available to IDP surrounding host communities, we must ensure that IDPs also have access.

8. **Assessment, Surveillance, Monitoring and Evaluation**
   Sections II and III clearly show a lack of data on HIV and IDP situations. As mentioned in recommendation 5, a comprehensive multi-sectoral assessment should occur in all 8 IDP priority countries. Baseline data must be collected to allow for monitoring and evaluation of HIV interventions over time. In countries undertaking HIV sentinel surveillance or population-based HIV biological and/or behavioural surveys, sample size should provide sufficient power to disaggregate between IDPs and non-displaced populations, as well as gender and age.

9. Training and Capacity Building

During the multi-sectoral assessments of the countries, a component on HIV-related skills and capacities of UN agencies, its partners, and IDPs should be included. Given the limited information we have, it is likely that training and capacity building will be a major component of all HIV and IDP proposals and interventions.

10. Resource Mobilisation

Section I shows that specific HIV activities for IDPs are often not included in their countries' approved HIV proposals. Thus, there will be a need for significant resource mobilisation. For the most part, this should be at the country level in an integrated fashion with existing country programmes. However, at the initial stages, specific earmarked funding for HIV and IDPs may be necessary to fill the gap until advocacy among governments, UN agencies, donors, NGOs and others ensure that IDPs are covered under country programmes.

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Acronyms

AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Care
ART	Antiretroviral Treatment
BSS	Behavioural Surveillance Survey
CAS	Country Assistance Strategies
DFID	Department for International Development
DRC	Democratic Republic of Congo
FARC	Revolutionary Armed Forces of Colombia
FNL	National Liberation Forces
GBV	Gender-Based Violence
GFATM	Global Fund to fight AIDS, Tuberculosis and Malaria
GLIA	Great Lakes Initiative on AIDS
HIV	Human Immunodeficiency Virus
IDP	Internally Displaced Person
IRIN	Integrated Regional Information Networks
JSI	John Snow International
KAPB	Knowledge, Attitude, Practice and Behaviour
LRA	Lord's Resistance Army
MAP	Multi-Country HIV/AIDS Program
MDG	Millennium Development Goal
NGO	Non-governmental organization
NSP	National Strategic Plan for HIV
OCHA	Office for the Coordination for Humanitarian Affairs
PEPFAR	President's Emergency Plan for AIDS Relief
SC-UK	Save the Children UK
SNAP	Sudanese National AIDS Control Program
SPLA	Sudan People's Liberation Army
UN	United Nations
UNAIDS	United Nations Program on HIV/AIDS
UNHCR	United Nations High Commissioner for Refugees
WHO	World Health Organization

Glossary

Antenatal (HIV) sentinel surveillance: anonymous and unlinked HIV testing of blood voluntarily drawn from pregnant women during their first-time visit to antenatal clinics to test for syphilis. The data are used as a proxy measure for HIV prevalence of the population between 15-49 years of age.

Antiretroviral treatment (ART): is a mixture of medications that slows down the reproduction and replication of HIV in the body.

Behavioural Surveillance Survey (BSS): a population-based survey that monitors, evaluates and tracks trends in HIV/AIDS-related knowledge, attitudes and behaviours in the general population as well as subgroups that are particularly vulnerable to the infection.

Staging of HIV Infection:

- **Low**: less than 1% HIV prevalence among the high-risk groups.
- **Concentrated**: high prevalence (>1%) in high risk groups and a low prevalence ($\leq$1%) in the general population.
- **Generalised**: $\geq$1% HIV prevalence among the general population.

HIV Prevalence: the ratio of the number of HIV cases present in a statistical population at a specified time and the number of individuals in the population at that specified time. Prevalence is useful because it is a measure of the commonality of disease. It helps physicians with the probability of certain diagnoses and is routinely used by epidemiologists, health care providers, government agencies, and insurance companies. This measure is the norm when reporting on HIV infection.

HIV Incidence: a measure of occurrences of the disease in a specified time interval. In contrast, prevalence involves all affected individuals, regardless of the date of contraction. This is difficult to measure and thus generally not reported.

Internally Displaced Person (IDP): are persons or groups of persons who have been forced or obliged to flee or to leave their homes or places of habitual residence, in particular as a result of or in order to avoid the effects of armed conflict, situations of generalized violence, violations of human rights or natural or human-made disasters, and who have not crossed an internationally recognised State border.[3]

Knowledge, Attitude, Practice and Behaviour (KAPB) surveys: similar to a BSS.

Refugee: is a person who "owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group, or political opinion, is outside the country of his nationality, and is unable to or, owing to such fear, is unwilling to avail himself of the protection of that country..."[4]

Seroprevalence: the frequency of individuals in a population that have a particular element (e.g. antibodies to HIV) in their blood serum.

Sentinel (HIV) Surveillance: involves anonymous and unlinked HIV testing of blood voluntarily given at different selected sites in a country. They are used as proxies to represent different geographical locations within a country.

Voluntary HIV Counselling and Testing: follows a regimen of pre-test counselling, testing (as desired by the client and after informed consent is provided), and post-test counselling (which may involve one or more sessions depending on the client's needs). Individual risk assessment and risk reduction planning are integral components of pre- and post-test counselling.

Introduction

Internally displaced persons (IDPs) are persons or groups of persons who have been forced or obliged to flee or to leave their homes or places of habitual residence, in particular as a result of or in order to avoid the effects of armed conflict, situations of generalized violence, violations of human rights or natural or human-made disasters, and who have not crossed an internationally recognised state border.[3] There are approximately 25 million IDPs globally, over 2.5 times the number of refugees. Although there is much speculation on the relationship between HIV/AIDS and IDPs, little is known. Given the unique and precarious situation in conflict-affected countries, the HIV and health concerns of IDPs should be a priority for governments and humanitarian actors.

The purpose of this paper is four-fold: 1) to assess the national strategic plans (NSPs), approved HIV proposals for the inclusion of IDPs among the 8 Office for the Coordination for Humanitarian Affairs (OCHA) priority IDP countries - Burundi, Colombia, Democratic Republic of Congo (DRC), Liberia, Nepal, Somalia, Sudan and Uganda; 2) to research the current HIV/AIDS and IDP situation in the 8 countries; 3) to examine how the relationship between HIV and IDPs is portrayed in the media; and 4) to provide recommendations and next steps on how to improve HIV policies and interventions for IDPs using 10 strategies based on United Nations High Commissioner for Refugees' (UNHCR) 2005-2007 HIV Strategic Plan.[1]

SECTION I: Inclusion of IDPs in National Strategic Plans and Proposals

Executive Summary

A systematic literature review, examination of current NSPs and approved HIV proposals by major donors (World Bank, Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) and the President's Emergency AID Relief (PEPFAR)) for the 8 OCHA priority IDP countries (Burundi, DRC, Columbia, Liberia, Nepal, Somalia, Sudan and Uganda) was undertaken.

Seven (87%) of the 8 NSPs mentioned IDPs while 3 (38%) listed specific HIV interventions. All 8 countries had approved GFATM proposals with an HIV component; 6 (75%) mentioned IDPs and 5 (62%) stated interventions. Three (50%) of the 6 eligible African countries had approved World Bank MAP projects and 1 (33%) mentioned IDPs and specified a need for IDP activities. However, the World Bank funded Great Lakes Initiative on AIDS (GLIA) provides interventions for IDPs and includes 3 of the 8 countries. Of the 8 countries, only Uganda is a PEPFAR country; IDPs are mentioned but no interventions are specified in the approved proposals.

Specific HIV interventions are not included in the majority of the 8 priority IDP countries' NSPs. Similarly, specific HIV interventions for IDPs are not specified in some of the approved HIV proposals for the 8 countries. This lack of specific HIV interventions among NSPs and some HIV-approved proposals from major donors suggests that insufficient HIV programmes are delivered to IDPs in the 8 priority IDP countries. Advocacy at all levels is needed to ensure that IDPs are included in IDP-affected countries' NSPs and HIV proposals. Assessment of HIV interventions for IDPs in those countries that have included them in their approved proposals needs to be undertaken, and the possibility of having some funds directed towards IDPs should be sought in those countries that do not yet have such interventions targeting IDPs.

Introduction

The challenge posed by HIV/AIDS is a formidable one, which the international community has attempted to tackle in multiple ways. At the turn of the 21st century, the Millennium Development Goals (MDGs) were designed to reorganize and coordinate UN activities and goals. Goal number six relates to HIV/AIDS and other diseases- "to combat HIV/AIDS, malaria and other diseases."[5] Generally, HIV/AIDS proposals are funded by three major sources: individual governments, bilateral donors, private foundations and multilateral donors. The total HIV/AIDS funds available for developing countries grew from an estimated US $300 million in 1996 to US $6.1 billion in 2004, which is still $4-6 billion short of what is needed for effective prevention, care and treatment.[6] The role and scope of the four major groups involved in funding HIV/AIDS initiatives in the world is briefly summarised below.

