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

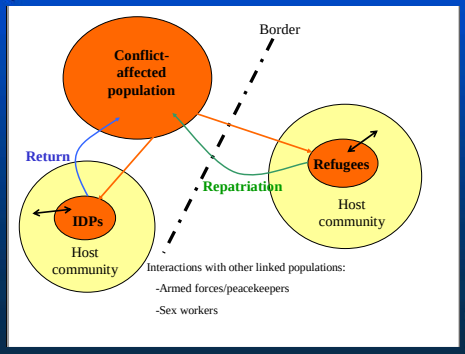
Background

- Insufficient knowledge about HIV among IDPs
  - Vulnerabilities, risks, transmission, interventions
  - Misinterpretation of data and unsubstantiated rumours

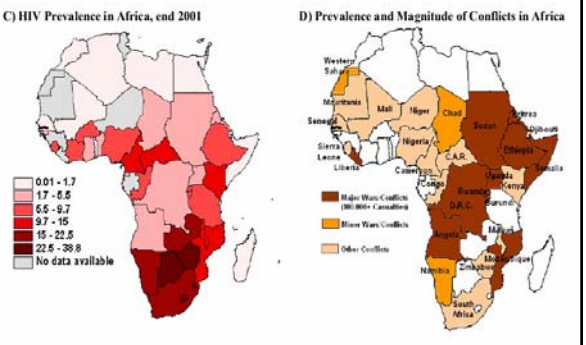
  "The rate of HIV/AIDS infection in northern Uganda is nearly double that in the rest of the country…"
  Source: Associated Press, Sept 27, 2004

  "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

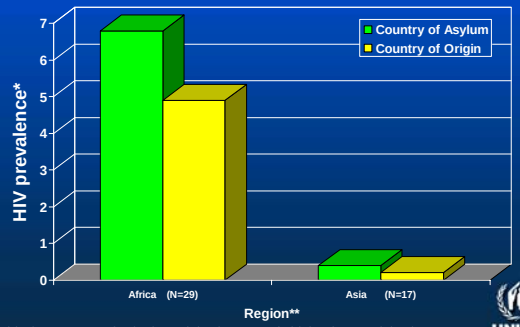


HIV and Conflict



Mock NB, Duale S, Brown LF, et al. Conflict and HIV: A framework for risk assessment to prevent HIV in conflict-affected settings in Africa. *Emerg Themes Epidemiol* 2004;**1**(1):6.

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



* Weighted means: country of asylum by population size, country of origin by refugee population size
** N refers to countries of asylum with ≥10,000 refugees

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

Modified from Spiegel PB. HIV/AIDS among Conflict-affected and Displaced Populations: Dispelling Myths and Taking Action. *Disasters* 2004;**28**(3):322-39.

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

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

	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	117,000 - 6,700,000	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 program, 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.[1]

* 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.[2]

** Colombia and Nepal are not part of MAP but are other World Bank assistance programs. Colombia's Country Assistance Strategy (CAS) for 2003-06 makes no specific reference to HIV/AIDS, refugees or IDPs.[3] 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.[4]

HIV Behav. and Bio. Surveys and Assessments 2007

Country	No. of IDPs 2005/06	Country HIV Prevalence (low - high) 2005	IDP HIV Prevalence	Behav. Surv. Survey	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[1]	no	2002, 2007
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	2006
Sudan	5,300,000 – 6,700,000	2.3 (0.7 – 7.2)	1.0% 2002-Bahri, Kassala, Khartoum, Omdurman	no	no
Uganda	1,300,000 – 1,400,000	4.1 (2.8 – 6.6)	no	no	no

1. Mulanga C, Edidi Bazepeo S, Kasali Mwamba J, et al. Political and socioeconomic instability: how does it affect HIV? A case study in the Democratic Republic of Congo. AIDS 2004;18(5).
2. Sudan National AIDS Control Program. Situation Analysis: Epidemiological Surveys & Response Analysis: HIV Process: Federal Ministry of Health, Nov 2002.

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

Key Issues

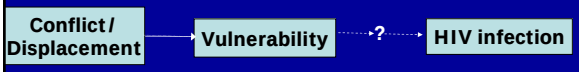
- Protection, human rights, SGBV
- Coordination
- Inclusion and integration
- Modification of policies, strategies and progr. from other emergency affected pop.
- Urban, dispersed vs. camp-like situations
- Underground/difficult to access (e.g. like IVDUs)
- Directed to IDPs/returnees directly or to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

First Global Consultation Meeting on HIV and IDPs

Situational analyses and assessments

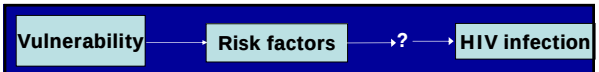
Dr M Carael, consultant

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



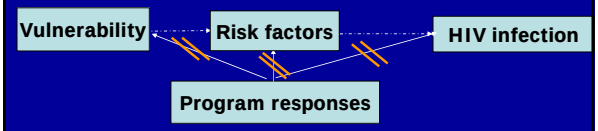
Risk factors for HIV

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

1. A district assessment tool	Quantitative information *such as data on reproductive health, HIV/STI epi data.*
2. Semi-structured observations	Visits and record reviews of Health & other services
3. Semi-structured interviews	IDPs & conflict-affected populations Populations most at risk
4. Semi-structured interviews	Key informants, *such as leaders, service providers, stakeholders*
5. Focus groups	IDPs & conflict-affected populations

*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

*Adapted from refugees tool

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

- Maoist insurgency: 1996 – 2006
- 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 situation)
- 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
  - Incorporated condom availability for uniformed forces, NGO HIV -Workplace policies and codes of conduct

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

Recommendations (cont'd)

- 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: 322.462Km
- IDP : 1 738 363
- Hommes : 48%
- Femmes : 52%

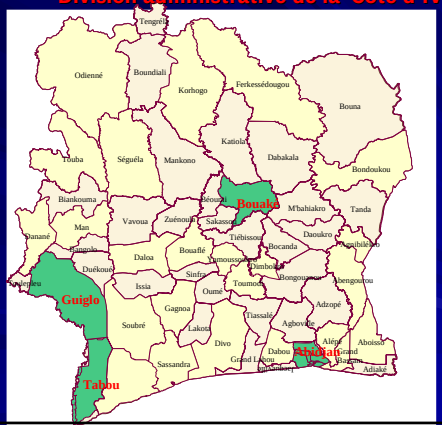
BACKGROUND (1)

