Report

First Global Consultation on HIV and Internally Displaced Persons

Presentations

24 and 25 April 2007
Presentations

HIV and IDP overview

Session 1. HIV and IDP Assessment Tool
HIV and IDP assessment Tool
Nepal
Cote d'Ivoire
Democratic Republic of Congo

Session 2 and 5. HIV programmes for IDPs
Uganda
Democratic Republic of Congo
Eastern Europe
Zimbabwe
Colombia
Myanmar
Overview of HIV among Internally Displaced Persons (IDPs)

1st Global Consultation on HIV and IDPs
Paul Spiegel, UNHCR
24 April 2007

Objectives and Outcomes

Objectives:
1. Review current concepts and knowledge on HIV and IDPs
2. Document current HIV and IDP assessment tools and programmes
3. Chart future needs and action

Expected Outcomes:
1. Consensus on an HIV and IDP needs assessment tool for high and low HIV prevalence settings
2. Documentation of lessons learned from field
3. Plan of future action

Background

- Insufficient knowledge about HIV among IDPs
  - Vulnerabilities, risks, transmission, interventions
  - Misinterpretation of data and unsubstantiated rumours
    “The rate of HIV/AIDS infection in northern Uganda is nearly double that in the rest of the country…”
    Source: Associated Press, Sept 27, 2004
    “About half the girls who escape from the rebels are found to be HIV positive, doctors say.”
    Source: BBC, Sept 27, 2004
- Numerous actors, programmes and reports
- Humanitarian reform process/cluster approach
- (Re)formation of IASC task force
- Upcoming framework paper
- UNHCR lead org. for HIV among displaced persons

Displacement Cycle

HIV and Conflict

HIV Prevalence by Asylum Country and Country of Origin by Region, 2004

**HIV Risk Factors for Conflict-Affected Populations**

**Key Factors**
- Area of origin HIV prevalence
- Surrounding host population (pop.) HIV prevalence
- Level of interaction bw DP and surr. host pop.
- Type and location of DP env. (e.g. urban vs. camp)
- Phase of emergency
- Length of time; conflict, existence of camp

**Increased Risk**
- Behavioural change
- Gender violence/transactional sex
- Reduction in resources and services (e.g. health, education, community services, protection, food)

**Decreased Risk**
- Reduction in mobility
- Reduction in accessibility
- Slowing down of urbanisation
- Increase in resources and services in host country

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**Inclusion and Integration**

- Lack of integration and inclusion of IDPs in countries plans and proposals (2005)
  - 18% of key countries with ≥5,000 IDPs included specific activities in National Strategic Plans (N=56)
  - 13% for Global Fund proposals (N=91; all rds)
- Need for concerted advocacy

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**HIV and IDP Data**

1. Little reliable data on HIV prevalence among IDPs alone
   - Sudan and DRC have some data that need to be examined
2. Some repro. health/HIV assessments but few behavioural surveillance surveys specifically among IDPs identified
3. Need to undertake IDP-specific behav. and bio. population-based surveys
   - To target interventions and measure effectiveness
   - Data will allow us to advocate for IDPs
4. Assessments and surveys in IDP-affected areas should have sufficient sample size to allow for disaggregation

---

**HIV and IDP Interventions**

1. Country and context-specific
   - Often politically sensitive
2. Not comprehensive
3. Sometimes integrated with surrounding communities
4. Not necessarily take into account specific vulnerabilities of IDPs
   - Lack livelihoods, SGBV, coping mechanisms
5. Not often plan for return

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**Multi-Country HIV/AIDS Program (MAP) for Africa 2005**

<table>
<thead>
<tr>
<th>Country</th>
<th>No. of IDPs</th>
<th>HIV Prevalence</th>
<th>Activities</th>
<th>Inclusion and Integration</th>
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<tbody>
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<td>2,130,000</td>
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<td>2005-2006</td>
<td>Yes</td>
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<tr>
<td>Somalia</td>
<td>2,000,000</td>
<td>0.0 - 0.1%</td>
<td>2005-2006</td>
<td>Yes</td>
</tr>
<tr>
<td>Uganda</td>
<td>1,900,000</td>
<td>0.0 - 0.1%</td>
<td>2005-2006</td>
<td>Yes</td>
</tr>
</tbody>
</table>

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**HIV Behav. and Bio. Surveys and Assessments 2007**

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5. Not often plan for return
Key Issues

- Protection, human rights, SGBV
- Coordination
- Inclusion and integration
- Modification of policies, strategies and progr. from other emergency affected pop.
- Urban, dispersed vs. camp-like situations
- Underground/difficult to access (e.g. like IVDUs)
- Directed to IDPs/returnees directly or to surrounding populations/all persons in areas of return
- Advocacy
- Resource mobilisation
First Global Consultation Meeting on HIV and IDPs

Situational analyses and assessments

Dr M Carael, consultant

24-25 April 2007
Geneva

Vulnerability factors for IDPs and affected populations

- Poverty
- Nutrition/food security
- Education
- Health
- Violence, abduction
- Insecurity, isolation
- Disruption of families
- Domestic labor
- Others

Risk factors for HIV

- Norms of sexual and reproductive behaviors
- Unprotected casual sex, commercial sex, multiple partners, sexual networks
- Injecting drug use and sharing equipment
- Blood safety & universal precautions

Protection factors and program responses

- Social networks, support structures
- Access to information and services (VCT, STIs care and treatment)
- Access to means of protection (condoms, lubricants, clean needles and syringes, safe blood)

Challenges of conducting HIV situation assessment of IDPs

- Multiple topics to be investigated
- Multiple sites
- Context and socio-economic factors may be critical
- Population often with no “sampling frame”
- Lack of quantitative data
- The assessment needs to be quick
- Assessment team may include researchers & non-researchers, multiple disciplines

How to decide which method?

- What are the public health questions?
- What stage of program development or implementation are you in?
- What are the resources?
- How much time do you have?
Rapid Assessment Procedures (RAP)?

- A “Packaged” set of quantitative and qualitative research methods
- Field notes are data, in addition to quantitative data
- to be applied in a short-term focused research
- May include researchers and non-researchers, working in teams

Pros and Cons of RAP

**Pros**
- Many samples improve coverage & reliability of findings
- Can collect quantitative & qualitative data
- Participation is a development benefit all by itself
- Data collection process is flexible & dynamic

**Cons**
- Harder to harmonize
- Data management more problematic due to various sample sizes
- Harder to analyze because of quantity of data
- Less “scientific”

Draft tools for District assessment

<table>
<thead>
<tr>
<th>Draft tools for District assessment</th>
<th>District assessment tool*</th>
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<tbody>
<tr>
<td>1. A district assessment tool</td>
<td>General district information</td>
</tr>
<tr>
<td>2. Semi-structured observations</td>
<td>Inventory of actors and coordination mechanisms</td>
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<tr>
<td>3. Semi-structured interviews</td>
<td>Protection programs in place</td>
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<td>4. Semi-structured interviews</td>
<td>HIV prevention, care and treatment</td>
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<tr>
<td>5. Focus groups</td>
<td>HIV surveillance and M&amp;E</td>
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<tr>
<td></td>
<td>* Adapted from refugees tool</td>
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</tbody>
</table>

District assessment tool*

- General district information
- Inventory of actors and coordination mechanisms
- Protection programs in place
- HIV prevention, care and treatment
- HIV surveillance and M&E

8-10 Semi-structured interviews with key informants-

- District officials
- Community leaders, teachers, health providers,
- Young people leaders
- Uniformed services
- Service providers

15-20 semi-structured interviews with IDPs, most at risk & conflict-affected men and women

- IDPs
- Migrants
- Injecting drug users
- Sex workers
- PLWHA
- Widows
- Working children
Four to six focus groups

• Categories of respondents such as IDP, migrants and young people
• 3 groups with women, 3 with men
• Similar age group
• 8 to 10 participants each
• Duration of 90 minutes
• Participants selected by local NGOs

Lessons learned (1)
Misconceptions About RAP

• You need to count what each person says
• More data is (always) better
• More informants are (always) better
• Not conducting the analysis at the same time as data collection
• Not cross checking and triangulating across different sources, on the same issue

Lessons learned (2)
Feedback to data collectors

• Feedback needs to be regular, as frequent as possible
  • Evening meetings
• Should be a reciprocal process between team members
• Should include summarizing themes, and exploring concepts in greater depth

First conclusions on tools
after one field test

• The draft tools seemed quite robust over sites
• The “district assessment tool” suffered from the lack of data
• Long term versus short term IDPs
• Guidance needed on ethical issues: informed consent, working children, compensation for interview, donations
• Are the tools relevant outside low HIV prevalence countries?
HIV and Conflict Assessment Nepal