The first grouping is comprised of national governments that fund certain HIV/AIDS initiatives listed in their respective NSPs. Countries are responsible for drafting and implementing their own NSP that outlines an agenda and plan of action for all HIV/AIDS activities in the country for a specific period of time (usually varying between two to six years). National strategic planning increases national commitment to and ownership of HIV/AIDS programmes but there can be problems with the approach. The World Bank's Global HIV/AIDS Programme of Action explains that NSPs tend to be all-encompassing and do not prioritise issues or groups of people; they lack clear goals and responsibilities and tend to be uncosted or unrealistically costed. It recommends that future NSPs concentrate on developing HIV/AIDS strategies based on available epidemiological information, and should assign specific responsibilities to actors that can then be held accountable for project implementation.[6]

The second grouping consists of bilateral donors, who work together on specific HIV/AIDS projects. The two largest contributors are the United States'(US) PEPFAR[7] and the United Kingdom's (UK) Department for International Development (DFID). PEPFAR is a five year US $15 billion global initiative that combats HIV/AIDS in fifteen countries: Botswana, Ivory Coast, Ethiopia, Guyana, Haiti, Kenya, Mozambique, Namibia, Nigeria, Rwanda, South Africa, Tanzania, Uganda, Vietnam and Zambia.[7] By contrast, DFID focuses on poverty alleviation and manages Britain's aid to poor countries worldwide.[8] Of the 8 countries discussed in this paper, Burundi, Sudan and Uganda have received British financial support for HIV/AIDS programmes. After the US, the UK is the second biggest bilateral donor on HIV/AIDS; it spent more than £270 million pounds in 2002-03.[9]

The third grouping is comprised of private foundations, the largest being the GFATM and the Bill and Melinda Gates Foundation. GFATM was created in 2001 to facilitate and expand the partnership between governments, civil society, the private sector and affected communities. Its mandate is to attract, manage and disburse funds to fight HIV/AIDS, tuberculosis and malaria, but not to implement the projects directly.[10] The Gates Foundation was established in 2000, and currently has an endowment of US $28.8 million, part of which goes to its Global Health programme (which includes all HIV/AIDS related projects).[11]

The fourth grouping is made up of multilateral donors, which include the World Bank and regional development banks. The World Bank has adopted a dual track approach, by creating the Multi-Country HIV/AIDS Programme (MAP) for Africa and the Caribbean, and by developing regional collaboration plans, such as the Great Lakes Initiative on AIDS (GLIA). The World Bank is the largest long-term investor in prevention and migration of HIV/AIDS in developing countries. Its most recent report on the epidemic shows how over the last 15 years, it has substantially increased its assistance to HIV/AIDS programmes; the cumulative total of commitments made exceed now US $2.5 billion. MAP was the first to fund African HIV programmes on a billion-dollar scale, and today 29 countries and 4 regional projects are underway. Consequently, funding for HIV/AIDS programmes in Africa have increased rapidly, from an average of US $10 million annually 10 years ago to $250-300 million annually in each of the last four years. The World Bank expects to launch more MAP programmes in Ghana and Ethiopia, and preparations are also underway in Kenya and Eritrea.[6]

The three largest funding efforts are those of PEFPAR, GFATM and the World Bank. For this reason, we have chosen to assess their approved HIV proposals to the 8 countries. However, future research should explore and evaluate the proposals of the other major donors to better determine funding for HIV/AIDS activities for IDPs.

Methodology

Data collection:

IDP population estimates come from the Global IDP Project[12] and the US Committee for Refugees and Immigrants.[13] Any range in IDP numbers for a particular country exemplifies uncertainty and potential discord regarding the number of people affected by conflict. A search for IDPs and refugees was conducted in the following country-specific documents: HIV/AIDS NSP, World Bank MAP as well as World Bank Country Assistance Strategies (CAS), PEPFAR, and the GFATM proposals for Rounds 1 to 4. The key words used include 'HIV', 'IDP', 'displaced' and 'refugee'. Documents in Spanish and French were searched with the appropriate translations. Any mention of IDPs and/or refugees was followed by a search for listed HIV activities. These have been referenced in the appendices for further consultation. The findings are also displayed graphically in the tables and pie charts of this section.

Literature Review:

The literature review is based on articles found on the internet and from reports circulated by several UN agencies and non-governmental organizations (NGOs). PubMed and Google were the main internet search engines used, and their sites were last visited in September 2005. Only documents with data on HIV and IDPs were further analyzed. For both the PubMed and Google searches, the following key terms were used in the search: 'HIV and IDP', 'HIV and displaced', 'HIV sentinel surveillance', and 'HIV prevalence.' From more than 400 results found on PubMed, only 3 references are relevant to this research. They have been used in the literature review below and full references have been provided at the end of this document.

HIV/AIDS National Strategic Plans

Table 1: Summary of HIV/AIDS National Strategic Plans and their Inclusion of Refugees and IDPs

	Country	# of IDPs*	Plan Exists	Covers the Period	Mentions Refugees	Activities Refugees**	Mentions IDPs	Activities IDPs**
1	Burundi	117,000	yes	2002-2006	yes	no	yes	no
2	Colombia	1,580,396 - 3,410,041	yes	2004-2007	no	no	no	no
3	DRC	2,170,000 - 2,330,000	yes	1999-2008	yes	yes	yes	yes
4	Liberia	130,000 - 464,000	yes	2004-2007	yes	yes	yes	yes
5	Nepal [1]	100,000 - 200,000	yes	2005-2006	yes	yes	yes	yes
6	Somalia [2]	370,000 - 400,000	yes	2005-2006	yes	no	yes	no
7	Sudan	5,300,000 - 6,700,000	yes	2003-2007	yes	no	yes	no
8	Uganda	1,300,000 - 1,400,000	yes	200/1-2005/6	yes	no	yes	no
	Total	11,067,396 - 14,697,041	8		7	3	7	3

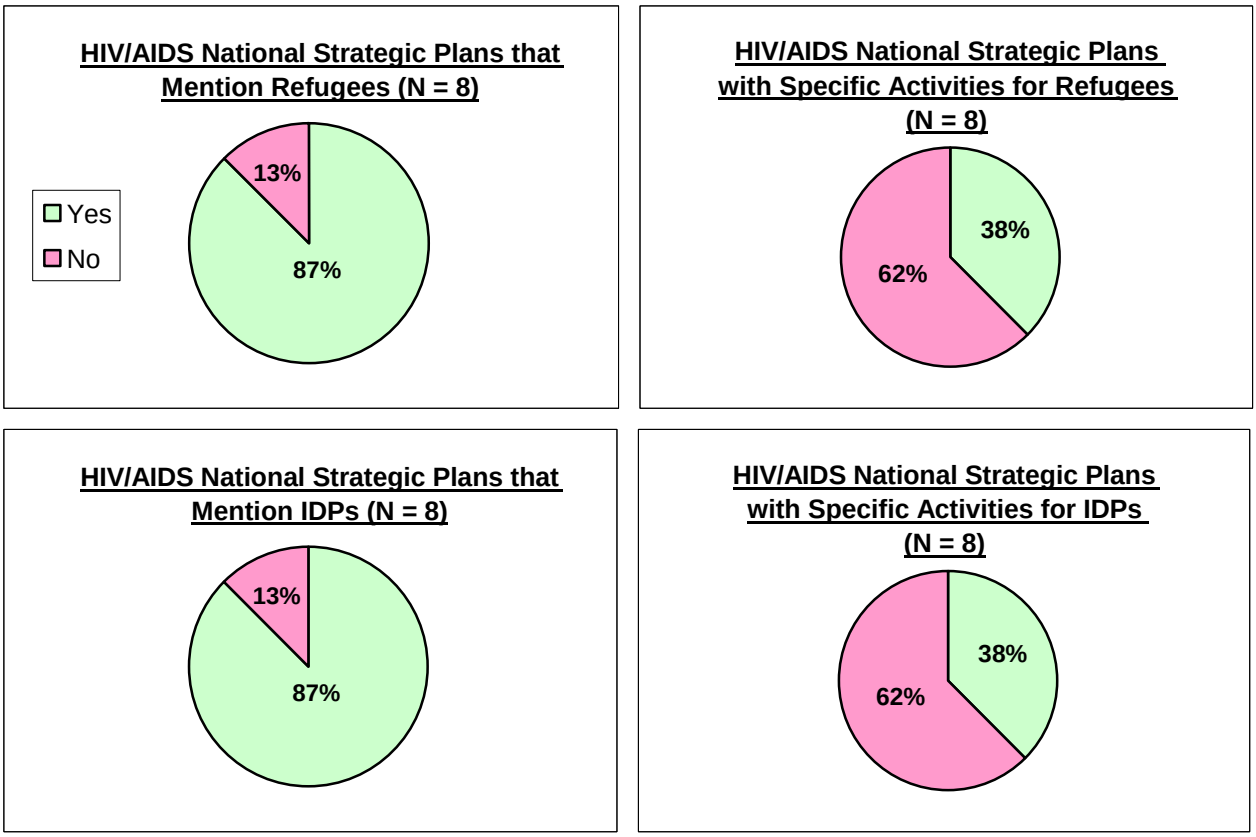
* Estimates from Global IDP Project and the US Committee for Refugees and Immigrants.

** See appendix for country specific activities on refugees and IDPs.

[1] Nepal's NSP for 2002-06 had no mention of refugees or IDPs; the 2004-2005 NSP included refugees but not IDPs; and the 2005-2006 NSP includes IDPs but not refugees.

[2] The Somali NSP is comprised of the *HIV/AIDS Strategic Information and Data Review 2005*, *Plan of Action 2005* and the *Implementation Support Plan 2005-6*. Refugees and IDPs are not referred to in the *Plan of Action.*

Figure 1: HIV/AIDS National Strategic Plans and their Inclusion of Refugees and IDPs



8 OCHA Priority Countries are Burundi, DRC, Colombia, Liberia, Nepal, Somalia, Sudan and Uganda.

Multi-Country HIV/AIDS Programme (MAP) for Africa

Table 2: Summary of HIV/AIDS MAPs for Africa and their Inclusion of Refugees and IDPs

	Country	# of IDPs	HIV Proposal Approved	Mentions Refugees	Activities Refugees	Mentions IDPs	Activities IDPs
1	Burundi	117,000	yes (2002-06)	yes	no	yes	no
2	Colombia **	1,580,396 - 3,410,041	N/A				
3	DRC	2,170,000 - 2,330,000	yes (2004-08)	yes	yes	yes	no
4	Liberia	130,000 - 140,000	no				
5	Nepal **	100,000 - 200,000	N/A				
6	Somalia	370,000 - 400,000	no				
7	Sudan	5,300,000 - 6,700,000	no				
8	Uganda *	1,300,000 - 1,400,000	yes (2001-06)	no	no	no	no
	Total	11,067,396 - 14,697,041	3 of 6	2	1	2	0

N/A = Not Applicable
The World Bank launched MAP in 2000 with an initial amount of US$ 500 million to fight HIV/AIDS in sub-Saharan Africa.
One regional programme, the Great Lakes Initiative on AIDS (GLIA), includes Burundi, DRC, Uganda, as well as Rwanda, Kenya and Tanzania. GLIA approved proposals include IDPs but there were no activities for IDPs in the first year of implementation.[14]
* Uganda is also part of the US President's Emergency Plan for AIDS Relief (PEPFAR). Its *Focus Country Operation Plan* for 2005 does not refer to refugees but states a higher prevalence of HIV among IDPs. No activities are mentioned for either group.[15]
** Colombia and Nepal are not part of MAP but are other World Bank assistance programmes. Colombia's Country Assistance Strategy (CAS) for 2003-06 makes no specific reference to HIV/AIDS, refugees or IDPs.[16] Nepal's CAS for 2004-07 speaks of halting the spread of HIV in the country by 2015 but makes no mention of refugees or IDPs.[17]