- 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

Division administrative de la Côte d'Ivoire



BACKGROUND

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	MISSION COORDINATION
Adult prevalence: 4.7% **Est. number of PLWH**: 390000-820 000	**Coordination**: UNHCR with UNAIDS **Technical working group** Task Force IDP & HIV (new) **Participants**: UN agencies, government, NGOs

METHODS AND ANALYSIS

COLLECTION

- Quantitative data gathering for Abidjan, Bouaké, Guiglo and Tabou
- Semi-structured qualitative interviews with key informants
- Semi-structured qualitative interviews with IDPs and host populations (target groups)
- Focus group discussions
- Site observation

ANALYSIS

- Summarised interviews
- Identified the needs of IDPs and host communities
- Assessed the impact of conflict on HIV vulnerability and risk of HIV infection

IMPACT OF CONFLICT

CONFLICT → **DISPLACEMENT**

Presence of men in uniform

Destruction/closure/absence of health services (Bouaké, Guiglo, Tabou)
Interrupted/no HIV interventions

Overloaded health services (Abidjan)

Increased reliance on traditional healers

School closure / overload (all sites)

Unemployment due to loss of investment

VULNERABILITY TO HIV

impoverishment
unemployment
family fragmentation/loss
disrupted social networks
dependence (external aid, relatives, third parties)

RISK OF HIV

sexual trading (with militias, soldiers and civilians)
sexual exploitation (by families, militias, soldiers and civilians)
early sexual relations
unsafe sex (unprotected, multiple partners)

PREVENTION

VULNERABILITY AND RISK FACTORS	RECOMMENDATIONS
General population ▪ growth in materialistic needs **IDPs** ▪ widespread reliance by female IDPs on men earning wages ▪ extramarital sexual relations during war-induced separations **Children** ▪ now sexually active as of 9 yrs (Tabou) **Displaced Children** ▪ unaccompanied, out of school, with dependants ▪ loss of parental authority due to loss of employment / humiliation **Students** ▪ Increase in room sharing ▪ Sexual trade among girls **Displaced Students** ▪ Loss of financial support from parents	**Develop a strategy to ensure social and economic independence among IDPs** **Begin HIV prevention targeting children** **Develop a protective mechanism for displaced children** **Reinforce prevention interventions among students**

PREVENTION

HIV KNOWLEDGE	CONDOMS
Minimal knowledge among target group ▪ only sexual transmission and ABC ▪ sometime none at all ▪ no updated information since the war (Guiglo) **Good knowledge among PLWH support group** (Abidjan)	**Poor availability** ▪ particularly in rural locations **Low use**: - when there is dependence on a partner who refuses - despite knowledge of partner's HIV+ status - among non-sex worker partners and soldiers (incl. UN) **Stated use**: - with sex workers (according to SW and clients)
RECOMMENDATIONS	**RECOMMENDATIONS**
Improve quality and dissemination of information on HIV	**Improve condom availability and use**

PREVENTION

HIGH RISK GROUP PROFILES	VCT
Female sex workers & clients ▪ Displaced Ivorian and displaced Liberian refugees ▪ Men in uniform (Bouaké, Guiglo, Tabou) ▪ All ages, professions and nationality (Abidjan) **Male sex workers & clients** ▪ Poor young men with richer women (Tabou, Guiglo) ▪ Increase with demand from men in uniform and UN soldiers (Bouaké)	**Uptake** ▪ Mostly due to illness or pregnancy ▪ Sometimes a prerequisite for marriage by some religious leaders ▪ Low uptake among PLWH partners and at-risk groups (sex workers, etc.) **Confidentiality and counselling** ▪ Breach of confidentiality ▪ No counselling **VCT follow-up** ▪ Multiple cases of + result without referral for treatment, care and support
RECOMMENDATIONS	**RECOMMENDATIONS**
Design an HIV prevention for male and female sex workers and clients	**Improve VCT access, quality, confidentiality and referral**

PEOPLE LIVING WITH HIV

STIGMA AND DISCRIMINATION	TREATMENT, CARE AND SUPPORT
Among PLWHs ▪ Threat of rejection by family and sexual partner if status is revealed ▪ Loss of authority and rejection by children ▪ Impoverishment ▪ with loss of employment due to war/illness ▪ accentuated by the influx of unemployed displaced relatives **Among displaced PLWHs** ▪ Rejection of displaced PLWHs by host family (incl. children)	**By site** ▪ Minimal or none at all **Barriers among PLWHs** ▪ Cost of treatment ▪ Lack of nutrition (led to stop in treatment) **Displaced PLWHs** ▪ ARV adherence difficulties (close living conditions and risk of revealing status through suspicious behaviour) ▪ lack of health care/ARVs due to war causing some displacement
RECOMMENDATIONS	**RECOMMENDATIONS**
Address stigma and discrimination and support PLWHs (incl. IDPs)	**Ensure access to treatment, care and support**

RECOMMENDATIONS

SEXUAL EXPLOITATION	COORDINATION, M&E
Perpetrators ▪ Militia (Bouaké), soldiers (Bouaké) (incl. UN peacekeepers), police ▪ Teachers (Bouaké), civilians (Abidjan) **Victims** ▪ Children (some forced by parents to enter sex work), women, sex workers (Abidjan) **Services** ▪ Bouaké: no PEP kits ▪ Guiglo: medical, psycho-social	**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	**RECOMMENDATIONS**
Implement and enforce the law and sanctions on sexual violence (incl. UN peacekeepers) **Ensure psycho-medical service access**	**Implement a coordinating mechanism at all levels**

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	NEXT STEPS PLANNED
▪ **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**	▪ **Report dissemination** (May) ▪ **Workshop for ministries** (May) "Une réponse complémentaire et multisectorielle sur les 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'Éducation 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

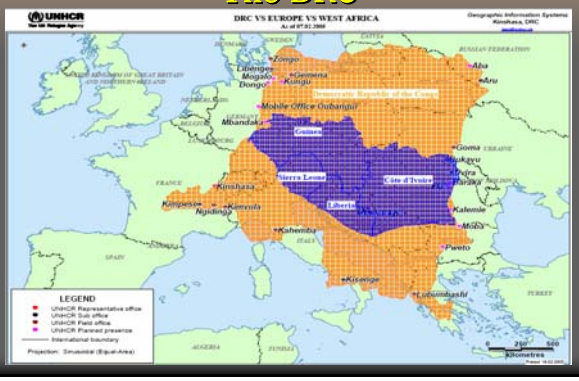
Asapsu, ASA, Caritas, Alliance des religieux et Rip+