Global HIV and IDP Consultation
24th April 2007

Pratap Kumar Pathak
Joint Secretary
Ministry of Home Affairs
Government of Nepal

Ann Burton
Senior Regional HIV/AIDS Coordinator
UNHCR

Outline

1. Background
2. HIV Situation
3. Assessment tool development
4. Analysis
5. Main findings and recommendations
6. Next steps

Background

- Over 12,000 dead and reportedly >200,000 displaced
- Attacks on local government officials, police, professionals, main landowners and members of other political parties
- Escalation in 2001 and renewed displacement to:
  - Urban centres
  - Large cities of Kathmandu, Biratnagar and Nepalgunj
  - Across the border to India
- By now displacement had also started to affect the general population

HIV Situation in Nepal

- Concentrated epidemic among populations at higher risk
- General population prevalence estimated at 0.55%
- 2005 surveys estimated HIV prevalence:
  - 2% among sex workers in the Kathmandu and Pokhara valleys
  - IDUs 51.7% in the Kathmandu valley; 31.6% in the Eastern terai
- Seasonal labour migrants identified as at-risk group: integrated bio-behavioural surveillance in 2006
  - 1.1% in Western and 2.8% in Mid-Far Western sample were HIV positive

HIV and Conflict Assessment

- Conducted November 20th to December 1st 2006
- Joint Assessment by UNHCR and UNAIDS in coordination with NCASC
- NCASC, seven UN agencies, four NGOs (in varying capacities) and various government ministries at local level participated
- 3 multi-agency teams to KTM valley, Ilam and Nepalgunj consisting of six to seven persons each
Interagency coordination

- Preparatory work by UNAIDS and UNHCR in Nepal
  - Determined study sites
  - Invited and liaised with other participants
  - Hired consultants to prepare background documents, prepare draft tools and to plan and organize the field work

- Core group developed the draft assessment tools – consultant, UNHCR and UNAIDS

- Two day briefing in KTM before field work with all team members

- Field-based coordination and support provided by various UN agencies and NGOs

Development of Assessment Tools

- Main consideration - adapting existing tools for a low level/concentrated epidemic

- District assessment tool
  - Based on existing UNHCR tool and adapted (including MARPs, additional Protection)

- Key informant interviews and focus group questionnaire guides
  - Based on the Reproductive Health in Refugees Needs Assessment tools and adapted (HIV and IDP situations)

- Affected groups questionnaire guides
  - Developed using tools from a variety of sources (Mobility and HIV assessment tools, UNHCR/WHO Substance Use Assessment in Conflict-affected Populations project)

- Reference made to IASC Guidelines

Analysis

- Teams met every night and went over key points of information gathered that day
  - Analysis began during data collection
  - Triangulation and cross checking

- Team members summarized interviews into a standard format with key themes for each interview guide and target group

- 1-2 people per site completed the district assessment tool

- One person from each site compiled individual reports into the site report

- Consultant summarized field reports into the final report

Results

Overall

- Three sites
  - Differentially affected by the conflict
  - At different stages of the HIV epidemic
  - Different socio-economic profiles

- The conflict has had a profound impact on the three selected districts BUT

- Impact of conflict on HIV vulnerability and risk varied considerably from site to site

Migration/displacement

- Increased rural-urban migration/displacement (particularly for young people)

- Increased migration to India and elsewhere - mostly of males

- People stayed away longer - waited until peace restored to return
### Coordination
- Coordination of the HIV response at District level poor
  - Irregular meetings (only for World AIDS Day)
  - No matrix of agencies and their areas of operation
  - No funding

- HIV is often seen as only a health issue
- Impacted by the conflict as District staff occupied by more overt humanitarian concerns

### Protection
- Fragmentation of families and needs of vulnerable women and children were often not addressed – Banke > Ilam

- Increase in male and female sex workers in Nepalgunj during height of conflict (2003-04)

- Increased number of children and women in potentially abusive and exploitative situations
  - e.g. child labour increased dramatically in Kathmandu

- Reports of increased sexual violence including rape

### Prevention
- Disruption of some HIV prevention programs:
  - Outreach to sex workers in Banke and IDUs in Kathmandu

- Coverage of HIV prevention in at-risk populations inadequate
  - sex workers in Banke and IDUs in Ilam

### Uniformed forces
- Large increase in uniformed forces as large numbers of army and armed police moved into Banke district
  - Greater demand for sex work

- Uniformed forces not adequately covered by HIV prevention
  - BCC, access to services and condoms all poor

### Care, support and treatment
- Care, treatment and support impacted for PLWH:
  - Services highly centralised
  - Unable to keep follow up appointments
  - Economic insecurity for PLWHs

- Signs of a higher burden of HIV in some more isolated districts but inadequate care, treatment and support in these districts

### Recommendations
- Even in low level/concentrated epidemics a coordinated and multi-sectoral response to HIV during and post-conflict is essential

- Stronger protection mechanisms needed for most vulnerable in conflict-affected settings, including measures to improve economic security

- Improve coverage and quality of targeted HIV prevention to most-at-risk populations – a low level epidemic demands targeted prevention interventions even in conflict
Recommendations (cont’d)

• Strengthen HIV prevention among migrants using a multi-staged approach: before migration, during transit, at destination points and on return
  • Bi-country programming

• Strengthen HIV prevention in uniformed services at district level
  • Training of senior officers
  • Institutional barriers

• Integrate HIV into post-conflict planning
  • Areas of return
  • Cantonments

• Improve care, treatment and support of PLWHs and their families in districts with a higher HIV burden:
  • Decentralised services
  • Strengthened referral linkages

Next steps

• $150,000 allocated from DFID System-wide project
  • Addressing HIV prevention in sex workers and IDUs
  • Training of uniformed forces
  • Community-based HIV prevention in areas of return

• Strengthening post-conflict angle of response
  • Peace process and inclusion of IDPs
  • Government initiatives (protective and restorative justice)
  • Services provided for IDPs

State Response to HIV Issues of IDPs

• Comprehensive peace accord and demobilization of armed forces
  • Barracking of Nepal Army
  • Cantonment of combatants
  • Creation of enabling environment for IDPs
  • Protection of human rights: ensuring right to life
  • Protection of women and children
  • HIV education for migrant labour

State Response to HIV Issues of IDPs cont’d

• National Comprehensive Policy on IDPs
  • Protective and restorative justice
  • Registration and certification of IDPs
  • Relief support for IDPs
  • Comprehensive programme for rehabilitation
  • Basic human development services
  • Free health service for IDPs
  • Sustainable livelihood opportunities

Challenges Beforehand

• Increased unsafe migration due to conflict and displacement
• Enabling environment for safe return of IDPs
  • Distress, trauma and lack of confidence
  • Revival of health services at conflict prone areas
  • Implementation of peace process and programme for IDPs
  • Sustainable livelihood opportunities for IDPs
  • Protection of women and children
  • Coordinated and integrated mobilization of resources
INTERAGENCY HIV ASSESSMENT MISSION IN CÔTE D’IVOIRE

INTERNALLY DISPLACED PEOPLE AND THEIR HOST COMMUNITIES

INTRODUCTION
- Population: 17 M
- Superficie: 322.462Km²
- IDP : 1 738 363
- Hommes : 48%
- Femmes : 52%

BACKGROUND (1)
- Located in West Africa, CI has a generalized epidemic, HIV rate is 4.7% (EIS 2005)
- National framework of AIDS’ control:
  - Ministry of HIV/AIDS control
  - Health Ministry for treatment PLWHIV
  - Family and Social Affairs Ministry: OVC
  - Ministry of solidarity and casualties of disaster

BACKGROUND (2)
- Several conflicts are taken place in the country since 1989 & 2002 with IDP and refugees from neighbor countries in conflict.
- Chosen sites: Abidjan, Bouaké, Guiglo and Tabou

BACKGROUND
- Determine the links between conflict, vulnerability to HIV and risk of HIV infection
- Develop advocacy strategies and programmes for HIV prevention, treatment, care and support for populations affected by HIV and conflict

OBJECTIVES
- Determine the links between conflict, vulnerability to HIV and risk of HIV infection
- Develop advocacy strategies and programmes for HIV prevention, treatment, care and support for populations affected by HIV and conflict

HIV IN CÔTE D’IVOIRE
- Adult prevalence: 4.7%
- Est. number of PLWH: 390000-820 000

MISSION COORDINATION
- Coordinator: UNHCR with UNAIDS
- Technical working group Task Force IDP & HIV (new)
- Participants: UN agencies, government, NGOs
RECOMMENDATIONS

SEXUAL EXPLOITATION
Perpetrators
- Militia (Bouaké), soldiers (Bouaké) (incl. UN peacekeepers), police
- Teachers (Bouaké), civilians (Abidjan)
Victims
- Children (victims forced by parents to enter sex work), women, sex workers (Abidjan)
Services
- Bouaké: no PEP kits
- Guiglo: medical, psycho-social

COORDINATION, M&E
Weak national coordination
- CNLS (National Response coordinating structure since 2004)
- MLS (CNLS technical secretariat)
Minimal/no site coordination
Monitoring and evaluation
"National framework for monitoring and evaluation" - Not implemented

RECOMMENDATIONS
Implement and enforce the law and sanctions on sexual violence
Ensure psycho-medical service access

PRACTICAL STEPS
- To address specifically IDP’s problems according to strategic plan and EIS results.
- To involve National framework
- Specific laws on HIV/AIDS, health reproduction and gender (for example upcoming law on sexual violence).