Global Fund to fight AIDS, Tuberculosis and Malaria

Tables 3-8: Summary of GFATM's approved HIV Proposals and their Inclusion of Refugees and IDPs by Round

	Country	Round 1	Mentions Refugees	Activities Refugees	Mentions IDPs	Activities IDPs
1	Burundi	(2003 - 2004) yes	yes	no	no	no
2	Colombia	no				
3	DRC	no				
4	Liberia	no				
5	Nepal	no				
6	Somalia	no				
7	Sudan	no				
8	Uganda*	(2003 - 2005) yes	yes	yes	yes	yes

	Country	Round 2	Mentions Refugees	Activities Refugees	Mentions IDPs	Activities IDPs
1	Burundi	no				
2	Colombia	(2004 -2006) yes	yes	no	yes	yes
3	DRC	no				
4	Liberia	(2004 - 2006) yes	no	no	yes	no
5	Nepal	(2004 - 2005) yes	no	no	no	no
6	Somalia	no				
7	Sudan	no				
8	Uganda*	no				

	Country	Round 3	Mentions Refugees	Activities Refugees	Mentions IDPs	Activities IDPs
1	Burundi	no				
2	Colombia	no				
3	DRC	(2004 - 2006) yes	no	no	no	no
4	Liberia	no				
5	Nepal	no				
6	Somalia	no				
7	Sudan	(2005 - 2006) yes	yes	no	no	no
8	Uganda*	(2004 - 2006) yes	no	no	no	no

	Country	Round 4	Mentions Refugees	Activities Refugees	Mentions IDPs	Activities IDPs
1	Burundi	no				
2	Colombia	no				
3	DRC	no				
4	Liberia	no				
5	Nepal	no				
6	Somalia	(2005 - 2006) yes	yes	yes	yes	yes
7	Sudan	(2005 - 2007) yes	yes	yes	yes	yes
8	Uganda*	no				

	Country	Round 5	Mentions Refugees	Activities Refugees	Mentions IDPs	Activities IDPs
1	Burundi	yes	yes	yes	yes	yes
2	Colombia	no				
3	DRC	no				
4	Liberia	no				
5	Nepal	no				
6	Somalia	no				
7	Sudan	no				
8	Uganda*	no				

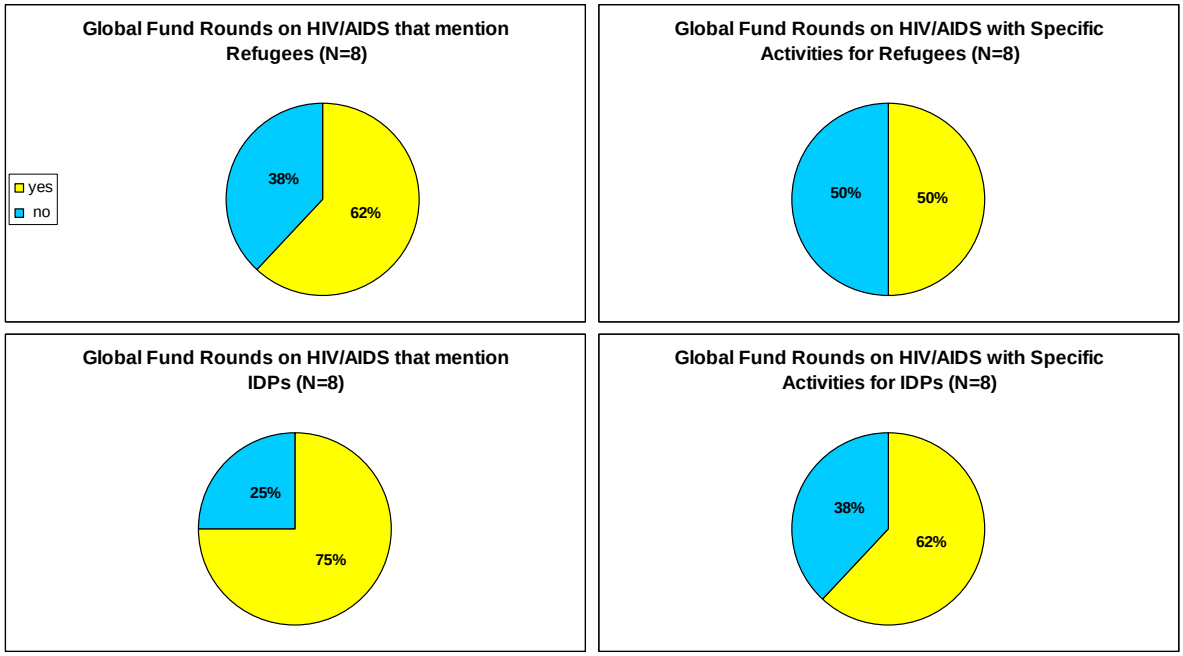
*Uganda is also part of the US President's Emergency Plan for AIDS Relief (PEPFAR). Its *Focus Country Operation Plan* for 2005 does not refer to refugees but states a higher prevalence of HIV among IDPs. No activities are mentioned for either group.[15]

Total of Five Rounds:

Country	Mentions Refugees	Activities Refugees	Mentions IDPs	Activities IDPs
Burundi	yes	yes	yes	yes
Colombia	yes	n	yes	yes
DRC	no	no	no	no
Liberia	no	no	no	no
Nepal	no	no	no	no
Somalia	yes	yes	yes	yes
Sudan	yes	yes	yes	yes
Uganda	yes	yes	yes	yes
TOTAL	**5**	**4**	**6**	**5**

Burundi, Sudan and Uganda are involved in two sets of GFATM rounds. Data from the most recent rounds (Burundi 5, Sudan 4 and Uganda 3) were used in the totalling the results of the five rounds. Note that in Burundi and Sudan's case, IDPs are not mentioned in the earlier rounds (round 1 and 3, respectively) but are mentioned in the later ones (round 5 and 4, respectively). In contrast, Uganda mentioned IDPs in round 1 but not in 3. Consequently, Burundi and Sudan's inclusion of IDPs are evolving while Uganda's is not. The figures below show that the GFATM proposals have include more HIV/AIDS activities for IDPs in the 8 countries than the World Bank and governments. However, the overall poor track record highlights and heightens the need for IDP-centred HIV/AIDS outreach programmes.

Figure 2: HIV/AIDS GFATM Proposals and their Inclusion of Refugees and IDPs



SECTION II: HIVAIDS and IDP Country Profiles

Executive Summary

The 8 country profiles in this section contextualise the HIV/AIDS and IDP situations for each country and provide data, if any, about HIV/AIDS among the IDP population. HIV data for the general population came from the 2004 epidemiological update of the UNAIDS and the World Health Organization (WHO), with the exception of Somalia where data was provided by a recent population-based survey led by WHO.[18] The HIV prevalence among the 8 countries with an IDP population estimated from 11.1 to 14.7 million persons ranges from 0.3% to 12.4% with a median of 3.2%; however, there are few data focusing on IDP prevalence. Numerous articles made strong declarations on the effects of HIV among IDPs but most provided little data. Reports claiming twice the HIV prevalence among IDPs in Northern Uganda to the overall population did not examine trends that showed a decrease from 27.0% in 1993 to 11.9% in 2002. We could only find HIV prevalence data for IDPs in Sudan[19] (2002) and DRC[20] (2002). In all other countries, data collected in IDP affected areas were not disaggregated according to displaced and non-displaced persons.

Recent population-based behavioural surveillance surveys (BSS) and/or sentinel surveillance surveys from Burundi, Colombia, DRC, Somalia and Sudan were used to better convey the situation for IDPs in the respective countries. There were very little data on HIV and IDPs for Liberia and Nepal.

In conclusion, there are insufficient data to conclude how conflict and internal displacement affect HIV prevalence. Statements that conflict increases HIV transmission among IDPs or that IDPs consistently have higher HIV infections than the general population are not supported by data. Overall, most of the 8 priority IDP countries have a relatively low HIV prevalence compared to surrounding countries in their respective region. The overall dearth of data on HIV interventions, prevalence and behaviour among IDPs shows that governments, UN agencies and NGOs have not prioritised this area. Comprehensive HIV multi-sectoral assessments among IDPs are needed to provide data to direct programming and to serve as a baseline to allow for the monitoring and evaluating their effectiveness. Serial HIV prevalence and behavioural surveillance studies are needed among IDPs. These surveys should have a sufficient sample size to allow for the disaggregation of results according to displaced and non-displaced populations as well as gender and age.

Table 9: Summary of IDP and HIV Situation by Country

Country	No. of IDPs	2003 est. HIV prevalence (low - high)	IDP est. HIV prev.	IDP-specific BSS	IDP-specific HIV/RH assessment
Burundi	117,000	6.0 (4.1 - 8.8)	no	2001-02	No
Colombia	1,580,396 - 3,410,041	0.7 (0.4 – 1.2)	no	no	2001
DRC	2,170,000 - 2,330,000	4.2 (1.7 – 9.9)	7.1% in 2002 in Kisangani	no	2002
Liberia	130,000 - 140,000	5.9 (2.7 – 12.4)	no	no	no
Nepal	100,000 - 200,000	0.5 (0.3 – 0.9)	no	no	no
Somalia	370,000 - 400,000	0.9% in 2004	no	no	no
Sudan	5,300,000 - 6,700,000	2.3 (0.7 – 7.2)	1.0% in 2002 in Bahri, Kassala, Khartoum, Omdurman	no	no
Uganda	1,300,000 - 1,400,000	4.1 (2.8 – 6.6)	no	no	no
Total	11,067,396 - 14,697,041	Range: 0.3 – 12.4			

HIV/AIDS and IDP Country Profiles

1. Burundi:

IDP Situation:
In this country of seven million, hundreds of thousands of people have been displaced from their homes since the early 1990s to escape fighting between the government and Hutu rebel groups. Many others, predominantly Hutus, were forcibly displaced into camps by the government in the second half of the 1990s. The number of IDPs peaked in 1999, with over 800,000 displaced people (12% of total population), and then decreased in 2003 when the ceasefire was signed. From mid-2003 to mid-2005, over 165,000 IDPs returned to their areas of origin. At the same time, however, more people were displaced in Bujumbura Rural Province, the area around the capital, as the National Liberation Forces rebel group refused to make peace with the government. The total number of IDPs in camps as of mid-2005 was estimated at 117,000; in addition, an unknown number of IDPs reside with host families. The highest number of IDPs is in Gitega Province but internal displacement have also taken place between 1993 and 2005 in the following provinces: Bubanza, Bujumbura, Bururi, Cankuzo, Cibitoke, Karuzi, Kayanza, Kirundo, Makamba, Marie, Muramvya, Muyinga, Mwaro, Ngozi, Rutana, Rural and Ruyigi. The majority of IDPs have been displaced in communes of origin.[21] A Global IDP Project Survey in 2005 found that 20% of the households surveyed in all of Burundi had a least one member displaced in the last two years and that there are more women in IDP sites than men.[21]

HIV/AIDS Situation:
Burundi's adult HIV prevalence at the end of 2003 was 6.0%, with a low estimate of 4.1% and a high estimate of 8.8% compared to 5.4% in 2002.[22] AIDS is the primary cause of adult deaths and is an important cause of infant mortality.[23] There are no HIV seroprevalence data for the IDP population.