INTERAGENCY HIV ASSESSMENT MISSION OF INTERNALLY DISPLACED PEOPLE AND THEIR HOST COMMUNITIES IN CÔTE D'IVOIRE

INTERAGENCY HIV ASSESSMENT AMONG IDPs AND HOST POPULATIONS IN THE DEMOCRATIC REPUBLIC OF CONGO

Dr Dieudonne T.S. YIWEZA
Snr Regional HIV/AIDS Coordinator
Central Africa

The DRC



The DRC

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 out side: Latest estimates: 1,1 mio IDPs (OCHA, 2006), 413,000 ref. still in surr. 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

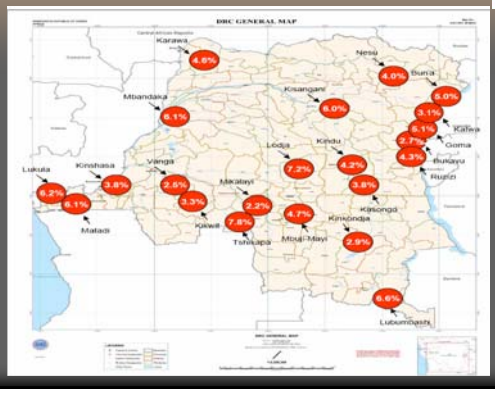
Humanitarian situation…

- Insecurity➔ populations of humanitarian inaccessible
- 2006: First time in over 40 years: Democratic elections
  - Improved security situation: more returns to area of origin expected [refugees and IDPs]
  - Still poor geographical accessibility (transport & communication)

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

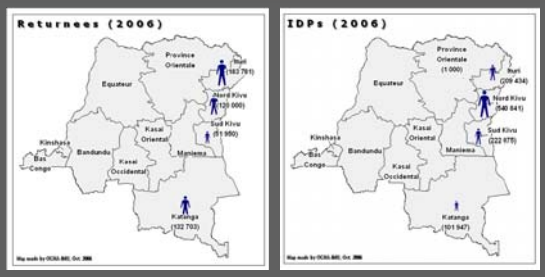
HIV situation in 2005



Background to the study

- 4 provinces called « provinces of Conflicts »; 5 locations
  - Orientale (Ituri: Bunia)
  - North Kivu (Goma: Rutchuru 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, BIT, 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...

... services

MINIMAL VCT AVAILABILITY/USE

- Low uptake/knowledge among respondents
- Too 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…

… among HOST POPULATION

MINIMAL CONDOM USE due to:

- Unavailability
- Lack of knowledge (benefits/use)
  - Belief it may slip in uterus (Bunia)
  - Among high risk/vulnerable groups (sex workers, men in uniform, young people)
- Price
- Lack of pleasure
- Association with prostitution
- Long-term sexual partner

… among IDPs and war victims

ADDITIONAL FACTORS:

- Trauma and fatalism
- Destitution and self-reliance
  - Particularly among women and children separated (by force/choice)

Je compte 19 partenaires sexuels hommes qui ont refusé d'utiliser le préservatif lors de nos relations sexuelles bien que j'ai insisté sur mon état sérologique. Parfois ce refus s'accompagne de violences ou du chantage. Et quand je leur dit, je vous protége, ils prennent prétexte pour me rétorquer en ces termes : « Si tu es réellement séropositive tu ne peux pas le déclarer comme tu le fais et c'est bien la preuve que tu ne l'est pas. » [une PVV]

Nineteen of my sexual partners have refused to use a condom, even though I told them that I was HIV positive. Sometimes, they also become violent or resort to blackmail. And when I tell them that I am protecting them, they say: "If you were truly HIV positive, you wouldn't tell me. This is proof that you're not". [a female PLWH]

Findings on protection needs…

… among host population

PEOPLE LIVING WITH HIV

- Face widespread stigma and discrimination

« le jour qu'on saura que je suis VIH positive, c'est bien ma mort. »
« The day they find out I am HIV positive will be my death. »

VICTIMS OF SEXUAL AND GENDER-BASED VIOLENCE

- Victims are not always referred to VCT (Moba)
- Rape victims are stigmatised and isolate themselves
- Perpetrators are not prosecuted
- Psychosocial services are weak (Bunia)

… among IDPs

CHILDREN

- Lack of protection for children in IDP camps (noted during early stages of the war, Bunia)
- No services for street children in Bunia

WOMEN

- Lack of food and shelter (Bunia)

Findings …

… on treatment care and support services

- Available in Goma, Bunia and Uvira
- None in Moba (no referral either)

… on access for IDPs

Very limited everywhere: poor accessibility: geographical and financial

… on coordination

CLUSTERS

- HIV coordination in health cluster in Uvira
- No coordination in Moba

… on monitoring and evaluation

EFFORTS

- None in Moba

EFFECT OF CONFLICT

- Interrupted STI monitoring in Uvira

Findings on conflict and HIV…

… with increased HIV vulnerability

POVERTY (Pillage, destruction of fields)

- Sex work for women and men
- Long term sexual partnership with financial support

FAMILY SEPARATIONS

- Women obliged to leave their families (forced labour, sexual expoitation by men in uniform
- Children
  - Drop out of school
  - Live in the streets

LACK OF PARENTAL AUTHORITY

- When IDP families rely on their children's income

GROWTH IN MATERIALISM

- With displacement and resulting exposure to urban life

STRONG PRESENCE OF MEN IN UNIFORM

- Concentration of sex workers around (UN/FARDC) soldier barracks

…with decreased HIV vulnerability

SCHOOLING OF GIRLS

- Linked to the presence of female role models in NGOs
- Also to the growth in private schools (where child mothers are accepted) and UNICEF

La fille est [devenue] une marchandise. J'ai une amie, sa mère l'a chassée de chez elle car elle ne voulait plus faire la prostitution. Elle est partie habiter avec des amies. Elle a un enfant de 5 ans. Avant [la guerre], elle étudiait avec moi. [Une lycéenne]

Daughters [have become] a commodity. I have a friend whose mother chased her out of her home because she refused to continue working as a prostitute. She went to live with her friends. She has a five year old child. Before [the war], she was studying with me. [A female high school student]

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 Heath 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 (ISAC)
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