CONCLUSION

MISSION ACHIEVEMENTS
- First joint UN, government and NGO exercise in Côte d’Ivoire
- Establishment of a common coordination mechanism with member organisations of the mission
- Clear mission follow-up in terms of programming due to improved planning and oversight

NEXT STEPS PLANNED
- Report dissemination (May)
- Workshop for ministries (May)
- "Une réponse complémentaire et multisectorielle aux Recommandations de la mission IDP/VIH"
- Workshop (May)
- "Addressing IDP and refugee access to HIV services in Abidjan"
- Pre-launch workshop (June)
- "Towards integrated services in Tabou district"
- Pre-launch workshop (June)
- "Towards integrated services in Guiglo district"

PARTICIPANTS
Ministère de la Lutte contre le SIDA
Ministère de la Santé et de l’Hygiène Publique
Ministère de l’Education Nationale
Ministère de la Famille et des Affaires Sociales
Ministère de la Défense
Ministère de la Solidarité et des Victimes de guerre
WFP, UNDP and UNFPA
Asapsu, ASA, Caritas, Alliance des religieux et Rip+

INTERAGENCY HIV ASSESSMENT MISSION OF INTERNALLY DISPLACED PEOPLE AND THEIR HOST COMMUNITIES IN CÔTE D’IVOIRE
Humanitarian situation in DRC
- Vast country, poor transport and communication means: main IDPs hidden and/or trapped in inaccessible areas
- Congolese suffered through years of war, poverty and complex emergencies:
  - Massive displacement of population inside and outside: Latest estimates: 1.1 mio IDPs (OCHA, 2006), 413,000 still in surrounding countries
  - Widespread of human rights violations including: torture, forced labour, rape, forcible recruitments, burning of villages, kidnapping and summary executions
  - Women and children tend to suffer most: 11,361 case of sexual abuse 1st quarter of 2006
- Humanitarian needs are enormous, context is ever-changing
- Difficult to distinguish IDPs from host population: 90% of IDPs live with host families forced to share despite the precarious situation

HIV in DRC
- Overall prevalence: 4.2% (2005)
- PLWHA (0-49 yrs): 1,230,000
- National Strategic Plan (1999-2008) is obsolete, need review and update
- Rural areas and youth, women more and more affected
- Most HIV related services in few capital cities
- 4.66% of those in need of ART have access to it
HIV situation in 2005

Background to the study

- 4 provinces called « provinces of Conflicts »; 5 locations
  - Orientale (Ituri: Bunia)
  - North Kivu (Goma: Rutshuru and Massisi)
  - South Kivu (Uvira: Fizi)
  - Katanga (Moba and Mitwaba)
- 20 pers. in 5 interagency teams from the Capital city +
- 2-3 facilitators from local NGOs and Govt in the field
- 7 assessment days each

IDPs and Returnees

Preparation and Process

The research instruments

- TOOL APPROPRIATION AND FAMILIARISATION
  - Basic information
  - Semi-structured questionnaire for key informants
  - Semi-structured questionnaire for target group
  - Focus group theme discussion

Interagency coordination

PARTICIPANTS

- UN (UNHCR, UNHCHR, IMO, OCHA, UNFPA, WHO, UNICEF, UNAIDS, BTF, Monuc, …)
- Ministry (NAC, PNLS, MOH)
- NGO (SWAA, GTZ, …)
- Lead: UNHCR
- Co-leads: UNAIDS/UNICEF/UNFPA/WFP/WHO

The analysis

- Summarised interviews and site observation notes
- Identified needs in terms of HIV prevention, treatment, care and support, protection, coordination, monitoring and evaluation
- Examined the impact of conflict on HIV in terms of vulnerability and risks

Findings on HIV prevention...

- MINIMAL VCT AVAILABILITY/USE
  - Low uptake/knowledge among respondents
  - Few or none in sites
  - Breaches of confidentiality
  - No referral for treatment, care and support

- MINIMAL PMTCT
  - Unstable staff and compliance difficulties among pregnant women in North Kivu
  - Interrupted during war in Uvira
  - None in Bunia, Moba

- BLOOD SAFETY
  - Blood tested in Goma and Bunia (blood bank)
  - But only occasionally in Moba and Uvira

- UNIVERSAL PRECAUTIONS
  - Followed in Goma
  - Not systematically in Bunia, Uvira, Moba and Mitwaba (stock depletion, etc.)

- STIs
  - Syndromic approach in Uvira,
  - But limited in Bunia and all other locations
**Findings on HIV prevention...**

<table>
<thead>
<tr>
<th><strong>among HOST POPULATION</strong></th>
<th><strong>among IDPs and war victims</strong></th>
</tr>
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<tbody>
<tr>
<td>MINIMAL CONDOM USE due to:</td>
<td>ADDITIONAL FACTORS:</td>
</tr>
<tr>
<td>- Unavailability</td>
<td>- Trauma and fatalism</td>
</tr>
<tr>
<td>- Lack of knowledge (benefits/use)</td>
<td>- Stigmatization and self-reliance</td>
</tr>
<tr>
<td>- Among high risk/vulnerable groups (sex workers, men in uniform, young people)</td>
<td>Particularly among women and children separated (by force/choice)</td>
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<tr>
<td>- Price</td>
<td></td>
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<tr>
<td>- Lack of pleasure</td>
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<tr>
<td>- Association with prostitution</td>
<td></td>
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<td>- Long-term sexual partner</td>
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**Findings on protection needs...**

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<td>PEOPLE LIVING WITH HIV</td>
<td>CHILDREN</td>
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</tr>
<tr>
<td>- Face widespread stigma and discrimination</td>
<td>- Lack of protection for children in IDP camps (noted during early stages of the war, Bunia)</td>
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<tr>
<td>- Le jour qu'on saura que je suis VIH positive, c'est bien ma mort. -</td>
<td>- No services for street children in Bunia</td>
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</tr>
<tr>
<td>- The day they find out I am HIV positive will be my death. -</td>
<td>- Lack of food and shelter (Bunia)</td>
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<tr>
<td>VICTIMS OF SEXUAL AND GENDER-BASED VIOLENCE</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Victims are not always referred to VCT (Moba)</td>
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<tr>
<td>- Rape victims are stigmatised and isolate themselves</td>
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<tr>
<td>- Perpetrators are not prosecuted</td>
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<td>- Psychosocial services are weak (Bunia)</td>
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**Findings on conflict and HIV...**

<table>
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<tr>
<th><strong>POVERTY (Pillage, destruction of fields)</strong></th>
<th><strong>GROWTH IN MATERIALISM</strong></th>
<th><strong>with increased HIV vulnerability</strong></th>
</tr>
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<tbody>
<tr>
<td>- Sex work for women and men</td>
<td>- With displacement and resulting exposure to urban life</td>
<td><strong>SCHOOLING OF GIRLS</strong></td>
</tr>
<tr>
<td>- Long term sexual partnership with financial support</td>
<td>- Strong presence of men in uniform</td>
<td>- Linked to the presence of female role models in NGOs</td>
</tr>
<tr>
<td><strong>FAMILY SEPARATIONS</strong></td>
<td>- Concentration of sex workers around (UN/FARDC) soldier barracks</td>
<td>Also to the growth in private schools (where child mothers are accepted) and UNICEF</td>
</tr>
<tr>
<td>- Women obliged to leave their families (forced labour, sexual exploitation by men in uniform)</td>
<td></td>
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</tr>
<tr>
<td>- Children</td>
<td>- with increased HIV vulnerability</td>
<td></td>
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<tr>
<td>- Drop out of school</td>
<td></td>
<td></td>
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<tr>
<td>- Live in the streets</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>LACK OF PARENTAL AUTHORITY</strong></td>
<td></td>
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<tr>
<td>- IDP families rely on their children’s income</td>
<td></td>
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</tbody>
</table>
Findings on conflict and HIV

... with increased risk of HIV

**UNSAFE SEX**
- Lack of knowledge on HIV, condom use and pregnancy
- Found among high risk/vulnerable groups (men in uniform, sex workers, IDPs)
- Due to condom stock depletion
- Also to trauma and fatalism

**EARLY SEXUAL RELATIONS**
- 8 years, instead of 12 (Bunia)

**GROWTH IN SEX WORK INDUSTRY**
- Younger sex workers
- Can be instigated by parent
- Male clients are often men in uniform
- Female clients are older, wealthier women