HIV/AIDS and IDP Situation:
IDPs are mentioned in the country's NSP 2002-06,[24] the World Bank's MAP 2002-06,[25] and the Great Lakes Initiative on AIDS (GLIA) project;[14] however, they do not contain specific activities designed for IDPs. The GFATM round 1 approved proposal with an HIV component for 2003-04 does not mention IDPs;[26] however, IDPs are included in the most recent round 5 GFATM proposal and there are activities directed towards IDPs.[27] It is important to note that the Burundian NSP states, without providing evidence, that the promiscuity in IDP camps and agglomerations is one of the principle causes of HIV/AIDS in the country.[24]

The Burundian Red Cross interviewed 731 persons for a BSS in IDP sites located in the Makamba, Rutana and Bururi provinces in 2001-02. The study showed that IDPs could accurately at least one mode of transmission of HIV; 96.5% mentioned unprotected sex, 79.5% sharp objects with infected people, and 30.5% contaminated blood. Few IDPs knew about mother-to-child transmission. The BSS reported that radio (87.8%) and religious sermons (27.3%) were the most effective means of raising HIV awareness. In terms of prevention, 91.8% spoke of abstinence, 54.0% suggested not sharing sharp objects, 45.3% mentioned condoms, and only 10.3% knew about antiretroviral drugs reducing mother-to-child transmission. The fact that few people know of and use condoms is particularly worrying given that 53.6% of young people claimed to have sexual relations before 15 years of age. The BSS also showed some

worrying attitudes among the population towards people living with HIV/AIDS. In addition, 96.2% support prenuptial screening and 86.9% favour screening before the conception of a child.[28]

2. Colombia:

IDP Situation:
Colombia has suffered from 4 decades of socio-political violence, and represents the American continent's longest running internal conflict. All parties use "dirty war" strategies, namely the targeting of civilians, which explains why internal displacement is a direct and intended consequence of the conflict. Colombia has the world's second largest IDP population, and accounts for most of Latin America's 3.7 million IDPs as well as nearly all the new displacements in the region. Recent figures from the Global IDP Project estimates over 3 million Colombians displaced by violence since 1985.[29] Only 22% of Colombians have fled in large groups due to a high level of insecurity and continuous lack of protection; the majority prefers to flee as individuals and families and do not acknowledge their displaced status for fear of retribution.[30] Indigenous people and Afro-Colombians make up 40% of all IDPs, and most of them worked in agriculture before being displaced. IDPs tend to move to nearby villages, then to towns, and finally to major urban centres.[31] Most displacement is rooted in coca, oil and economic disputes, and agents of displacement include paramilitary and guerrilla groups, as well as the Colombian armed forces. Security measures have not improved, and conflict is not only prompting intra-urban displacements, but is also spilling over international borders. Displacement has taken place in the North-Eastern departments of North of Santender, Magdalena, and Bolívar (2005), as well as in the regions of Medio Atrato and Urabá (2005), the department of Cundinamarca (2004) and in the South-Western departments of Putumayo, Nariño and Valle del Cauca (2005).[32]

HIV/AIDS Situation:
Colombia's adult HIV prevalence at the end of 2003 was 0.7%, with a low estimate of 0.4% and a high estimate of 1.2%.[33] Knowledge of the existence of HIV/AIDS is almost universal (99%) but few IDPs know about the modes of transmission.[32] There are no HIV seroprevalence data for the IDP population.

HIV/AIDS and IDP Situation:
Colombia's adult HIV prevalence at the end of 2003 was 0.7%, with a low estimate of 0.4% and a high estimate of 1.2%.[33] Knowledge of the existence of HIV/AIDS is almost universal (99%) but few IDPs know about the modes of transmission.[32] There are no HIV seroprevalence data for the IDP population. In the last 10 years the predominant pattern of sexual transmission has changed, with a progressive increase in heterosexual transmission, since the ratio of male to female cases has fallen from 8:1 between 1990 and 1994 to 3:1 between 2000 and 2003. In some regions, like in the Caribbean coast and north eastern region, where HIV infection has affected men and women with greater parity since early nineties, the number of new infections in young women is reportedly increasing at a greater speed than it is in men, and the female to male ratio is close to 1:1.

The high vulnerability of Colombian women to the HIV/AIDS epidemic is determined by the cultural context that calls for sexual relations dominated by men; forced

displacement is another aspect that is increasingly affecting minors and women, generating uprooting, lack of protection, and marginality, and fostering forced sexual labor.[34] In the few studies made in the country on the use of condoms by adolescents and young people, it has been found that women report a lower frequency of use than men of their same age. The difference in reported condom use among young males and females is more evident in the Caribbean region, where the lowest rate of condom use was reported, and among youths and adolescents living in the context of forced displacement.[35, 36]

HIV/AIDS and IDP Situation:

The NSP 2004-07[37] does not mention IDPs nor does the World Bank's CAS 2003-06[16] make any specific reference to HIV/AIDS or the displaced. However, the GFATM round 2 approved proposal with an HIV component for 2004-06 mentions IDPs and has specific HIV activities for them.[38]

The Women's Commission for Refugee Women and Children, in collaboration with Marie Stopes International, Profamilia and Columbia University conducted an assessment of reproductive health among IDPs in Colombia from November 11 to 18, 2001. The team concluded that IDPs suffer a critical lack of access to reproductive health services because health care is largely decentralised and poorly managed by the government, and the UN focuses on supporting local and national initiatives. The report explains that IDPs are the most likely to receive limited emergency assistance, however, this does not include reproductive health care.[32] Less than 1 in 4 (22%) of IDPs are registered and receive government assistance for fear of reprisals from armed groups and government.[30] IDPs have also claimed that the Revolutionary Armed Forces of Colombia (FARC) have tested women and men for HIV and have not only discriminated against people living with HIV/AIDS but also killed them.[32]

A local organization called Profamilia, which provides some of the reproductive health services in the country, has only just begun outreach programmes to IDPs; however, they charge a small user fee which may limit IDPs' access to medicines and care. Condoms and clean delivery kits are neither free nor widely available to IDPs. Moreover, IDPs who seek health care are stigmatized for being IDPs. Thus, many chose to go without medicines and services while others could not afford to pay for health care. In addition, the team reports that women, girls and adolescent IDPs are particularly prone to experiencing terrible reproductive health problems. Gender-based violence (GBV), including rape followed by murder, sexual servitude, forced conception and abortions, perpetrated by armed actors is largely unaddressed.[32] The likelihood of contracting HIV may increase in such circumstances, though there are no data to prove this assertion. The study concludes that there is little HIV/AIDS prevention and education for IDPs, and that although some adolescents have heard about HIV/AIDS in school, they do not practice preventive meansure.[32]

3. Democratic Republic of Congo:

IDP Situation:

The humanitarian crisis in DRC is one of the most severe in the world, with an estimated 2.17 million Congolese internally displaced.[39] The US Committee for Refugees and Immigrants estimated that at least one million IDPs receive no humanitarian aid due to their inaccessibility.[40] Two wars have devastated the country, first by the military coup in 1997 of Mobutu Sese Seko by Laurent Kabila, followed in 1998 by the purges of former foreign supporters. The region-wide conflict has involved troops from seven external countries, and to this day insecurity persists and the country remains divided. The North and East are rebel-controlled territory while the South and West are controlled by the government; communication and travel between the two remain highly restricted. Approximately 90% of the IDPs are in the east, 75% of whom live in rebel-controlled areas[40] and 80% of families in rural areas of the North and South Kivu Provinces have fled their homes at least once in the past 5 years.[41]

The major factor causing displacement is the plunder of natural resources by warring parties (1998-2005), but people have also been forced to flee because of continued fighting between various armed groups (generally in both North and South Kivu, as well as in Ituri District, Kasaï Oriental and Katanga Provinces), as well as fighting between UN peacekeepers and Ituri militia. Women and children from Eastern Congo have also fled to escape abduction and sexual violence, and demobilised Mai Mai fighters abuses against the population in Beni, North Kivu, have caused displacement.[42] Widespread rape of women and children has been reported.

HIV/AIDS Situation:

DRC's adult HIV prevalence at the end of 2003 was 4.2%, with a low estimate of 1.7% and a high estimate of 9.9%.[43] Good quality data on HIV infection in DRC is difficult to find in the Eastern part of the country. Although a system of HIV sentinel surveillance among women attending antenatal care (ANC) clinics was established in 1985, sentinel surveys have not been conducted regularly and sites have not been used consistently.

Save the Children-UK (SC-UK) released a report of an HIV sentinel survey among pregnant women in the health zone of Kalemie in December 2001.[44] Kalemie is located in Eastern DRC and has been heavily affected by armed conflict. The population surveyed was both conflict-affected non-displaced and displaced persons; no distinction between the two was made in the analysis. Two diagnostic HIV tests were done in four sites from 568 pregnant women, and 142 (24.2%) respondents were HIV positive. In 1999, ANC sentinel surveillance in Kalemie was 2.8% compared with 24.2% in this 2001 survey; no other data are available for this health zone during the intervening years.[45] Such a trend would indeed be concerning if the data are correct given the rate of increase. Furthermore, the HIV prevalence in Kalemie is much higher compared with the overall HIV prevalence for DRC at 4.2%.[44] However, there are some questions regarding the reliability and quality of the SC-UK survey, as HIV-2 was very high relative to HIV-1 which is unlikely in DRC and it is unclear what quality control measures were undertaken. Further HIV studies need to be undertaken in Eastern DRC that include disaggregation between displaced and non-displaced persons before conclusions can be made.