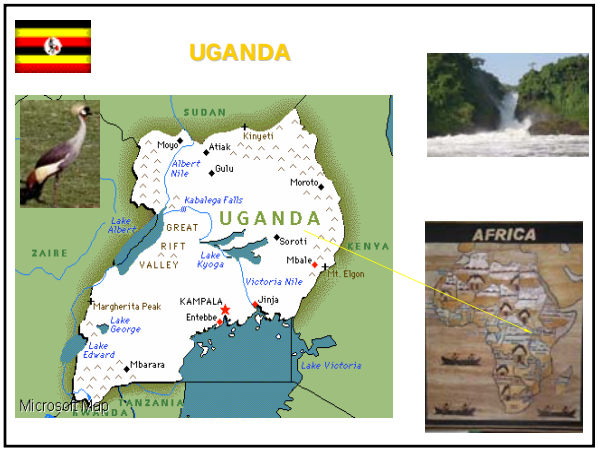
Geneva, 24th – 25th April 2007

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

Population (2006): 28.8 M
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)

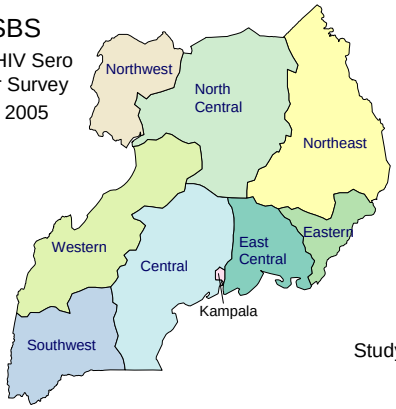
Sources: Ministry of Education, www.education.go.ug; Ministry of Health, www.health.go.ug/health_ind.htm; 2005 World Population Data Sheet; www.mgls.gov.ug/lcvc; www.globalhealthfacts.org; Department for International Development, www.dfid.gov.uk; UNOCHA, CAP 2007; World Bank Profile Tables, www.worldbank.org; UNDP, Human Development Report 2005; Department of Economic and Social Affairs (DESA) Population Division (2004); WHO Strategy paper for 2006, UN OCHA situation report Uganda 2006

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

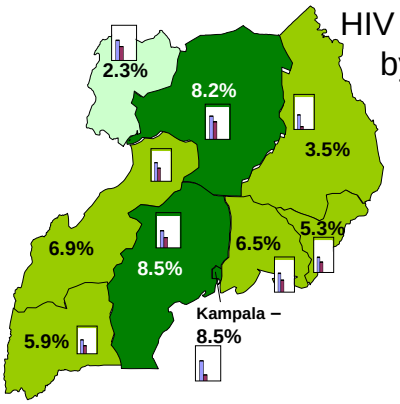
Source: Ministry of Health, www.health.go.ug/health_ind.htm , Uganda HIV/AIDS Sero-behavioural Survey 2004-2005

UHSBS
Uganda HIV Sero Behavior Survey
2004 - 2005



Study Areas

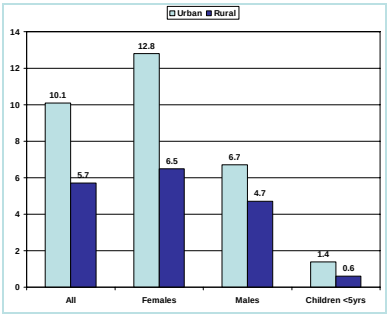
HIV Prevalence by Region



Uganda total: 6.4%

Percent of men and women 15-49 who are HIV positive

Urban-Rural HIV Infection Prevalence



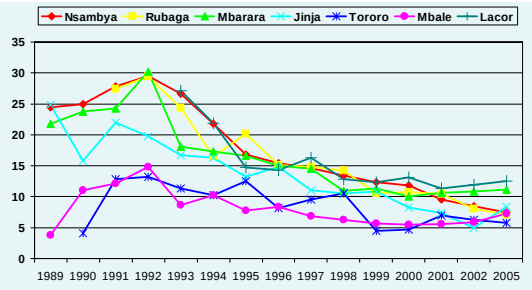
- Urban residents have a significantly higher risk of HIV infection
- The urban-rural disparity stronger for women and children than for men.

UGANDA and WAR

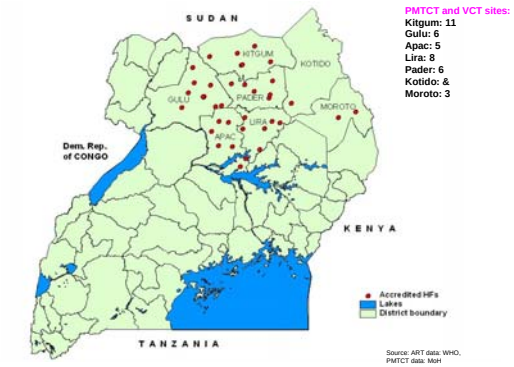
- Uganda is affected by a 20-year conflict in the North, which caused the internal displacement of 1.6 million people.

Total estimated displaced people by end of 2006

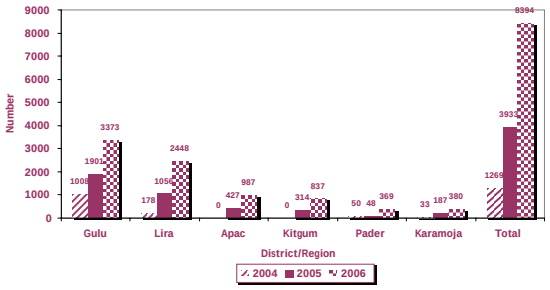
Trends in Antenatal HIV prevalence in selected sentinel sites



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



Number of Patients on ART in Northern Uganda& Karamoja: 2004 - 2006



Source: WHO

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%)

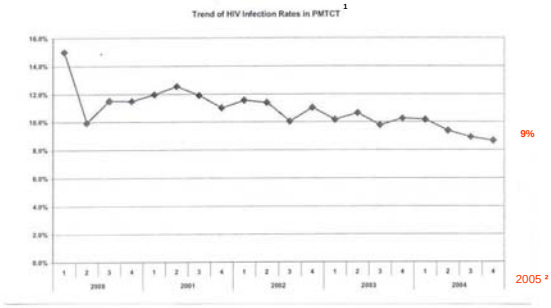
4- Enrolment uptake was higher in conflict-affected (100%) than in peaceful regions (75%).