**SGBV**
- Perpetrated by militias and men in uniform
- Can be gang raped or taken hostage
- Victims are girls and women of all ages (Bunia: 5 months-72 years)

Constraints and Opportunities

- Security, logistics
- Difficult to distinguish IDPs from host population
- High expectancy from affected population
- Poor presence of NGOs in the field
- Poor operational capacity of local NGOs
- Disperse and remoteness
- “Competition” among actors

- High engagement of local communities and affected population
- High engagement of UN agencies and NAC to participate
- ++ local NGOs emerging even no funds available
- High expectancy from affected population

Recommendations

- Community awareness and empowerment through “community conversations”
- Work with authorities against impunity [Cluster Protection]
- Establish the minimum essential package [IASC]
- Follow the “community assistance approaches”
  - 1-2 health facilities per province [WHO, cluster lead for health]
  - Schools [Unicef, cluster lead for Education]
  - Local CBO/FBO [UNP, UNFPA]
  - Prepare for scaling up of Govt extension plans for comprehensive package

The humanitarian Response in DRC

- DRC is pilot country of a number of new coordination and funding tools: cluster approach, Good Humanitarian Donorship (GHD) Initiative, the Pooled Fund (PF), the UNAIDS Division of Labour and the expanded Central Emergency Response Fund (CERF)
- Efforts to decentralise [the coordination of] humanitarian response on going, still need to improve

Next steps in DRC

**Goals of the HAP**
1. emergency response to crises
2. support for a return to “ self-sufficiency”.

**HIV and AIDS strategy**
1. Minimum essential package (5SAC)
2. Prepare, support NAC establishment of comprehensive HIV package (VCT, PMTCT, ART)

- Inter-agency planning missions to selected zones
- Develop practical action plans
- Use MAP fund for starting
- Apply for Pooled funds and CAF through the Humanitarian Coordinator

Thank you!
First global consultation meeting on HIV and Internally Displaced Persons

UGANDA EXPERIENCE
Filippo Ciantia

Outline of presentation
• Uganda: country HIV epidemic
• North Uganda conflict:
  – The epidemic
  – The services
  – The management structure
• The 3 ones as the way forward
  (One framework)

UGANDA
Area: 241,040 sq.Km
Annual Population growth rate: 3.4%
Fertility rate: 6.7 (NU 7.1)
Children under 18: 16.9 M (58.6%)
Pro-capita income: 380 $
Human Development Index: 144
IDP camps in Northern Uganda: 220
People living in IDP camps: 1.4M (April 2007)


HIV/AIDS epidemic in Uganda
• National prevalence 6.4% in adult population (15 – 49 yrs)
• 1,000,000 Ugandans living with HIV now
  – 860,000 Adults, 140,000 Children
• In 2006: 136,000 new infections
• Only 13% of people know their sero-status
• 202,000 HIV+ people estimated in need of ART of these 86,000 in ART at the end of 2006
• 2,100,000 AIDS Orphans

UGANDA and WAR

- Uganda is affected by a 20-year conflict in the North, which caused the internal displacement of 1.6 million people.

Trends in Antenatal HIV prevalence in selected sentinel sites

- Urban residents have a significantly higher risk of HIV infection.
- The urban-rural disparity stronger for women and children than for men.

Total estimated displaced people by end of 2006

Map of Uganda showing the ART sites in Northern Uganda & Karamoja

Source: ART data: WHO, PMTCT data: MoH
**PMTCT**

- PMTCT program received a great response by the communities, and especially by internally displaced women (HIV test counseling acceptance rate more than 90%, testing 100%).
- Despite insecurity 47% (Kitgum) and 57% (Pader) enrolled mothers delivered in HC
- PMTCT coverage: from 25% (2002) to 69% (2006) in Kitgum and Pader District
- Comprehensive PMTCT service is a tool to spread awareness about health care to women in Uganda

---

**CHARACTERISTICS OF PMTCT PROGRAMS IN PEACEFUL, POST-CONFLICT AND CONFLICT-AFFECTED REGIONS IN UGANDA**

1. Overall HIV prevalence: 5.7% (regional range 2.4% – 7.7%).
2. Good pre-counselling (83%), testing (87%), enrolment (93%) and NVP access (43%), with regional variation.
3. HIV prevalence was not significantly different between conflict (6.9%) and peaceful regions (6.7%).
4. Enrollment uptake was higher in conflict affected (100%) than in peaceful regions (75%).
5. HIV prevalence was lower in internally displaced camps (4.6%) than outside (6.0%).
6. Internally displaced camps had higher rates of pre-test, test and post-test than other centres.
7. Similar estimated PMTCT coverage in conflict affected and peaceful regions, with high regional variability.

---

**Prevention: Protection and Psychosocial Issues**

- There is an evident need to have more information on the level of the GBV (SWAY and others)
- The provision of PEP for GBV survivors as a standard measure to prevent HIV is not supported by all parties in Uganda.

The MOH draft GBV trainer’s manual (2004) states that “PEP is a matter of considerable controversy and its benefit in prevention of HIV following GBV has not been confirmed”.
- OVCs care and support of vulnerable and affected are basic responses
Prevention and Behaviour Change

- ABC is an essential aspect of the response
- Role of Civil Society
- Openness and inclusiveness: individuals and groups adopt any of the ABC elements depending on their cultural, social and economic circumstance
- The silent epidemic STIs (HSV2 very high prevalence!)
- The debate on circumcision

STI Prevalence

Herpes Prevalence by Region

- Uganda total: 44
- Percent of men and women 15-49 who have herpes

Hepatitis B Prevalence by Region

- Uganda total: 44
- Percent of men and women 15-49 who have hepatitis B

Syphilis Prevalence by Region

- Uganda total: 3.1
- Percent of men and women 15-49 who have syphilis

Example existing Multisectoral HIV/AIDS coordination structure
Example District Management structure

Cluster return home (2)

Information System:
- Different reporting format at various levels
- There is a national Health Management Information System & Cluster Information Management System in development

Recommendations
- Build on existing reporting system (HMIS)
- National cluster (Nacaes) to help identify and harmonize indicators to be collected to monitor impact

Cluster and return home (1)

- UN approach versus Humanitarian Approach (top down approach)
- Risk of creating parallel structures

Recommendations
- Use existing structures and create responsibility at government and district level
- Initial attempt to build capacity in existing structures

The Three Ones in North Uganda as a way forward

One framework
- Strengthen district HIV/AIDS action plans (DDP)

One coordinating body
- Strengthen district level coordination mechanisms (DAC and DAT)

One monitoring tool
- Monitor implementation of coordinated action plan through one common monitoring framework

NACAES as a national support of the 3 ones in North Uganda (Subcommittee of Health Nutrition HIV/AIDS National Cluster) (2006 Emergency Action Plan for NU to ensure access to basic services – to be adapted to the changing situation)
MSF-OCA HIV/AIDS programs in eastern DRC: activities, outcomes & challenges

Dr. Daniel O’Brien
MSF AIDS Working Group

DRC
- 1996 – 2007: Chronic War
  - 3.9 million war-related deaths
  - 3.2 million internally displaced persons
- 4 Projects Eastern DRC:
  - Bukavu: vertical
  - Walikali, Sabunda, Baraka: Integrated
- Components:
  - Free Medications and care
  - Generic Fixed Dose Combination ARVs
- MSF supported and supplied

Bukavu
- Population: 600,000
- Adult HIV prevalence 2.6%
- HIV project started in 2000. (IEC, STI)
- VCT and OI clinic in 2002.
- ART October 2003.
- PMTCT June 2006
- Partners: MoH, Local NGOs

Regional IDPs

Bukavu

CT
2006: 630/month, Prevalence 12%
Patients Characteristics ART baseline April 2002-Dec 2006

Number of patients started on ART 993 / 2586 (38%)

- Women: 66%
- Children: 60 (6%)
- ARV-naive: 99%
- % CD4 < 200: 76%
- D4T/3TC/NVP: 84%

WHO Clinical Stage at time of ART Initiation

- Stage 1: 4%
- Stage 2: 13%
- Stage 3: 53%
- Stage 4: 38%

Comparison of ART outcomes of programmes in chronic conflict with non-conflict settings in low and high income settings

<table>
<thead>
<tr>
<th></th>
<th>Bukavu (Chronic Conflic Setting)</th>
<th>ART-LINC [10] (Low Income Setting)</th>
<th>ART-CC [10] (High Income Setting)</th>
</tr>
</thead>
<tbody>
<tr>
<td>No. of patients initiating ART</td>
<td>994</td>
<td>4610</td>
<td>22,217</td>
</tr>
<tr>
<td>No. of patients on ART (Median duration on ART)</td>
<td>534</td>
<td>3744</td>
<td>24,310</td>
</tr>
<tr>
<td>6-month median weight gain (kg) [IQR]</td>
<td>2.5[0–5.5]</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>12 month Mortality (95% CI)</td>
<td>7.9% (95% CI 3.6–12.1)</td>
<td>6.4% (95% CI 5.1–7.7)</td>
<td>1.8% (95% CI 1.5–2.2)</td>
</tr>
<tr>
<td>12 month Loss to follow-up (95% CI)</td>
<td>5.4% (95% CI 3.2–7.5)</td>
<td>15% (No CI given)</td>
<td>5% (No CI given)</td>
</tr>
</tbody>
</table>