John Snow International (JSI) made an assessment of reproductive health in Goma and Kalima health zones from July 1-20, 2002 but cautioned against making generalizations for the country based on these findings, as the size of the country and the dangerous security conditions made it impossible to survey more than two zones. JSI found that knowledge of the prevention of sexually transmitted infections, including HIV/AIDS is low. Condoms were rarely available, particularly in the East, and rape was used as a weapon of war by armed factions. HIV voluntary counselling and testing services were only available in a few locations, most blood for transfusions was not screened for HIV and the practice of universal precautions was unpredictable outside international NGO facilities. With the exception of HIV programmes for youth in Goma and Bukavu, reproductive health services for adolescents were generally not available. This is primarily because the public health system has been destroyed by years of neglect and conflict. Less than 1% of government expenditure is spent on health in government territory, and the rebel government in the East has no health budget. [41]

Eastern DRC, where the majority of IDPs live, is a chronic health emergency. The minimum standards for reproductive health are not being met. The Ministry of Health estimates approximately 5% HIV prevalence in the country. However, surveys of blood donors in the Eastern region show an HIV prevalence of approximately 20%, which *suggests* that HIV prevalence is higher in the rebel-controlled area of the country; much more data are needed to substantiate this claim as blood donor data are suffer from significant biases.[46] JSI reported that most facilities visited were using syndromic diagnosis and treatment of sexually transmitted infections. Few health facilities had condoms and none conducted Information, Education and Communication activities on AIDS.[41] The National AIDS Control Programme, 80% of health facilities that transfuse blood do not test donated blood for HIV, but NGOs health facilities do test for HIV. According to JSI, condoms are only available in the two family planning facilities. In Goma, all facilities use syndromic diagnosis of sexually transmitted infections, and condoms are not generally available in health facilities but are occasionally found in pharmacies.[41] GBV is a huge problem in the country, especially as the stigma of rape and domestic violence persists, preventing many women from seeking medical help and counselling. In such circumstances, the risk of contracting HIV may increase, though there are no data to corroborate this claim.

The DRC Ministry of Health has also conducted a two-part survey of the HIV situation in the country. In July 2003, sentinel surveillance was done in 7 urban and 2 rural sites in the West of the country; from January to May 2004 sentinel surveillance in 5 urban and 3 rural sites in the Eastern regions (Bukavu, Bunia, Goma, Karawa, Kindu, Kisangani, Lodja and Neisu), where the majority of IDPs live, was undertaken.[47] Results of the second study in the Eastern part of the country will soon be published, but there are no data to disaggregate between the general population and IDPs.

HIV serosurveys were also conducted in 2002 by a team of doctors in 4 major cities: Kinshasa, Mbuji-Mayi, Lumbumbashi (government-controlled areas) and Kisangani (under the control of rebel factions). Pregnant women, blood donors, sexually transmitted infection disease patients, commercial sex workers, as well as IDPs, were voluntarily tested. The IDP sample came solely from Kisangani (N=112), and had the highest HIV prevalence of all groups (7.1%). This finding suggests that IDPs may be

more at risk to HIV than the general population in DRC.[20] However, more information and data are needed before generalizations about IDPs can be made. There are no other HIV-specific seroprevalence data for the other IDP populations in DRC.

HIV/AIDS and IDP Situation:
The NSP 1998-2008[48] does mention IDPs and has specific activities for them, while the World Bank's MAP 2004-08[49] and GLIA 2005[14] also mention IDPs but do not state specific HIV activities. In contrast, the GFATM round 3 approved proposal with an HIV component for 2004-06[50] does not mention IDPs.

4. Liberia:

IDP Situation:
Internal displacement began in 1989 due to the civil war between Charles Taylor's National Patriotic Front of Liberia and Samuel Doe's regime. However, since August 2005, 203,000 IDPs have been assisted home, leaving approximately 111,000 IDPs in the country. The major cause of displacement has been attacks on towns and villages and major human rights abuses.[51]

HIV/AIDS Situation:
Liberia's adult HIV prevalence at the end of 2003 was 5.9%, with a low estimate of 2.7% and a high estimate of 12.4%.[52] However, there is no reliable information on the HIV prevalence for the country. No countrywide HIV sentinel surveillance system has yet been established. There are no HIV seroprevalence data for the IDP population.

HIV/AIDS and IDP Situation:
The NSP 2004-07 mentions IDPs and has specific activities listed for them. The World Bank's MAP does not have an HIV approved proposal for Liberia.[53] The GFATM round 2 approved proposal with an HIV component for 2004-06 does mention IDPs but has not list any specific activities.[54]

5. Nepal:

IDP Situation:
Since 1996, the Royal Nepalese Army has fought the Communist Part of Nepal (Maoist). While originating from the western heartlands of Nepal, the conflict has spread to nearly all of the 75 districts of the country. There have been no reports of a mass displacement strategy by either warring parties. Some 200,000-400,000 people have been displaced since the beginning of the conflict.[55] The most recent estimate by the Global IDP Project estimates 100,000-200,000 IDPs.[56] The far western regions of the country are less economically developed and are affected by the current insurgency, which explains why the highest number of IDPs comes from these districts. Families of the army are specifically targeted by the Maoists, but persons from the poorer strata of society are also affected by the ongoing conflict. Most displaced people flee rural areas for the safety to the urban areas or choose to cross into India for greater protection. Displacement has also occurred because of natural disasters, notably 37,000 families were displaced by flooding and landslides in

2004.[56] Trafficking and other forms of sexual exploitation and violence against women, some of whom may be IDPs, have been reported.

HIV/AIDS Situation:
Nepal's adult HIV prevalence at the end of 2003 was 0.5%, with a low estimate of 0.3% and a high estimate of 0.9%.[57] Nepal has moved from a low-level epidemic in the late 1990s to a country experiencing a concentrated epidemic, particularly among injecting drug users and female sex workers. The epidemic could worsen for several reasons: high rate of male migration, prostitution, poverty, low socio-economic status of women, and illicit trafficking; [57] UNAIDS and WHO does not categorise IDPs as a high-risk group in this report. Nepal has a lower HIV prevalence compared with other countries in South-East Asia.[55] However, the far Western regions, where the majority of IDPs are concentrated, have one of the highest rise in HIV rates in South Asia.[58] There are no HIV seroprevalence data for the IDP population.

HIV/AIDS and IDP Situation:
The NSP 2005-06[59] mentions IDPs and has specific activities listed for them. No mention of IDPs is made in the World Bank's CAS 2003-06,[17] or GFATM round 2 approved proposal with an HIV component 2004-05.[60]

6. Somalia:

IDP Situation:
Somalia population estimates range from 7 to 9 million people; it is difficult to quantify the precise number since the majority are nomadic livestock herders and subsistence farmers. The exact number of IDPs is also difficult to estimate as nearly all Somalis have been displaced by violence at least once in their lifetime.[61] There are multiple causes of displacement: outbreak of civil war in 1988, human rights abuses in Aideed-controlled areas during the late 1990s, clan-based competition over resources as well as a combination of conflict and climatic extremes. At the height of the conflict it was estimated that there were over 2 million IDPs; the latest estimate by the Global IDP Project is between 370,000 to 400,000 people internally displaced. The origin of most IDPs is the southern part of country, particularly inter-reverie areas (Bay, lower/middle Shabele, Bakol and Gado regions). The largest IDP communities, approximately 250,000 people, are situated in Mogadishu area and other southern urban centres. People tend to flee the urban areas to main towns, and IDPs often flee northwards where there is greater stability and security.[62]

HIV/AIDS Situation:
Reliable information on HIV prevalence in Somalia has been lacking due to the absence of a strong central government with a capable ministry of health to compile epidemiological data. The progression of HIV/AIDS cannot be effectively monitored without baseline data, and a lack of data hamper countrywide HIV activities. UNAIDS/WHO was unable to provide data in its epidemiological fact sheet on Somalia for 2004. However, a recent nationwide ANC sentinel surveillance report for 2004 by WHO in Somalia shows a national median prevalence of 0.9 % with 0.6% in the capital Mogadishu; this is significantly lower than neighbouring countries of Kenya (14%) and Ethiopia (10.6%).[18] The 2004 sentinel surveillance report did not disaggregate according to non-displaced and IDPs.

A Knowledge, Attitude, Practice and Behaviour (KAPB) survey in June 2004 conducted by the United Nations Children Fund showed that 67% of men and 57% of women had heard about HIV and that 80% of men and 71% of women knew about AIDS. There are, however, misconceptions about the ways HIV is transmitted.[63] Stigmatization and discrimination against people living with HIV/AIDS is also a problem; health workers are likely to discharge them from hospitals, and women are more likely to be divorced and separated from their children. Social exclusion, victimization and blame are also burdens to be shouldered by HIV/AIDS infected people.[61] There are no HIV seroprevalence data for the IDP population.

HIV/AIDS and IDP Situation:
The NSP 2005-06 mentions IDPs but does not state specific activities for them.[64] The World Bank's MAP has no HIV proposal approved for Somalia. The GFATM round 4 approved proposal with an HIV component for 2005-06 both mentions IDPs and has HIV activities for them.[65] No data exist on the HIV prevalence among IDPs. In a qualitative HIV survey among IDPs in Somalia in 2004, 73% stated that HIV was not a problem and none claimed to have ever seen anyone with AIDS.[61] In the same study, no HIV interventions were reported in the IDP camps surveyed; however, civil society representatives in the towns of Bossaso and Hargeisa reported HIV awareness raising campaigns.[61]

7. Sudan:

IDP Situation:
About 6 million people are internally displaced in Sudan; 1.8 million live in and around Khartoum, 1.84 million are in Greater Darfur, over 650,000 are in Bahr al Ghazal, and large scale displacements have taken place in Unity State/Western Upper Nile, Greater Equatoria, Eastern Sudan, Transition Areas and other Northern states of Sudan.[66] The causes of these displacements are multiple: deliberate action against civilians, conflict in Darfur that has displaced 2 million people since February 2003, oil exploration (1989-2004), human rights violations, LRA activities in Eastern Equatoria, conflict induced hunger in the Nuba Mountains area and South Kordofan (1987-2002), as well as abductions and enslavement of civilians.[67] The patterns of displacement illustrate a correlation between war strategies and chronic population drain from the South to the North, as well movement of people both within and outside oil-producing states. The displaced live in camps or in overcrowded squatter areas in the big towns. They live under difficult economic conditions and may use illegal practices including prostitution and making local beer to earn their living.[19]

HIV/AIDS Situation:
By the end of 2003, Sudan's overall HIV prevalence was estimated at 2.3% with a low estimate of 0.7% and a high estimate of 7.2%.[68] Three decades of conflict have resulted in relative isolation of the southern provinces of the country. Consequently, little is known about the epidemiology of HIV infection in the region.