5- HIV prevalence was lower in internally displaced camps (4.6%) than outside (6.0%).

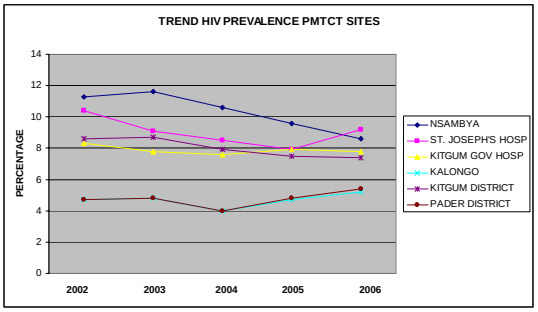
6- Internally displaced camps had higher rates of pre-test, test and post-test than other centres.

7- Similar estimated PMTCT coverage in conflict-affected and peaceful regions, with high regional variability.

Source: abstract n. TUPE0360



Source 1: PMTCT 2004 Annual Report MoH
Source 2: PMTCT 2005 Annual Report MoH



Prevention: Protection and Psychosocial Issues

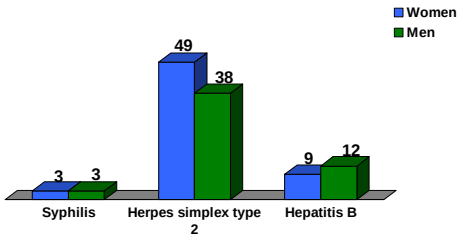
- There is an evident need to have more information on the level of the GBV (SWAY and others)
- The provision of PEP for GBV survivors as a standard measure to prevent HIV is not supported by all parties in Uganda.

  The MOH draft GBV trainer's manual (2006) 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

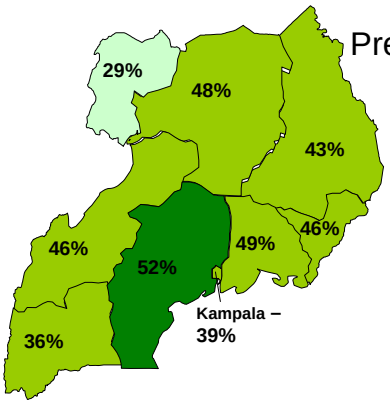
Prevention and Behaviour Change

- ABC is an essential aspect of the response
- Role of Civil Society
- Openness and inclusiviness: 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



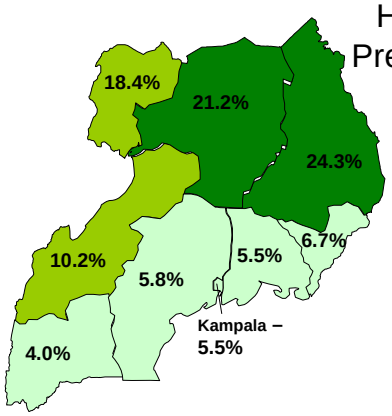
Herpes Prevalence by Region



Uganda total: 44

Percent of men and women 15-49 who have herpes

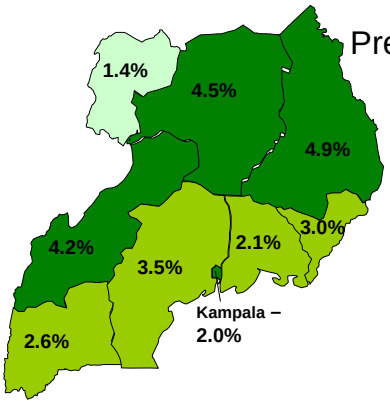
Hepatitis B Prevalence by Region



Uganda total: 44

Percent of men and women 15-49 who have hepatitis B

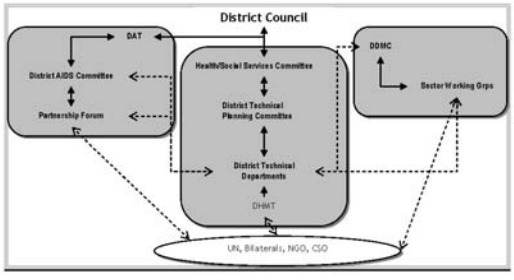
Syphilis Prevalence by Region



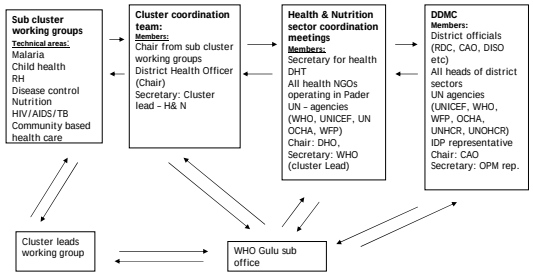
Uganda total: 3.1

Percent of men and women 15-49 who have syphilis

Example existing Multisectoral HIV/AIDS coordination structure



Example District Management structure



Cluster 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

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

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)

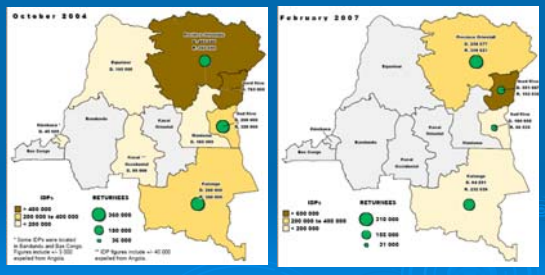
(2005 Emergency Action Plan for NU to ensure access to basic services – to be adapted to the changing situation)

MSF-OCA HIV/AIDS programs in eastern DRC:

activities, outcomes & challenges

Dr. Daniel O'Brien
MSF AIDS
Working Group

Regional IDPs



DRC

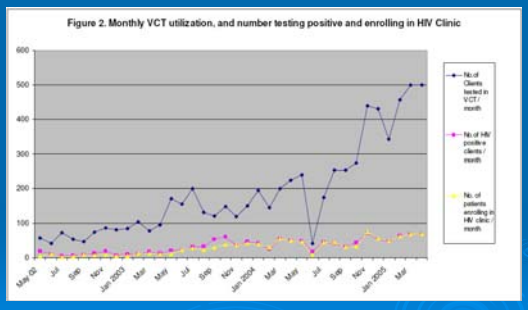
- 1996 – 2007 : Chronic War
  - 3.9 million war related deaths
  - 3.2 million internally displaced persons
- 4 Projects Eastern DRC:
  - Bukavu: vertical
  - Walikali, Sabunda, Baraka: Integrated
- Components
  - Free Medications and care
  - Generic Fixed Dose Combination ARVs
- MSF supported and supplied