Number of IDPs

<table>
<thead>
<tr>
<th>NORD KIVU (as of 01/07)</th>
<th>IDPs</th>
<th>RETURNENES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Beni</td>
<td>112</td>
<td>334</td>
</tr>
<tr>
<td>Rutshuru</td>
<td>385</td>
<td>530</td>
</tr>
<tr>
<td>Lukwi</td>
<td>139</td>
<td>252</td>
</tr>
<tr>
<td>Manihi</td>
<td>109</td>
<td>972</td>
</tr>
<tr>
<td>TOTAL NORD KIVU</td>
<td>551</td>
<td>1033</td>
</tr>
<tr>
<td>SUD KIVU (as of 01/07)</td>
<td>IDPs</td>
<td>RETURNENES</td>
</tr>
<tr>
<td>Shabunda</td>
<td>115</td>
<td>053</td>
</tr>
<tr>
<td>Kwenga</td>
<td>378</td>
<td>845</td>
</tr>
<tr>
<td>Kabare</td>
<td>484</td>
<td>585</td>
</tr>
<tr>
<td>TOTAL SUD KIVU</td>
<td>163</td>
<td>955</td>
</tr>
</tbody>
</table>

Integrated Projects:

Walikali

Integrated Programs

<table>
<thead>
<tr>
<th>Project</th>
<th>Start date</th>
<th>CT (%HIV)</th>
<th>Of/FU (%CT)</th>
<th>ART</th>
<th>PMTCT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Shabunda</td>
<td>Feb 05</td>
<td>1999 (4%)</td>
<td>41 (57%)</td>
<td>11</td>
<td>Yes</td>
</tr>
<tr>
<td>Walikali</td>
<td>Jan 06</td>
<td>1091 (6%)</td>
<td>45 (68%)</td>
<td>3</td>
<td>No</td>
</tr>
<tr>
<td>Baraka</td>
<td>July 06</td>
<td>424 (13%)</td>
<td>36 (63%)</td>
<td>5</td>
<td>No</td>
</tr>
</tbody>
</table>

Challenges

- Low HIV/AIDS awareness/knowledge
  - Health staff
  - Difficulty accepting ART
- Stigma/secrecy
- Unstable setting
- Minimal availability of other partners
- Mobile populations
- Sustainability
- HIV Diagnosis
- Stable Housing
- Food
- Decentralisation
- PMTCT
Episode of Acute Insecurity in Bukavu May – June 2004:

- In May 2004, Bukavu was the scene of intense fighting lasting until for 2 weeks.
- Hundreds of civilians were killed, thousands fled into nearby Rwanda, and unknown numbers of women were raped.

Preparing for Disruption--Factors Supporting ARV Adherence:

1. Advanced Planning
2. Patient Education
3. Human Resources Capacity
4. Communication Networks
5. Emergency Drug Stocks/Washout Medications
6. Secure Drug Storage
7. Decentralization of Care
8. Cooperation with Neighbouring HIV Treatment Facilities
9. Treatment Information Cards

Next steps

- Integration with NACP/MOH
  - ARVs (GF, WB)
  - Technical support
  - Training
- Handover of activities
  - MoH
  - NGOs (local/international)
- Non-naïve Patients

Questions?
Regional context: HIV in CEE/CIS

- 1.7 million PLHIV in 2006 - an increase x 20 in less than a decade
- Estimated 270,000 people newly infected in CEE/CIS 2006, about 90% in two countries: Russian Federation & Ukraine
- Almost one third of newly-diagnosed HIV infections in CEE/CIS in young people (15-24)
- Main mode of HIV transmission: using non-sterile injecting drug equipment

Gender dynamics

- 68.6 to 89% registered PLHIV male, but increasing HIV heterosexual transmission & narrowing of the male-female ratio in newly reported HIV infections from 4:1 to 2:1 indicating females increasingly at risk
- Weak gender analysis in risk behaviour & programming
- Trafficking for purposes of sexual exploitation increasing
  - 2003 IOM as many as 500,000 women and girls trafficked into the EU annually

Country context: IDPs in UNHCR countries assessed

- Armenia: 8,399 - 0.26% pop
- Azerbaijan: 686,586 - 8.1% pop
- Bosnia and Herzegovina: 182,747 c 6.1% pop
- Georgia: 246,695 – 5.5% pop
- Serbia: 206,798 – c 2.8% pop
- Turkey: 359,00 to 2 to 3 million – 0.5% to 4% pop

Georgia only country with information on number of registered PLHIV who are IDPs, Azerbaijan reportedly collects data, but not yet analysed it.

Country context: HIV prevalence & mode of transmission

- **HIV low prevalence** BiH, Georgia, Serbia, Turkey
- **Concentrated epidemics** in Armenia and Azerbaijan:
  - IDUs 8.4 to 10.2% in Armenia and 19.5 to 24% in Azerbaijan
  - FSWs 6 to 11% in Azerbaijan, ≤ 5% other countries
- Armenia, Azerbaijan, Georgia and Serbia - main mode of transmission injecting drugs (44% to 63%)
- BiH & Turkey main mode of transmission is sexual (≤ 53%)
- Reported MSM transmission in BiH (17.3%) & Serbia (15%) could be much higher due to stigma
**Country context: HIV, STIs and TB**

- Stigma and discrimination towards PLHIV in all countries and towards IDPs in some
- STI data under reported – weak surveillance, role of private doctors and high levels of self-treatment
- TB increasing especially amongst the poor and prison population
- MDR STIs and TB and HIV/TB co-infection

**Country context: Poverty, Displacement & HIV**

- Poverty in Southern Caucasus high (about 50%)
- Poverty and migration closely linked to HIV risk behaviour in S. Caucasus - up to 45% of PLHIV with history of migration to countries with higher HIV prevalence rates (Russian Federation and Ukraine)
- Increase in female headed households
- Multiple vulnerabilities among young Roma IDPs & links with HIV risk behaviour

**Country context: Age, sex, displacement & unemployment**

- 71% of Roma women compared with 39% Roma men unemployed in BiH
- 72% of Roma women compared with 35% Roma men unemployed in Serbia

**Country context: IDPs and knowledge of HIV**

- Level of/access to education a key factor in knowledge of HIV – displacement may disrupt education
- Azerbaijan - Reproductive health survey 2001 IDP women slightly lower knowledge than non IDP women. But non-IDP and refugee women living in conflict affected areas were least likely to be aware of HIV and STIs

**Country context: Poverty, Displacement & HIV**

*Georgia*

Poor living conditions, poverty, low self-esteem and lack of opportunities were attributed to injecting drug use amongst male IDPs living in Collective Centres and in Gali.

Photo: Young male IDPs outside Collective Centre in Zugdidi showing poor living conditions

**Challenges: HIV & IDPs**

- The needs of IDPs are much broader than HIV and should be seen in the context of their overall socio-economic status, well-being and future uncertainty.
  - Living conditions of IDPs are often below the minimum standards with many (after 10 to 15 years) residing in CCs
  - Compared with the general population, the health status of IDPs is poorer (especially for stress related disorders)
  - A higher % of IDP households cannot afford to do not seek health care - difficulties obtaining free of charge commodities
  - Access to health care poor amongst IDPs & Roma (lack of ID), stigma, traditional medicine)

- BUT IDPs are not a homogenous group and age, sex, urban/rural residence, having peers or parents who inject drugs/sell sex, or living in extreme economic hardship are important vulnerability factors for engaging in HIV risk behaviours
Challenges: HIV interventions for IDPs

- Evidence base weak – absence/poor age, sex, diversity disaggregated data
- Confusion between risk and vulnerability in HIV programming
- IDPs should be covered by national programme if engaging in HIV risk behaviour & able to obtain essential package of targeted interventions
  - BCC
  - Condoms
  - Harm reduction
  - STI diagnosis treatment and care
  - VCT with referral to treatment, care and support

Challenges: Weak HIV prevention and treatment programmes

- Limited HIV prevention interventions in place for populations most at-risk of HIV - weak capacity for working with FSWs and MSM
- Coverage of targeted interventions considerable country variations (e.g. IDUs 4 to 50%)
- HIV testing of all pregnant women in some countries without counselling, consent, and access to ARV
- Proposed targeted PMTCT for Roma women BiH
- Blood safety
  - Azerbaijan estimated 31% of transfused blood screened
  - Georgia limited/absence HIV test kits in Abkhazia & South Ossetia & insufficient test kits in Georgia Proper for IDUs