Few data are available for IDPs in Southern Sudan. One study by the US Naval Medical Research Unit in 1994/05 in Juba attempted to study HIV among various subgroups of the population. However, the sample sizes of the subgroups were too small and the study too biased to allow for any conclusions to be made.[69]

The Ministry of Health also sought a more comprehensive HIV/AIDS strategic plan for 2003-07, and arranged in 2002 a nationwide survey consisting of two parts; the situation analysis, comprised of both behavioural and epidemiological studies, and the response analysis, which evaluated the level of commitment of government ministries, as well as international and local organizations. In June and July 2002, blood samples were tested for HIV from both women attending ANC clinics as well as high-risk groups defined as commercial sex workers, truck drivers, tea sellers, prisoners, university students, soldiers, street children, patients attending sexually transmitted infection clinics, tuberculosis patients, refugees and IDPs. The ANC sentinel surveillance covered 14 of the 26 states. Among the 3,355 ANC samples, the prevalence was 1.0% among the Sudanese non-displaced pregnant women (N=2,548), 1.0% among the IDP pregnant women (N=417) and 4.0% among refugee pregnant women living in the Eastern States (N=390). The IDPs came from Bahri, Kassala state, Khartoum, and Omdurman. The Sudanese National AIDS Control Programme (SNAP) explained the low HIV prevalence among IDPs by the fact that most of those surveyed lived in isolated camps outside cities and had little access to them. IDPs were also originally from the South (Upper Nile and Bahr El Ghazal states), which are known for their low prevalence. SNAP referred to the IDPs tribal origins as an additional influencing factor, as the Nilotic tribes are seen a conservative community.[19] SNAP also conducted a BSS among some of the populations surveyed, however, unlike for refugees, there were no data for IDPs.[19]

A 2003 population-based HIV sero-behavioural survey undertaken in post-conflict areas of Yei and Rumbek in Southern Sudan provides rare data on the region which has a high density of IDPs. The sample population came from the general population aged 15-49 years in Yei town and Rumbek town. Twenty-seven clusters from Yei and 30 clusters from Rumbek were selected and 1034 blood samples from Yei and 962 from Rumbek were tested for HIV. The HIV prevalence in Rumbek town was 0.4% while in Yei it was 2.7%; the HIV prevalence was significantly higher in Yei town (4.2%) than in rural areas outside of Yei town (0.7%) or in Rumbek town. Using a form of ANC sentinel surveillance in addition to the population-based survey, the HIV prevalence was found to be 2.3% among pregnant women *both* in the towns of Rumbek and Yei. The area was heavily affected by conflict in the late 1990s, when the Sudan People's Liberation Army succeeded in recapturing both towns in March 1997. Consequently, at one point in time, 20% of the population in Rumbek and 45% of the population in Yei had been internally displaced within Southern Sudan due to the war.[70] However, the sample size was too small to calculate the HIV prevalence for IDPs, and target groups selected for further testing were comprised only of pregnant women and STI patients in Yei and soldiers in both towns.

<u>HIV/AIDS and IDP Situation:</u>
The NSP 2003-07 mentions IDPs but has no activities for them.[71] The World Bank MAP has no HIV approved proposal for Sudan. The GFATM round 3 approved proposal with an HIV component for 2005-06[72] does not mention IDPs. By contrast, the GFATM round 4 proposal for 2005-07[73] mentions IDPs and has listed specific programmes for them. As mentioned above, the 2002 SNAP report estimates 1% of HIV prevalence among IDPs.[19]

8. Uganda:

IDP Situation:
The Global IDP Project estimates 2 million IDPs in Uganda; 16,000 children in 20 night commuter centres in Gulu, and approximately 18,000 children abducted throughout the conflict.[74] It is difficult to know exactly where the displaced have settled, especially as rebels routinely burn settlements to discourage IDPs from living in camps. Displacement in Uganda is occurring in several districts simultaneously. In the Teso region, inter- and extra- communal violence among the Karamajong has caused displacement. In the West, displacement is related to the Allied Democratic Forces' actions against civilians.[75] Acholiland, consisting of Gulu, Kitgum and Pader districts, is the most severely affected part of the conflict in Northern Uganda, with 1.3 million displaced people, which represents 90% of the population.[76] IDPs in Acholiland are experiencing a severe humanitarian emergency with mortality rates in excess of emergency thresholds, especially in Kitgum and Pader. Conflict, insecurity and displacement are ongoing. The minimum basic services for IDPs are not being met. Water and latrine provision is inadequate, most people die outside of health facilities, and there is low bed net coverage and measles vaccination coverage is borderline.[76] Widespread abduction and rape of women and children has been reported.

HIV Situation:
By the end of 2003, Uganda's overall HIV prevalence was estimated at 4.1% with a low estimate of 2.8% and a high estimate of 6.6%.[77] Surveillance activities in Uganda have demonstrated a decline in HIV prevalence in the 1990s but the magnitude of the epidemic remains an enormous challenge for the country.

The Ugandan Aids Control Programme began sentinel surveillance in Acholiland by opening a site in Lacor hospital in Gulu in 1993. Data show a steady decline in HIV prevalence over the last decade; in 1993, ANC sentinel surveillance showed an HIV prevalence of 26%, in 1997 16.2%, in 2001 11.3% and in 2002 11.9%.[78] The Ugandan Ministry of Health's STD/HIV/AIDS Surveillance Report in 2003 collected data from 56 districts in the country using 19 sentinel surveillance sites; HIV prevalence rates varied greatly in the country. In 2002, 1.3% prevalence at Nebbi was the lowest recorded prevalence and 11.9% at Lacor was the highest. The median HIV prevalence for all sites was 5.0% in 2002 compared with 5.4% in 2001 and 5.2% in 2000.[79] Despite the data trends discussed above, World Vision published a report on Northern Uganda in 2004 that erroneously claimed that the HIV infection rates were soaring among the persons in the war-affected areas, including IDPs.[80] There are no HIV seroprevalence data for the IDP population in Northern Uganda.

HIV/AIDS and IDP Situation:
In 2005, a WHO team conducted a health and mortality survey in Northern Uganda. 3,830 households in Gulu, Kitgum and Pader districts were interviewed. AIDS was the 2nd leading cause of death after malaria and fever; these are self reported causes of death and thus some biases exist. WHO also found that crude mortality rates in the Acholi region were well above the emergency threshold of 1 death per 10,000 deaths per day. In discussing the causes of excess mortality among IDPs, the survey attributed it to the high level of violence (especially in Kitgum and Pader), overcrowding and poor camp conditions, and barriers to health service access and malnutrition.[76]

SECTION III: Media Coverage of HIV and IDPs

Executive Summary

There have been numerous biased and misleading reports by the media on HIV/AIDS and IDPs. Sweeping generalizations are often made with insufficient data. Reports make claims about the spread of HIV among IDPs in Burundi, Colombia, DRC, Liberia, Nepal, Somalia and Uganda despite the fact that HIV prevalence has never been measured in these populations. News coverage on the HIV situation in Sudan has attempted to provide a more balanced and informed account of the reality of the ground, yet no mention was made that the 1% HIV prevalence among IDPs was the same as the general non-displaced Sudanese population in 2002. Such information could help to quell growing fears that IDPs are responsible for spreading HIV in the country; a claim which remains groundless.

Reporters are held to the Declaration of Principles on the Conduct of Journalists that sets standards for ethical reporting. The media must constantly remember that its words can and will have a direct impact on the lives of IDPs around the world. Incorrect or misleading reporting will increase stigma among an already discriminated and marginalized population. To ensure accurate and unbiased reporting, humanitarian organizations must ensure that the information and data on which they report are valid and clearly explained to reduce the chance of misinterpretation. It would be helpful if journalists increase their knowledge of the HIV epidemic and have HIV/AIDS experts working with displaced populations review their conclusions before articles go to print. Such precautions may ensure less biased and more accurate reporting that may ultimately reduce the unfounded HIV discrimination against IDPs.

Introduction

Media coverage of HIV and IDPs varies enormously in quality and quantity. The situations in DRC, Sudan and Uganda have received far more press attention than those in Burundi, Colombia, Liberia and Nepal. Media outlets feed off one another's stories and recycle 'facts' about HIV/AIDS and displaced people without verifying sources. The inaccurate and misleading story by Muleme on Northern Uganda illustrates this trend well.[81] The article was first released by Associated Press, and then was fed into other news outlets that included The New York Times, The Washington Post and the Boston Globe. Allegations are often made suggesting that HIV prevalence among IDPs is higher than among the general population. This assumption is related to the supposition that war fuels the HIV/AIDS epidemic. However, these hypotheses are rarely accompanied by data that support these claims. This paper seeks to illustrate how IDPs can be wrongly portrayed in reports and media articles. Errors of this kind not only reinforce discrimination and stigmatization against this vulnerable group of people but also make it evident that research on HIV prevalence among IDPs is necessary to prevent such allegations and speculations in the future.