Bukavu

Bukavu

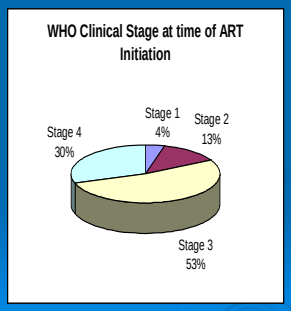
- Population: 600 000
- Adult HIV prevalence 2.6%
- HIV project started in 2000. (IEC, STI)
- VCT and OI clinic in 2002.
- ART October 2003.
- PMTCTJune 2006
- Partners: MoH, Local NGOs

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%

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

	Bukavu (Chronic Conflict Setting)	ART-LINC [10] (Low Income Setting)	ART-CC [10] (High Income Setting)
No. of patients initiating ART	494	4810	22 217
No. of patient years on therapy (Median duration on ART)	534	3744	24 310
Baseline Median CD4 count	123 [IQR 57 – 195]	108 [IQR 37 – 210]	234 [IQR 98 - 380]
6 month median weight gain (kg) [IQR]	2.5[0-5.5]	-	-
6 month Median CD4 gain (cells/ml) [IQR]	163 [IQR 82 – 232]	106 [IQR 43 – 180]	103 [IQR 32 - 192]
12 month Mortality	7.9% (95% CI 3.6–12.1)	6.4% (95% CI 5.1 – 7.7)	1.8% (95% CI 1.5 – 2.2)
12 month Loss to follow-up	5.4% (95% CI 3.2-7.5)	15% (No CI given)	5% (No CI given)

Integrated projects: Walikali

Number of IDPs

NORD KIVU (as of 01/07)	IDPs	RETURNEES
Beni	112 334	0
Walikale	28 965	30 500
Lubero	224 608	0
Nyiragongo	14 367	0
Masisi	109 572	67 150
Rutshuru	61 821	6 285
TOTAL NORD KIVU	551 667	103 935
SUD KIVU (as of 01/07)	IDPs	RETURNEES
Shabunda	11 035	36 850
Mwenga	53 780	8 645
Walungu	24 415	15 885
Kabare	47 495	700
Kalehe	26 890	6 455
TOTAL SUD KIVU	163 615	68 535

Integrated Programs

Project	Start date	CT (%HIV)	OI /FU (%CT)	ART	PMTCT
Shabunda	Feb 05	1999 (4%)	41 (57%)	11 (27%)	Yes
Walikali	Jan 06	1091 (6%)	45 (68%)	3 (7%)	No
Baraka	July 06	424 (13%)	36 (63%)	5 (14%)	No

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

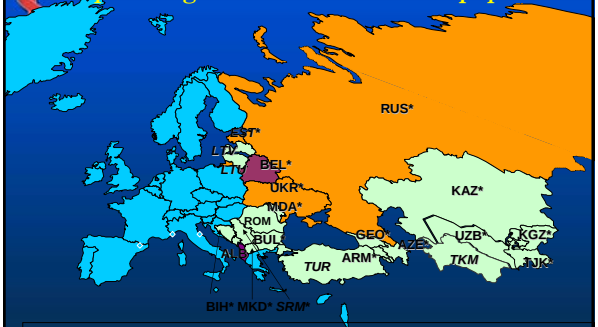
Questions?

HIV AMONG DISPLACED POPULATIONS IN THE SOUTHERN CAUCASUS, TURKEY & SOUTH EASTERN EUROPE

UNHCR, Geneva
25 April 2007

Hilary Homans

People living with HIV as % of total population



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 (c 53%)
- Reported MSM transmission in BiH (17.3%) & Serbia (15%) could be much higher due to stigma

Country context: HIV, STIs and TB

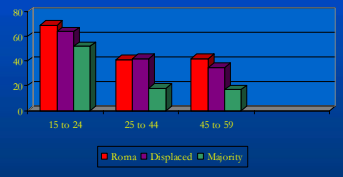
- Stigma and discrimination towards PLHIV in all countries and towards IDPs in some
- STI data under reported – weak surveillance, role of private doctors and high levels of self-treatment
- TB increasing especially amongst the poor and prison population
- MDR STIs and TB and HIV/TB co-infection

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

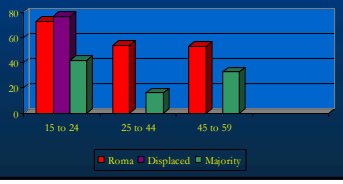
Country context: Age, sex, displacement & unemployment

BiH



71% of Roma women compared with 39% Roma men unemployed

Serbia



72% of Roma women compared with 35% Roma men unemployed

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

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

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 so 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

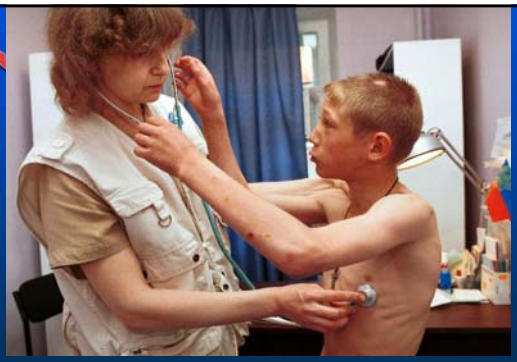
Challenges: Weak vulnerability reduction programmes

- 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



Health services for children living/ working on the street

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

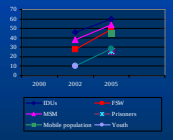
Lessons learned - UN response Armenia

- ✓ 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

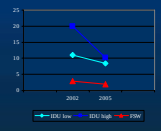
✓✓✓ Results of joint efforts and appropriate programming– Armenia

- Improvements in knowledge about HIV

% correct knowledge of HIV amongst selected population groups 2002 and 2005 in Armenia



- Changes in risk behaviour and decrease in HIV prevalence in risk groups



HIV prevalence risk groups: Armenia

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 most 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 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

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

Mainstreaming HIV/AIDS within Humanitarian Assistance for Internally Displaced Populations: Lessons from Zimbabwe