Challenges: Weak vulnerability reduction programmes

- Burn out – protracted stage
- Funds move to new emergencies
- Weak interventions/capacity to implement Principles of vulnerability reduction:
  - Integrate & simultaneously address economic & social rights
  - Ensure government funding for services is based on integration, equity and efficiency
  - Promote community participation in managing the delivery of an integrated package of social services and special protection for vulnerable children
  - Reduce the enhanced HIV risks faced by girls through structural efforts to prevent the coercion of girls into sex and sex work, to increase economic opportunities for girls apart from sex work
  - Reduce adult legal drug use to reduce modelling of addictive behaviour for youth

Challenges: Weak vulnerability reduction programmes

Programmes to reduce vulnerability to HIV need to:

- Address the risk environment
- Reduce social impediments to reducing risks
- Include non health /drug/ HIV interventions
- Change laws, standards and administrative procedures
- Address social marginalisation
- Empower vulnerable adolescent girls and boys to be able to protect themselves
- Address social, material and economic inequities and link HIV prevention to overall development issues

Lessons learned - Government response Armenia

- Evidence based response & resources used appropriately
- Commitment to Three Ones
- Emphasis on risk and vulnerability in national HIV prevention programme
- 100% safe blood
- Targeted interventions to most at risk populations with good coverage
- Willingness to focus on IDPs in collective centres engaging in HIV risk behaviour
Lessons learned - UN response Armenia

- Proposal to mainstream HIV/AIDS into Poverty Reduction Strategy Paper
- Attention to HIV indicator in MDG and refugee and non-refugee HIV knowledge levels
- UNHCR chair of UN Theme Group on HIV/AIDS & committed to HIV programming
- UNHCR part of joint programme (with UNAIDS, UNDP & UNFPA) to reduce stigma and discrimination and empower PLHIV
- Willingness to increase gender sensitivity in HIV programming through UNTG on Gender

Results of joint efforts and appropriate programming - Armenia

- Improvements in knowledge about HIV
- Changes in risk behaviour and decrease in HIV prevalence in risk groups

Next steps/future thoughts Country level

- Poverty should be reflected in national HIV programmes
- HIV should be mainstreamed into PRSP
- Clarity between risk & vulnerability required
- Gender sensitive evidence-based programming based on stage of epidemic and at-risk populations
  - collect, disaggregate and use HIV data by age, sex, mode of transmission and diversity
  - urgently scale up HIV targeted prevention interventions & access to treatment, care & support
- Increased collaboration with other agencies to
  - ensure coordinated and coherent national response
  - establish integrated programmes to address TB, HIV and STIs amongst key populations including IDPs

Next steps/future thoughts UNHCR HQ

- Capacity Building of HIV/AIDS Focal Points in
  - effective HIV/AIDS programming & international best practice
  - creation of enabling & protective environment
  - vulnerability reduction strategies
  - how to increase the participation of IDPs in programme, design, implementation, monitoring and evaluation
  - AGDM programming
  - SGBV protocols
- Encourage lesson learning and share good practice on HIV programming for IDPs across the region

Next steps/future thoughts

Country level

- UNTG advocacy – many countries missing the epidemic
- Make the money work - influence national programme
- UNHCR support to evidence base on risk behaviour
  - HIV risk behaviour studies amongst IDPs and if necessary, advocate for targeted prevention interventions in settings (e.g. collective centres) where HIV risk behaviour may occur
  - IDPs as seasonal migrant workers and advocate for increased HIV prevention programmes directed to male migrants
  - IDPs amongst children living/working on the street, and living in institutional care (juvenile detention facilities, orphanages and boarding schools) and advocate for increased HIV prevention targeted interventions for them & vulnerability reduction strategies
- Build capacity of local orgs. to work with most vulnerable
- Address stigma and discrimination in health & related workers

Islene Araujo, MD Msc

Overview

- Humanitarian Situation
- Programme Planning and Preparedness
- HIV/AIDS Humanitarian Response
- Challenges
- Lessons Learnt

Overview

Humanitarian Situation

Programme Planning and Preparedness

HIV/AIDS Humanitarian Response

Challenges

Lessons Learnt

Rapid assessment of HIV impact in early July

(internal IOM UNAIDS report available)

- Hundreds of family break-ups
- Anecdotal reports of rape, women forced into prostitution and unsafe sex
- Sex workers, street children and those suspected rounded up
- Disruption of condom programs – thousands of male condom outlets and most female condom outlets destroyed
- HBC services suffered most: some NGOs lost contact with 50% of their clients and up to 30% of their volunteers
- Some disruption of ART services

1,700,000 people have been displaced
- Half of them stayed in the open air in the middle of the winter

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1,700,000 people have been displaced
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**Programme Planning and Preparedness**

**NEEDS ASSESSMENTS**
- HIV/AIDS questions were incorporated in general humanitarian assessments – 1 or 2 questions
- UNAIDS and UN TWG leadership on mainstreaming indicators on existing tools
- IOM and UNICEF engaged all their humanitarian partners to conduct an nationwide HIV/AIDS assessment

**COORDINATION, PARTNERSHIPS AND DIVISION OF LABOUR**
- UNAIDS called for an extraordinary UN Technical Working Group Meeting
- Joint working plan to address HIV
- IOM – HIV prevention, later on GBV with UNFPA
- UNICEF – re establishment of care networks – HBC
- NAC support in the response was limited
- Humanitarian partners meeting was called – IASC meeting and sub groups – chaired by IOM and UNICEF

**RESOURCE MOBILIZATION**
- Regular UNAIDS donor meetings
- Humanitarian Appeals – CAP
- UNICEF allocated a substantial portion of the funds received from UNICEF National Committees
- IOM, in partnership with UNFPA and PSI put together a funding proposal for HIV response and gender-based violence, which was supported by DFID with a just over four hundred thousand dollars (USD401, 900.00). SIDA also contributed a further USD 240, 614 to the project.
- Social Mitigation projects funds – other organizations
CAPACITY BUILDING
- IASC Guidelines Training and Utilization
- Specific programmatic trainings
- Secondment of staff to key agencies (IOM, UNICEF)
- Gaps remained specifically on issues such as protection

HIV/AIDS
HUMANITARIAN
RESPONSE

Responses
- Joint collaborative effort led by UNAIDS, UNFPA, UNICEF, and IOM
- PSI key partner
- More than 40 national NGOs – many church based organizations

Programmes
- HBC
- HIV Prevention: BCC, IEC, Condoms, VCT
- GBV

GUIDELINES
for HIV/AIDS interventions in emergency settings

Members of the IASC TF for HIV/AIDS in emergencies

Mainstreaming Strategies
Prevention
- Mainstreaming HIV in food security
- Immediate response - acute phase of displacements:
- Using food distribution sites to raise awareness on HIV and AIDS and GBV, promote and distribute IEC materials and condoms
- GBV and HIV: IEC materials
- Referrals for GBV treatment: counselling service unit
Implementing Partners


Zimbabwe lessons learnt

- Define division of labour asap, taking into account comparative advantage of agencies
- Combined roles of UNAIDS and OCHA to ensure a multi-partner collaboration for comprehensive HIV programming
- Bring together humanitarian actors (with access to affected populations) with specialized agencies with experience in HIV programming in non-humanitarian settings

Lessons Learnt

- Joint programming was very beneficial
- Non traditional humanitarian partnerships was key
- IASC guidelines was very useful
- HBC – use of primary care givers as volunteers care facilitators
Lessons Learnt

- People want to be tested even within a emergency
- IEC – addressing needs of different groups is crucial
- GBV can and should be integrated
- Awareness during Food distribution was a success
- Specific capacity building of humanitarian staff in child protection and GBV is critical

Lessons Learnt

Capacity building
- Training of humanitarian workers in HIV/AIDS mainstreaming in preparation for emergency responses
- Rapid capacity strengthening in acute phases
- Secondment of staff from agencies and programs with specific HIV expertise (rather than recruiting and training new HIV staff or overloading existing staff).