A recent article on AIDS, conflict and the media in Africa discusses the International Federation of Journalists' Declaration of Principles on the Conduct of Journalists.[82] The article expounds upon the professional conduct for journalists engaged in gathering, transmitting, disseminating and commenting on news and information in

describing events. The authors provide four recommendations: firstly, avoid stigmatizing statements and ensure a balance view; secondly, avoid accurate but misleading statements; thirdly, avoid inaccurate statements by clearly stating sources and verifying their credibility; and fourthly, do not continuously repeat data and conclusions from other news sources without checking for accuracy.[82]

The following discussion focuses on recent media articles on HIV and IDPs in the 8 OCHA priority countries. A Millennium Group Task Force on HIV/AIDS explained that HIV/AIDS stigma is increasingly recognised as an important human rights issue and a central impediment to prevention and treatment. Stigma not only increases the suffering of people living with HIV/AIDS, but may also result in rejection by the family or community, loss of employment or access to education and social services, and violence. Fear of discrimination and marginalization make people, including IDPs, reluctant to be tested, counselled, treated or reveal their illness to their partners and peers.[83] Reporters have a duty to inform people in a manner that is ethical and respectful to the human dignity of all.

DRC

"The brutality of rape causes serious physical injuries that require long-term and complex treatment. There is a massive increase in sexually transmitted diseases (STD) including syphilis, gonorrhoea and HIV/Aids. Accurate statistics about the prevalence of HIV/Aids are unavailable. According to the National AIDS Program the rate may have reached over 20 per cent in the eastern provinces and could threaten more than half of the population within the next ten years."[84]

Source: Amnesty International, Oct 26, 2004.

The media, health care practitioners and advocacy groups are doing a good job in denouncing human rights violations in DRC. But these groups have failed to indicate clearly and systematically that the Eastern part of the country currently lacks HIV data. Thus, one can only speculate about how the atrocities are affecting the spread of HIV among the population. Although the fears of HIV spreading in DRC as a result of systemic rape in the East are highly alarming, sweeping generalizations must be avoided as the HIV/AIDS stigma risks marginalizing people, like IDPs, from the rest of society. The citations in the box above illustrate the problem. The report from the recent HIV sentinel surveillance in the Eastern part of the country is needed to help us better understand and react to this horrific situation. Misleading and inaccurate reporting on the alarming spread of HIV in the Eastern part of DRC only risks jeopardizing the security of IDPs.

Nepal

Headline: "Conflict Fuels HIV/AIDS Crisis"

Source: The Telegraph (Weekly), Nepal, July 28, 2004.

Despite a well written and balanced article, the headline is misleading and clearly states that conflict fuels the HIV/AIDS crisis in Nepal. However, the doctor quoted numerous times in the article clearly states that conflicts "greatly increase the *risk* of HIV transmission". This point is quite distinct from an actual increase in HIV transmission as there are competing factors for increasing and decreasing HIV transmission in conflict that must be evaluated according to the context of each emergency.[85]

Sudan

"The fact that many Sudanese will return to their homes from countries where the HIV/AIDS prevalence is very high, will doubtless increase the likelihood of a further spread of the epidemic." [86]

"Infection rates are particularly high among vulnerable groups, such as internally displaced persons (IDPs) and refugees." [86]

"Data from the mid-1990s onwards suggested the infection rates had risen rapidly in the conflict-affected areas of southern and western Sudan. According to a national prevalence and behaviour survey conducted in 2002, HIV prevalence was already four percent among pregnant women attending clinics in refugee camps." [86]

Source: Integrated Regional Information Networks, Sept 6, 2005.

Sudan has been in the media spotlight for several months now due to the conflict in Darfur and the recent ceasefire signed between the Islamic government in the north and the rebel factions in the predominantly Christian and animist south. The large number of IDPs and the alleged human rights violations in the country have led to numerous press articles on HIV among IDPs.[66] However little is known about the epidemiology of HIV infection in the country. Articles report basic and often baseless generalizations such as the "war fuels HIV/AIDS", "IDPs are more vulnerable to infection", and "HIV prevalence among IDPs is higher than the rest of the population".[86] None of the articles mentioned the SNAP report that estimates a 1% HIV prevalence among IDPs, which is comparable to the 1% prevalence rate found among non-displaced Sudanese.[19]

The Integrated Regional Information Networks (IRIN) initially reported what some experts felt was a biased and inaccurate article on HIV among refugees and IDPs in Southern Sudan. After discussion, IRIN pulled the original article from their website and added a revised version that took into account the views of a wider range of experts that provided readers with a more balanced and nuanced article.[86] Future media coverage may seek to emulate this type of reporting, which provided a more analytical and detailed account of the difficult and highly context-specific situations

of HIV among IDPs and refugees. The media should also seek to verify data quoted by other reports rather than just repeating them verbatim and seek out other sources of data. Sudan is one of the only countries to have HIV prevalence among IDPs available, and it should have been included in the original article on HIV in Sudan.

Uganda

"The rate of HIV/AIDS infection in northern Uganda is nearly double that in the rest of the country…"[81]
Source: Associated Press, Sept 27, 2004

"About half the girls who escape from the rebels are found to be HIV positive, doctors say."[87]
Source: BBC, Sept 27, 2004

[AIDS is the] "leading cause for death, constituting 69% of deaths in Gulu area, or three times higher than direct killings during military confrontation."[80]

"Very little work has been done in the north because it is so unsafe, despite Gulu province in the north possibly having the highest prevalence rate of HIV/AIDS. It is feared that rates amongst the LRA, the army and displaced people are higher still."[88]
Source: Avert, Sept 16, 2005.

"In spite of the national decrease in HIV/AIDS, prevalence rates are actually on the rise in conflict areas, most notably in Gulu, the largest and most populated of the war-affected northern districts. Rates in this area were almost double the national average. If the conflict continues to spread further south and east, and a culture of war and displacement begins to take root, HIV prevalence rates are likely to rise elsewhere, and Uganda will lose many of the gains that the country has worked hard to achieve."[80]
Source: World Vision, 2004.

Uganda, unlike most other countries in sub-Saharan Africa, was considered until recently a glowing example of how to curb the HIV/AIDS epidemic. The country has been repeatedly used as a case study for other countries burdened by the spread of the disease. At the same time, an ongoing conflict persists in the northern part of the country between government forces and the LRA. There are an estimated 1.3 million people living in the war-affected region of the country, some 90% of the population.[76] National HIV prevalence is estimated to be 4.1% with a low estimate of 2.8% and a high estimate of 6.6%.[77]

Uganda is a good example of how the media outlets publish 'facts' about HIV/AIDS and IDPs without properly interpreting or verifying the data. World Vision published a report on Northern Uganda in 2004 that erroneously claimed that the HIV infection rates were soaring among the persons in the war-affected areas, including IDPs.[80] These incorrect statements were repeated by the international and local media. No one mentioned that the Ugandan AIDS Programme data demonstrates a large drop in HIV prevalence in Gulu, northern Uganda from 26% in 1993 to 11.9% in 2002. HIV prevalence has reduced dramatically in Gulu district despite the ongoing 19 year old

conflict. Such reporting is not only false but also dangerous for displaced persons. Perceived HIV status, regardless of one's actual status, carries with it a stigma that can destroy individuals, their families and even communities.[82]

Burundi, Colombia, Liberia and Somalia

In contrast with the other countries, there are no recent media articles written in English, French or Spanish on HIV/AIDS and IDPs in Burundi, Colombia, Liberia and Somalia that we could find. This observation is not too surprising, as the media tend to write articles on reports by NGOs and UN agencies; as there is little literature on the subject of HIV/AIDS and IDPs, there are few publications, and even fewer media articles. Ongoing conflicts, lack of funding, and difficulties in field research explain in part why there is a lack of data on HIV prevalence among IDPs.

Conclusion

Media coverage must become more attentive to the portrayal of IDPs in the news. Reports that allege high HIV prevalence among IDPs should be thoroughly reviewed and readers reminded how complex, difficult and dangerous these situations are to gather unbiased data. There are no HIV prevalence data on IDPs except in Sudan and one part of DRC, therefore any claims are speculative and should be prefaced as such or avoided altogether. Sensational claims cause IDPs to suffer from stigma and discrimination. Given the precarious living conditions of IDPs, recommendations to improve the reporting on HIV among IDPs include having humanitarian agencies verifying their data against biases and ensuring proper conclusions before releasing any information to the press as well as having technical experts reviewing articles before they go to press. Additionally, specific training on epidemiology and ethics of reporting on HIV/AIDS could be made available to reporters and editors.[82] Poor media reporting using faulty data risks aggravating an already difficult situation for IDPs. Negative consequences include heightening xenophobic fears among the general population and imposing mandatory HIV testing of IDPs by authorities. Bad media reporting can also pose serious obstacles to reintegration and reconciliation in any particular community.[82]

Overall Essential Factors and Recommendations

The recommendations from this paper are based on **Essential Factors** regarding HIV and displacement and the **10 Objectives** of UNHCR's HIV and Refugees Strategic Plan for 2005-2007.[1]

Essential Factors for HIV and IDPs must be considered when implementing the recommendations. These include:

1. IDPs are a **unique group** often with special needs. Consequently, specific HIV policies and interventions need to be developed that may vary from those for other persons in resource-poor settings. For example:
   - Many IDPs have suffered trauma and violence, including sexual violence, during conflict and flight. In addition, traditional community support structures are often destroyed during displacement. Thus, there are a variety of psycho-social issues in refugee populations which may not exist in more stable communities;
   - Unique opportunities for prevention, support and care may exist in IDP situations that are uncommon in other situations (e.g. information-education-communication materials during food distribution or supplementary feeding programmes, at transits centres during repatriation, and during registration).
   - Some IDPs wish to remain anonymous for a myriad of reasons including security concerns. It is a challenge for them to access HIV interventions and for the humanitarian community to deliver such services in a manner that does not put them or their families into danger. This is particularly true for IDPs living in non-camp situations.

   However, in many ways, IDP communities are similar to other communities worldwide, including the existence of "core" groups that can spread HIV to the broader IDP and surrounding host communities. Therefore, among the IDP population, specific HIV interventions should also be made available for commercial sex workers, intravenous drug users, and men having sex with men in an accessible manner that does not expose them to discrimination.

2. HIV and AIDS constitute not just a health issue but a problem that affects the socio-cultural fabric, human rights and long-term economic well-being of IDPs as well as the local population with which they interact. Thus, well-coordinated **multi-sectoral and multi-partner approaches** are critical to an effective HIV and AIDS programme. HIV and AIDS interventions must not be implemented in a parallel fashion, but be integrated within and complementary to existing programmes (e.g. health, protection, community services, and education). It is essential to work in close partnership with IDPs and their host communities, and with various national, sub-regional, regional and international actors (e.g. governments, United Nations agencies, international organizations, international and local non-governmental organizations, multilateral and bilateral institutions, religious institutions, and the private sector). All of this must be closely coordinated with the IASC humanitarian reform process that is currently being undertaken.