2005 – 2006

Islene Araujo, MD Msc

Overview

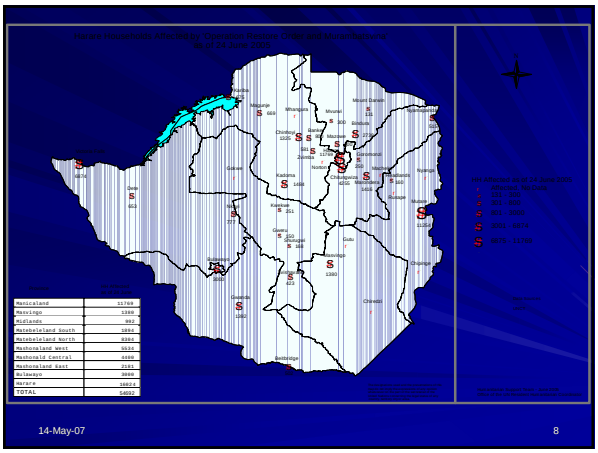
- Humanitarian Situation
- Programme Planning and Preparedness
- HIV/AIDS Humanitarian Response
- Challenges
- Lessons Learnt

- 700.000 people have being displaced
- Half of them stayed in the open air in the middle of the winter

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



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 HUMANITARINAN 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

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


01.09.2005 12:26

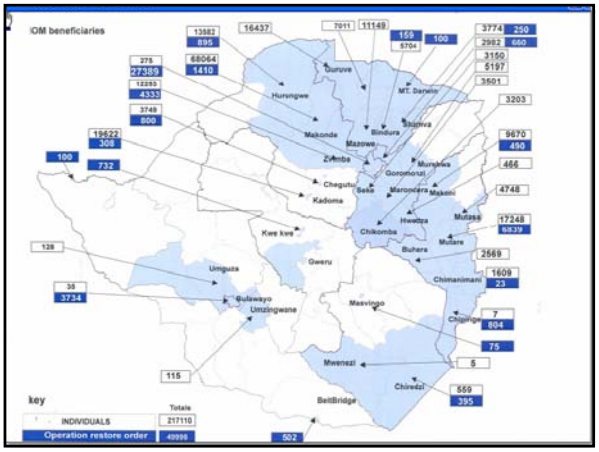

01.09.2005 12:06

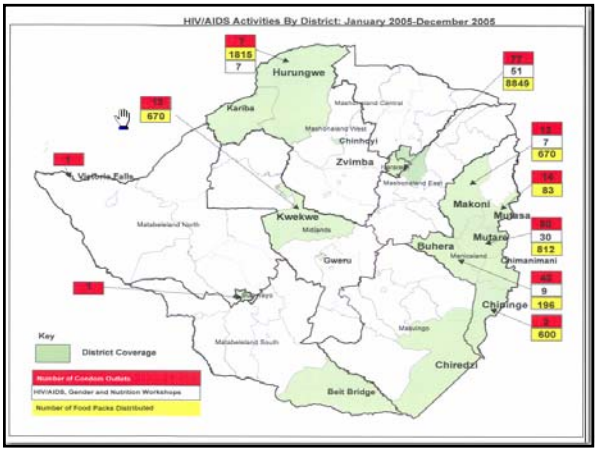

24.11.2005 02:06


09.03.2006 00:17

Implementing Partners

- **Anglican Diocese of Manicaland, Deseret, Connect, Centre for Health and Promotion of Women, New Dawn of Hope, Farm Orphan Support Trust of Zimbabwe, Population Services International, Christian Care, Lead Trust, Imbisa Refugee Services, Department of Social Welfare, Zimbabwe Community Development Trust, New Dawn Children Care Trust, ROKPA Trust of Zimbabwe, Help Age Zimbabwe, St James Home Based Care, New Hope Zimbabwe, Padare/Men's Forum On Gender, Just Joy Bridging Organization, MASO, Evangelical Fellowship of Zimbabwe, Crown Agents/John Snow International and Action Aid**





Zimbabwe lessons learnt

- **Define division of labour asap,** taking in 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

Preventing HIV and Aids among adolescents and young adults in contexts of internal displacement:

Field experience from Colombia

Contents of the presentation

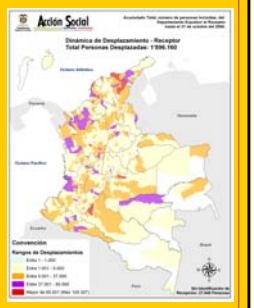
- Country context and characteristics of the internal displacement and of the epidemic of HIV and AIDS in Colombia
- Key actors and interventions
- Challenges and lessons learned

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 force.
- **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

Resultados

Indicador	desplazados	no desplazados
Cree saber mucho de ITS	12,3%	11,3%
Considera que el condón protege del VIH	65,0%	67,5%
Cree que el mosquito transmite el VIH	32,5%	28,3%
Cree que con una aguja infectada se transmite el VIH	70,9%	73,3%
Cree que el VIH se transmite al compartir platos	31,4%	28,8%
Invitaría a una persona con VIH a su casa	53,1%	55,4%
Ha tenido relaciones sexuales	51,0%	47,0%
Usó condón primera relación sexual	31,8%	36,6%
Más de dos parejas en los últimos 12meses	23,6%	18,6%
Usó condón última relación sexual	45,8%	48%
Usó condón primera y última rs	25,3%	29,0%
Ha sido obligado(a) a tener relaciones	12,3%	9,4%
Se ha realizado la prueba de VIH**	14,6%	9,3%
Nunca ha tenido o usado un condón	54,2%	50,4%
TOTAL	1.373	4.956

**De quienes han tenido relaciones sexuales

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.

Prevention → Emergency → Post-emergency

Action Plan for Humanitarian Assistance in contexts of internal displacement

- Assistance provided by the international community

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.

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
63.8% (191'657) adolescents and young adults receiving SRH services, including VCT, divided by sex and IDP status
6.000.000 condoms distributed
32 adolescents and young adults receiving ARVs out of **150** with an HIV + diagnose (**0.5** HIV prevalence)
28.420 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 particulary 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 confidenciality 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 estigma and to enhance the integration procesess, 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.