Lessons Learnt

Adaptation of service delivery models: HBC
- family care providers as volunteer care facilitators outside their immediate communities
- traditional training courses shortened, supplemented with basic self-learning materials. The use of Care Cards proved very useful in the context of a rapid training for emergency responses.
- New focus on crisis counseling (rather than basic nursing care)
- new monitoring tools

Lessons Learnt

Adaptation of service delivery models: VCT
- Enormous demand
- Many had thought of testing previously and were planning ahead, despite being homeless
- Now access through vouchers (urban centres) and mobile clinics (more remote places)
- Post-test and psychosocial support demand increased
- More than 3000 persons tested and counselled, HIV positivity rates around 25% (max 80% in a few sites)

Lessons Learnt

Adaptation of service delivery models: condom programming
- Restoring access to condoms for both those displaced and the general host population major priority – strong rationale
- Free distribution in immediate aftermath of crisis, but rapid restoration of social marketing systems, outlets
- Different approaches and methods of distribution; peers, together with food packs, by care providers
- Most charitable work by faith-based organizations – resistance to be overcome

Thank you,
Tatenda,
Syabonga
Preventing HIV and Aids among adolescents and young adults in contexts of internal displacement: Field experience from Colombia

Contents of the presentation

- Country context and characteristics of the internal displacement and of the epidemic of HIV and Aids in Colombia
- Key actors and interventions
- Challenges and lessons learned

Context of internal displacement
- Illegally Armed Groups (IAG)
- Growth and territorial expansion by the IAG
- Regional impact of the conflict
- Abundant financial resources of the IAG
- Duration of the Internal Armed Conflict
- The civil population as the victims

Characteristics of displacement
- Displacements occur within the same urban areas; between rural and urban localities in the same municipalities; towards other municipalities, and towards neighboring frontier countries.
- Causes: massacres, general and/or specific threats, assassination attempts with threats – indiscriminate attacks, armed confrontations, forced recruitment, extortion and the takeover of municipalities by armed forces.
- Confinements of civil populations are also registered: "Mobilization of the civil population within the residential rural localities is prohibited, blocking the entrance and exit of food and information".

The Evolution of Displacement
- According to the government between 1997 and October of 2006, there were more than 1,859,000 displaced persons. During 2005, it increased by 4% in relation to 2004.
- According to the NGO CODHES, between 1985 and 2004, more than 3,400,000 people have been displaced.
- 37% of the displaced population does not register due to the following reasons: 29% security; 25% do not know the procedures; 16% do not want to go through the process; 6% do not know where to go; 5% have been refused a declaration; 4% do not trust the government; 4% paperwork.

Characteristics of the HIV and Aids epidemic in Colombia
- Low-prevalence epidemic concentrated in vulnerable groups.
- 0.7 (0.4 – 1.2%) HIV prevalence
- 52,186 persons with an HIV+ diagnose, out which 7,510 persons have already passed away.
- Gender ratio 2:1
- Heterosexual transmission
- Important regional differences
Results from KAP-study

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Displaced</th>
<th>No Displaced</th>
</tr>
</thead>
<tbody>
<tr>
<td>Con sabe mucho de VIH</td>
<td>12.3%</td>
<td>11.3%</td>
</tr>
<tr>
<td>Consta que el condón protege del VIH</td>
<td>65.0%</td>
<td>67.5%</td>
</tr>
<tr>
<td>Consta que el mosquito transmite el VIH</td>
<td>20.0%</td>
<td>24.0%</td>
</tr>
<tr>
<td>Consta que un aguja infectada se transmite el VIH</td>
<td>70.0%</td>
<td>73.3%</td>
</tr>
<tr>
<td>Consta que el VIH se transmite al compartir platillo</td>
<td>31.4%</td>
<td>29.8%</td>
</tr>
<tr>
<td>Habla a una persona con VIH o su casa</td>
<td>61.1%</td>
<td>55.4%</td>
</tr>
<tr>
<td>Ha tenido relaciones sexuales</td>
<td>51.0%</td>
<td>47.0%</td>
</tr>
<tr>
<td>Uso condón primer relació sexual</td>
<td>37.0%</td>
<td>30.0%</td>
</tr>
<tr>
<td>Más de dos parejas en los últimos 12 meses</td>
<td>23.8%</td>
<td>18.6%</td>
</tr>
<tr>
<td>Uso condón última relación sexual</td>
<td>45.8%</td>
<td>48%</td>
</tr>
<tr>
<td>Uso condón primer y última vez</td>
<td>25.3%</td>
<td>29.0%</td>
</tr>
<tr>
<td>Ha ido o dirigirse a tener relaciones</td>
<td>13.3%</td>
<td>9.4%</td>
</tr>
<tr>
<td>Se ha realizado prueba de VIH</td>
<td>14.6%</td>
<td>9.2%</td>
</tr>
<tr>
<td>Nunca ha tenido o usado un condón</td>
<td>54.2%</td>
<td>50.0%</td>
</tr>
</tbody>
</table>

**Total:** 1,373 / 4,956

The Global Fund financed Project for Colombia (GFPC)

• “Construction of a comprehensive response to HIV and Aids among adolescents and young adults in contexts of internal displacement”

• The GFPC is more of a development project improving HIV and Aids indicators; than an HIV and Aids project improving development indicators.

Key actors and interventions

- There is a legal and political framework in place since 1994.
- IDPs are included as a vulnerable group in the National Strategic Aids Plan 2007-10.
- Assistance provided by the international community

The Global Fund financed Project for Colombia

- Components:
  1. Public policy
  2. Provision of quality services
  3. Work with adolescents and young adults in contexts of internal displacement

- Strategies:
  1. Training
  2. Empowerment and participation
  3. Sex-education
  4. Condom distribution
  5. Provision of VCT and ART
  6. Information, monitoring and evaluation
  7. Peer-education
  8. Social marketing
  9. Fund for social, cultural and income-generating micro-projects

Results

- An example of results until the 31st of March 2007
  - Indicators for the accomplishment of OBJECTIVE NO. 1
  - 52 local development plans addressing the needs related to IDPs and youth
  - Indicators for the accomplishment of OBJECTIVE NO. 2
  - 33.8% (191,857) adolescents and young adults receiving SRH services, including VCT, divided by sex and IDP status
  - 5,000,000 condoms distributed
  - 32 adolescents and young adults receiving ARVs out of 150 with an HIV + diagnose (8.5 HIV prevalence)
  - 28,429 voluntary and informed tests applied
  - Indicators for the accomplishment of OBJECTIVE NO. 3
  - 375,785 adolescents and young adults reached by the training and empowerment program
  - 999 youth and adolescents benefited directly by the social, cultural and income-generation micro-projects and 32,100 adolescents and young adults benefiting indirectly
  - 2,100,000 adolescents and young adults reached by the social marketing strategy focusing on promoting protective factors, with emphasis on the condom-use and the access to SRH services and more particularly VCT services

Challenges and lessons learned

- One of the key issues when working with populations in contexts of internal displacement in a country in conflict or post-conflict is to guarantee the security of persons who wants to access VCT services or turn out with an HIV positive diagnose. That is, the confidentiality has to be improved.

- Another key issue is to put importance on the security of the personnel working in this kind of programmes or projects
Challenges and lessons learned

• In order to reduce stigma and to enhance the integration process, it is important to consider to work in contexts of internal displacement rather than with internally displaced persons.

• Also, with the aim to promote acceptance and entry-points of HIV and AIDS programmes it is sometimes more efficient to assume a more comprehensive approach than promoting pure HIV and AIDS prevention and/or attention programmes.

Challenges and lessons learned

• One of the most important protection factor against HIV is the reconstruction of social networks and life-projects.

Challenges and lessons learned

• It is essential to provide opportune and flexible health services in order to not lose “the moment” when interacting, specifically with internally displaced populations.

Thank you!
Health Services and Data Collection among IDPs in Burma/Myanmar

Thomas Lee, MD, MHS
Assistant Professor of Medicine
UCLA School of Medicine
Director, Global Health Access Program (www.ghap.org)

Burma/Myanmar
- Complex emergency
- World’s longest civil war
- “Four Cuts”

Outline
- IDP situation
- HIV data and services
- Community-Based Organizations response
- Rapid Assessments

GHAP’s role: training, technical support, resource access, and funding (1998-)

Burmese Populations 2006
- 48-54 million citizens
- 1-2 million internally displaced
  - Eastern Burma app. 600,000 IDPs
- 1.2-1.6 million Burmese migrants workers in Thailand, 575,000 legally registered
- 150,000 refugees (mostly Karen) in official camps in Thailand

Militarization in Eastern Burma, 2006

Displaced Villages in Eastern Burma, 1996-2006
HIV Data

- UNAIDS: ANC 2.2% in 2000 to 1.3% in 2005
- JHBSHPH: 3.4% in 2000
- Limited Sentinel Surveillance: lack in key border areas

Table 1. HIV Sentinel Surveillance Data at ANC, 1992-2005. From the National AIDS Control Program of the Ministry of Health, India (WHO data).