3. Implementation of HIV and AIDS programmes in **emergency situations** is essential. Policies and interventions must begin at the onset of a crisis and continue throughout the displacement cycle; such HIV programmes in emergency

settings will be guided by the strategies and priorities set forth in the IASC guidelines.[2]

4. IDPs and their host communities generally interact closely and HIV programmes should be established that take into account this interaction. Thus, **integrated HIV programmes** that follow host government protocols, guidelines, and strategic plans should be implemented while parallel programmes should be avoided.

5. **Women and girls** are more susceptible to HIV due to gender discrimination and violence, biology, insufficient access to HIV prevention information and services, inability to negotiate safer sex, and lack of female-controlled HIV prevention methods. AIDS is affecting women most severely in places where heterosexual sex is a dominant mode of HIV transmission, as is the case in sub-Saharan Africa and the Caribbean. Adult women in sub-Saharan Africa are up to 1.3 times more likely to be infected with HIV than their male counterparts; this inequality is greatest among young women aged 15–24 years, who are approximately three times more likely to be infected than young men of the same age. Furthermore, women are more likely to take in orphans, provide home-based care, cultivate crops and seek other forms of income to sustain their families. The above factors may be more pronounced among IDP women and girls due to their vulnerability to sexual exploitation and violence throughout the displacement cycle. Policies and programmes must be prioritised and tailored to their needs as well as to the elderly who also have an increased burden.

6. **Young people**, aged 10-14 years, are at the centre of the epidemic. They are vulnerable to contracting HIV when they become sexually active due to socio-cultural, psycho-social and emotional factors. They may have insufficient information and understanding about HIV, they may display risky behaviour such as having consecutive and short-term sexual relationships, and they may lack access to the means to protect themselves. In some regions, intravenous drug use is spreading at an alarming rate among young people. These factors are enhanced among young IDPs who have been exposed to situations of conflict and displacement.

7. **Unaccompanied children, orphans and other children affected by HIV and AIDS** may experience economic hardship and psychosocial distress, suffer from increased malnutrition and illnesses, and may have a higher withdrawal rate from school than other children. These factors are enhanced among IDP children who have often fled from war, and may have lost one or both parents or been sexually exploited or violated. Early identification of IDP children made vulnerable by HIV and AIDS is critical in order to provide necessary support and to initiate family tracing and family reunification processes.

8. Policies and HIV interventions for **urban IDPs** can be more complicated because they are diverse groups who often live in widely dispersed areas, making them difficult to locate and access. Unlike IDPs living in camps, the type, level and cost of services provided to urban IDPs are not standardised and may vary considerably. HIV-related support and services for those who are not yet self-reliant should be provided through support, where necessary, to national health and education services and not by the creation of parallel structures and special

services for IDPs. However, as mentioned above, some IDPs may wish to remain anonymous and thus providing services to this group is complicated and must be done in a confidential and subtle manner, possibly without government support.

9. IDPs returning to their homes may have lower, higher, or equal HIV prevalence to those who never left. For those IDPs who have been exposed to HIV programmes supported by NGOs and UN agencies, their knowledge of HIV may be higher and their behaviour less risky than those who were non-displaced. Furthermore, IDPs may have acquired important and valuable HIV-related skills that can be used when they return home (e.g. those involved in providing camp-based health care and education). UNHCR and OCHA should play a key role in ensuring continuity between IDPs who return home and those who never left. Overall, HIV policies and programmes need to be directed towards all persons in the area of return and not solely for returnees in order to avoid stigma and discrimination and to have a broader effect.

The **10 Objectives** of the strategy, which relate to refugees and other persons of concern to UNHCR, are:

1. **Protection -** to ensure that refugees, asylum-seekers and other persons of concern who are affected by HIV and AIDS can live in dignity, free from discrimination, and that their human rights are respected, including their non-discriminatory enjoyment of the highest attainable standard of physical and mental health.
2. **Coordination and Mainstreaming -** to ensure that HIV policies and interventions for refugees are coordinated, mainstreamed and integrated with those at the international, regional, subregional, country and organizational levels.
3. **Durable Solutions** -to develop and incorporate HIV policies and interventions into UNHCR's programmes for durable solutions, including voluntary repatriation, local integration and resettlement, in order to mitigate the long term effects of HIV.
4. **Advocacy -** to advocate for HIV-related protection, policy and programme integration, and subregional initiatives for refugees, and other persons of concern in a consistent and sustained manner at all levels.
5. **Quality HIV Programming -** to ensure appropriate, integrated HIV interventions for refugees, IDPs, returnees and other persons of concern, in concert with national programmes in host countries and countries of return.
6. **Prevention -** to reduce HIV transmission and HIV morbidity through the implementation of culturally and linguistically appropriate health and community-based interventions.
7. **Support, Care and Treatment -** to reduce HIV morbidity and mortality; this includes access to antiretroviral therapy when available to surrounding host populations when appropriate.
8. **Assessment, Surveillance, Monitoring and Evaluation -** to improve programme implementation and evaluation.
9. **Training and Capacity Building -** to improve HIV related skills and capacities of UNHCR, its partners, refugees, and other persons of concern.
10. **Resource Mobilisation -** to increase funds and move beyond traditional donors to ensure the objectives stated in this strategic plan are achieved.

The recommendations from this paper are based on the 10 objectives of UNHCR's HIV and Refugees Strategic Plan for 2005-2007. They are based on UNHCR's mandate and role as cluster lead for protection, shelter, and camp coordination and management among conflict-affected population according to the recent IASC humanitarian reform process. The recommendations are also based on OCHA's mandate to coordinate humanitarian response, policy development and humanitarian advocacy.

1. **Protection**
   IDPs are often an oppressed minority group within a country who lack security and protection. HIV/AIDS is fundamentally linked to protection; UNHCR should include an HIV component in all of its protection policies and programmes at the global, regional and country levels. In its coordinating role, OCHA should ensure that no gaps regarding HIV/AIDS and protection occur and that such programmes are implemented in a complementary fashion.

2. **Coordination and Mainstreaming**
   OCHA will have a major role in coordinating the various HIV programmes in IDP situations. This coordination must occur in close collaboration with UNHCR and other UN agencies, governments and NGOs.

3. **Durable Solutions**
   IDPs should be able to return home and live in peace and dignity. Strong coordination and communication among all agencies providing HIV/AIDS programmes to IDPs need to occur when IDPs return to their area of origin. Issues such as continuation of antiretroviral treatment (ART), utilisation of HIV skills that IDPs may have learned while being displaced, and other important matters must be coordinated. Local integration is another possibility.

4. **Advocacy**
   As this paper clearly shows, advocacy is needed at the global, regional and country level to ensure that IDPs are included in their countries' HIV national strategic plans and proposals. Since UNHCR became a cosponsor of UNAIDS in June 2004, refugees and IDPs have systematically been included in new global policies, such as UNAIDS prevention policy paper and the new HIV and EDUCAIDS - The Global Initiative on Education and HIV/AIDS. However, a concerted effort at the country level, through the HIV/AIDS UN Theme groups needs to be undertaken. Countries who have specifically received HIV funds for IDPs (see section I of the paper) need to report on what has actually been implemented; priority countries that have not included IDPs in their proposals must see if some funds can be redirected to IDPs. All future HIV proposals (as well as other proposals from countries with IDPs) should include a specific component for IDPs. A campaign to advocate for inclusion of IDPs in country HIV programmes must also be directed at major donors. As section III shows, the media has published biased and discriminatory reports in some IDP situations. UN country theme groups as well as UNHCR and OCHA should monitor HIV and IDP media articles to ensure accurate and unbiased reporting occurs; they should respond accordingly when it does not. The same concept applies when UN agencies, governments and NGOs release reports on HIV and IDPs. Finally, as is currently done by UNHCR with media articles relating to HIV and refugees, a

group of individuals or organizations should be established to monitor how the media reports on HIV and IDPs and to respond accordingly.

5. **Quality HIV Programming**
   UNHCR and other UN cosponsors must ensure appropriate and integrated HIV interventions for IDPs occur in concert with national programmes. Minimum essential services as outlined in the IASC guidelines for HIV/AIDS interventions in emergency settings must be implemented. A similar level and quality of services as those received by surrounding host communities must be assured. Section II, clearly illustrates that there is insufficient information on IDP and HIV programmes to provide a clear picture of their needs and the gaps. A recent report in Northern Uganda reports that basic HIV services are lacking for IDPs. A comprehensive HIV/AIDS needs assessment, combined with assessments from other sectors in a multi-sectoral fashion, is needed in all 8 IDP priority countries.

6. **Prevention**
   The same points as for recommendation 5.

7. **Support, Care and Treatment**
   The same points as for recommendation 5. As antiretroviral therapy (ART) becomes available to IDP surrounding host communities, we must ensure that IDPs also have access.

8. **Assessment, Surveillance, Monitoring and Evaluation**
   Sections II and III clearly show a lack of data on HIV and IDP situations. As mentioned in recommendation 5, a comprehensive multi-sectoral assessment should occur in all 8 IDP priority countries. Baseline data must be collected to allow for monitoring and evaluation of HIV interventions over time. In countries undertaking HIV sentinel surveillance or population-based HIV biological and/or behavioural surveys, sample size should provide sufficient power to disaggregate between IDPs and non-displaced populations, as well as gender and age.

9. **Training and Capacity Building**
   During the multi-sectoral assessments of the countries, a component on HIV-related skills and capacities of UN agencies, its partners, and IDPs should be included. Given the limited information we have, it is likely that training and capacity building will be a major component of all HIV and IDP proposals and interventions.

10. **Resource Mobilisation**
    Section I shows that specific HIV activities for IDPs are often not included in their countries' approved HIV proposals. Thus, there will be a need for significant resource mobilisation. For the most part, this should be at the country level in an integrated fashion with existing country programmes. However, at the initial stages, specific earmarked funding for HIV and IDPs may be necessary to fill the gap until advocacy among governments, UN agencies, donors, NGOs and others ensure that IDPs are covered under country programmes.

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