<table>
<thead>
<tr>
<th>Group</th>
<th>Number of Districts</th>
<th>Number of Cases</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIV positive</td>
<td>10</td>
<td>1,215</td>
<td>10%</td>
</tr>
<tr>
<td>Non-positive</td>
<td>5</td>
<td>624</td>
<td>8%</td>
</tr>
<tr>
<td>Unknown status</td>
<td>5</td>
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India: ANC = 8% in some border districts, 2002
China: Kachin military recruits = 9%, 2006
Thailand: Mae Tao Clinic
ANC = 2.2%, 2005
Shan migrants = 4.9%, 1999

Border Data

India: ANC = 8% in some border districts, 2002
China: Kachin military recruits = 9%, 2006
Thailand: Mae Tao Clinic
ANC = 2.2%, 2005
Shan migrants = 4.9%, 1999

Distribution of Reported Cases of HIV Infection, 2004, Yunnan Province

Heroin Trafficking and Spread of HIV

Nagaland HIV/AIDS in India
The Hard-hit States

High prevalence districts
May not be valid

CIA World Factbook

Location of Bengal

Bengal is a state in India located in the northeastern region of the country.
**Government & Agencies**

- National Aids Control Program budget 2004: US$22,000
- GFATM withdrawal of US$98 million, citing "restrictions in access"—IDPs?
- Withdrawal of MSF France, ICRC
- 3D Fund: US$90 over 5 years (AusAid, DfID, EC, Netherlands, Norway, Sida)—IDPs?
- MSF Holland, PSI, other NGOs

**HIV-related services**

- Outreach services / Drop-in centers
- 30,000 STI treatments

**Cross-Border access to IDPs: Community-Based Organizations**

- Novel approach to healthcare delivery and data collection for IDPs
- IDPs actively gathering information among themselves
- Thailand: Karen, Karenni, Mon, Shan
- India: Arakan, Chin
- China: Kachin, Palaung

**Sample CBO Organizations**

- **Backpack Health Worker Team (BPWHT)**
  - 76 back pack teams
  - Target population: 160,000 IDPs (Karen, Karenni, Mon)
  - 2-4 health workers per team
  - Total back pack workers: 300
  - 80,000 cases per year

- **Karen Department of Health and Welfare (KDHW)**
  - 33 Mobile Health Clinics
  - Target population: 106,466 (Karen)
  - 3-5 health workers, plus support staff, per clinic
  - Total clinic health workers: 327
  - 138,000 cases per year

**Data Collection**

- Original goals: Programmatic, local capacity, feedback
- Human Rights
- Advocacy Reports
- Scientific Publications
- Conferences
- Partnership: Johns Hopkins Center for Public Health and Human Rights (Chris Beyrer)

**Chronic Emergency**

*Health and Human Rights in Eastern Burma*

**Rapid Assessment Surveys**

**Security concerns**
- Days in village limited
- Displacement of entire village
- Selected cluster inaccessible
- Risk to health workers, but no one else possible

**Context demands simplicity**
- Surveys by health workers during normal course of work
- Travel on foot up to one month
- 1-2 page limit
- Training time limited, Interview time limited = Quantitative

**Household census, vital events**
- Morbidity, RH, malaria, HIV KAP, etc.
Methods - Design

• Retrospective household surveys
  – Reporting of vital events, 12 month recall
  – Seven rounds 2000 – 2006, 2006 surveys currently being analyzed
  – Census

• Sampling (latest)
  – Two stage village-based cluster design
  – 100 clusters, 20 households / cluster
  – Random selection proportionate to village population (PPS)
  – Household selection: interval sampling

Eastern Burma IDP mortality

<table>
<thead>
<tr>
<th>Year</th>
<th>2002</th>
<th>2003</th>
<th>2004</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 5 Deaths</td>
<td>140</td>
<td>130</td>
<td>100</td>
</tr>
<tr>
<td>6 - 17 years</td>
<td>150</td>
<td>120</td>
<td>100</td>
</tr>
<tr>
<td>18+ years</td>
<td>450</td>
<td>450</td>
<td>450</td>
</tr>
<tr>
<td>Total Deaths</td>
<td>740</td>
<td>600</td>
<td>550</td>
</tr>
</tbody>
</table>


Selected Morbidity Indicators

<table>
<thead>
<tr>
<th>Morbidity Prevalence</th>
<th>N</th>
<th>Positive (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>P positive (respondents only)</td>
<td>1739</td>
<td>216 (11.2)</td>
</tr>
<tr>
<td>- children 1-5 years old (n=1463)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Malaria (MUAC)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- mild (12.5 cm - 13.5 cm)</td>
<td>1335</td>
<td>147 (10.8)</td>
</tr>
<tr>
<td>- moderate (11.0 cm - 12.5 cm)</td>
<td>36 (2.6)</td>
<td></td>
</tr>
<tr>
<td>- severe (&lt; 11.0 cm)</td>
<td>25 (1.8)</td>
<td></td>
</tr>
<tr>
<td>any malnutrition (&lt; 13.5 cm)</td>
<td>208 (15.0)</td>
<td></td>
</tr>
<tr>
<td>- child diarrhea in previous two weeks</td>
<td>1839</td>
<td>252 (13.5)</td>
</tr>
<tr>
<td>- burns in household</td>
<td>1818</td>
<td>13 (0.8)</td>
</tr>
</tbody>
</table>
Linking Morbidity and Mortality to Human Rights

BPHWT added short set of questions to health surveys to 2004 round
6 questions (+GBV)
Household level
12 month recall period


Sample Questions
- In the past 12 months, how many people, from your household:
  - were forced to work against their will
  - were shot, stabbed, or beaten by a soldier
  - had a landmine or UXO injury
- In the past 12 months, how many times has your household:
  - Had the food supply (including rice field, paddy, food stores, and livestock) been taken or destroyed?
  - Been forcibly displaced or moved due to security risk?


<table>
<thead>
<tr>
<th>Violation</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Forced labor</td>
<td>32.6%</td>
</tr>
<tr>
<td>Forced displacement</td>
<td>8.9%</td>
</tr>
<tr>
<td>Theft/ destruction of food</td>
<td>25.2%</td>
</tr>
<tr>
<td>Landmine injuries/deaths</td>
<td>1.3%</td>
</tr>
<tr>
<td>(13.3 / 10,000 per year)</td>
<td></td>
</tr>
<tr>
<td>Multiple rights violations</td>
<td>14.4%</td>
</tr>
</tbody>
</table>

Household displacement and health outcomes:

- Infant mortality: OR=1.72 (0.52 – 5.74)
- Child mortality: OR=2.80 (1.04, 7.54)
- Landmine injury: OR=3.89 (1.01 – 15.0)
- Child malnutrition: OR=3.22 (1.74 – 5.97)
- Malaria p’ sitemia: OR=1.58 (0.97 – 2.57)

Families reporting theft/destruction of food supply and health outcomes:

- Child mortality: OR= 1.19 (0.67 – 2.15)
- Crude mortality: OR= 1.58 (1.09, 2.29)
- Landmine injury: OR= 4.55 (1.23 – 16.9)
- Child malnutrition: OR= 1.94 (1.20 – 3.14)
- Malaria p’ sitemia: OR= 1.82 (1.16 – 2.89)

Exposure to multiple rights violations:

- Child mortality: IRR= 2.18 (1.11 – 4.29)
- Crude mortality: IRR= 1.75 (1.14, 2.70)
- Landmine injury: IRR= 19.8 (2.59 – 151.2)
- Malaria p’ sitemia: IRR= 2.34 (1.27 – 4.32)

Families reporting 3 or more violations &
Child mortality: IRR = 5.23 (1.93 – 14.4)
HIV KAP

• Preliminary 2006:
  – Two thirds had ever heard of HIV/AIDS
  – One third had ever seen a condom
  – Extremely poor knowledge about transmission

Maternal Child Health Centers
“MOM” (Mobile Obstetric Medics)

• Address High Maternal Mortality
• Address High Neonatal Mortality
• Mobile providers of Basic Emergency Obstetric Care and other essential RH services
• Provide training for local health workers and Traditional Birth Attendants (TBAs)
• Support from Gates Institute for Population and Reproductive Health

Adapt evidence-based interventions for IDPs

• Maternal
  – Antenatal Care
    • Deworming, ITN, Malaria Screening
    • Folate acid supplement
    • Education re essential newborn care / birth spacing / danger signs / breast feeding
  – Labor and Delivery Care
    • Skilled attendance at birth
    • Basic emergency obstetric care – e.g. misoprostol, kiwi
    • Clean and hygienic delivery
  – Postnatal care
    • Postpartum visit
    • Birth spacing supplies / education
    • Vitamin A supplement
• Neonatal
  – Clean and hygienic delivery
  – Essential newborn care (skin-to-skin contact / thermal care)
  – Early/Exclusive Breastfeeding

Example: Blood Transfusion

• Developed a field protocol for blood screening for emergency transfusions
• Based on “living blood bank” concept-prescreening of family, community for typing
• Heat stable rapid test algorithm based on disease prevalence
• Could allow for safe transfusion in IDP settings
• Rethinking the appropriateness of the “Basic” vs. “Comprehensive” dichotomy

MOM Platform for future HIV-related services for IDPs

• VCT
• PMTCT?
• Prophylaxis
• ART? (TB Community-based DOTS)
Conclusions

• IDP context is challenging for health care and for research—M & E
• Potential to understand direct and indirect impacts of conflict and human rights violations on health
• Building capacity among affected populations to do this work is a rights-based approach to health