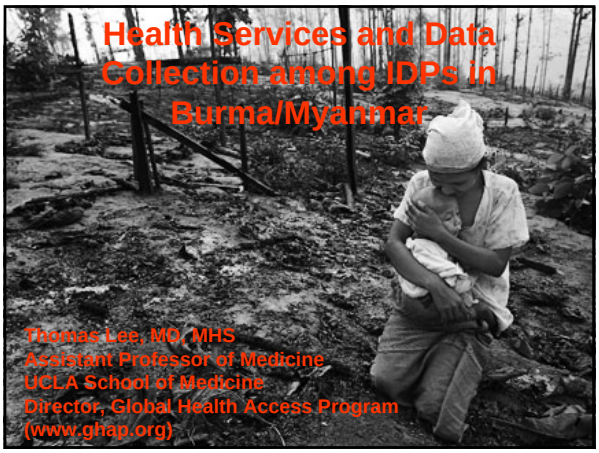
Challenges and lessons learned

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

Challenges and lessons learned

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

Thank you!



Health Services and Data Collection among IDPs in Burma/Myanmar

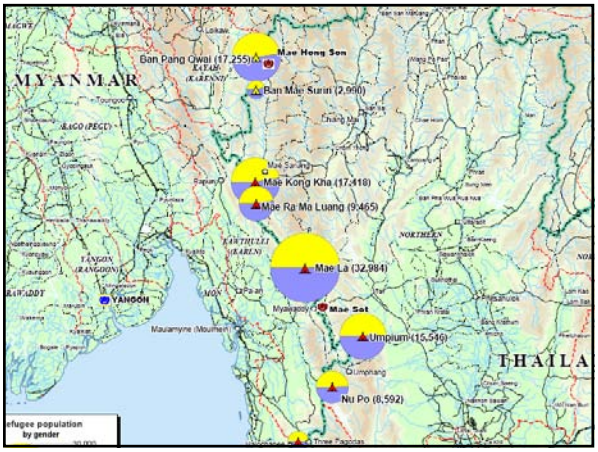
Thomas Lee, MD, MHS
Assistant Professor of Medicine
UCLA School of Medicine
Director, Global Health Access Program
(www.ghap.org)

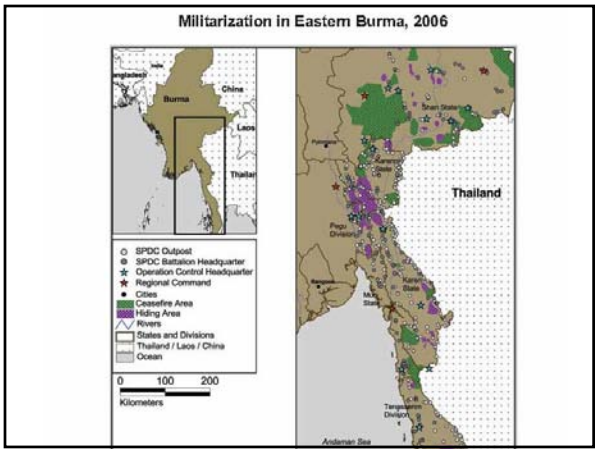
Burma/Myanmar

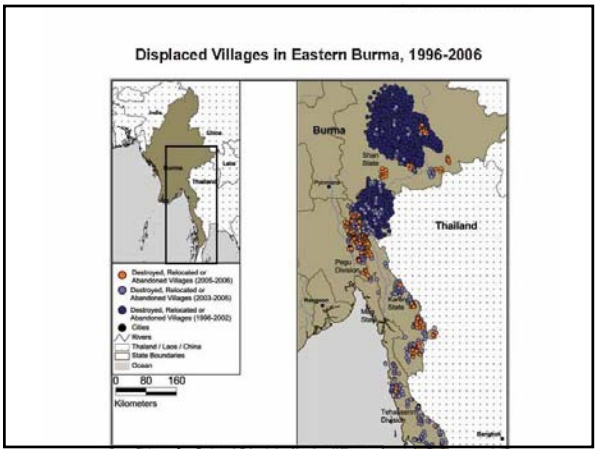
- **Complex emergency**
- **World's longest civil war**
- **"Four Cuts"**
- **Outline**
  - **IDP situation**
  - **HIV data and services**
  - **Community-Based Organizations response**
  - **Rapid Assessments**
- **GHAP's role: training, technical support, resource access, and funding (1998-)**

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







HIV Data

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

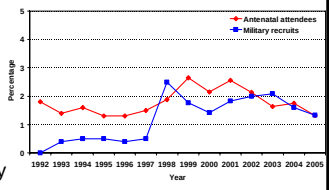


Table 2. HIV Sentinel Surveillance Data from March–April, 2002, from the National AIDS Control Program of the Ministry of Health, Burma (Myanmar)

Groups	Number of Sites	Total N	Number of People HIV+	Percent HIV+	Median	Minimum	Maximum
Male attendees with STDs	29	2,712	163	6.01	6.00	0	21.00
Female attendees with STD	8	692	63	9.09	12.55	1.00	38.18
Sex workers	2	185	55	31.35		11.00	55.17
IDUs	6	247	92	37.86	48.10	23.00	77.78
Antenatal clinic attendees	29	5,654	93	1.64	1.00	0	7.50
Blood donors	2	5,596	69	1.23		1.05	1.38
New military	2	1,199	25	2.09		1.00	2.17

Source: National AIDS Control Program of the Ministry of Health, Burma (Myanmar) [20]
DOI: 10.1371/journal.pmed.0020193.t002

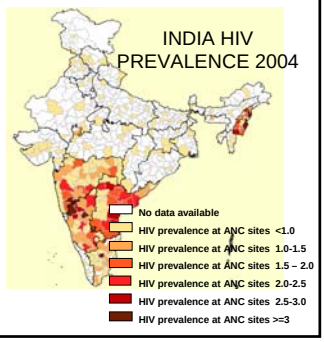
Border Data

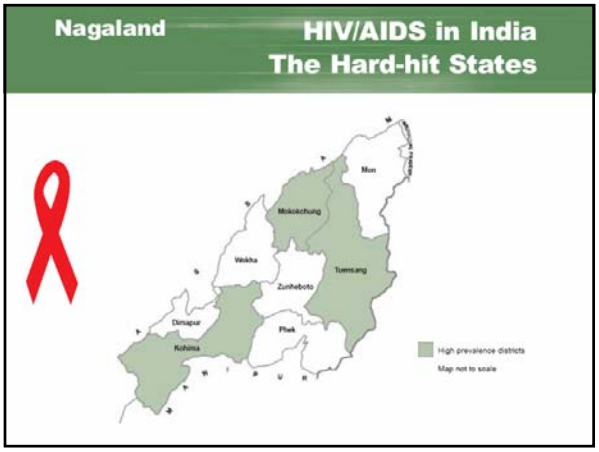
India: ANC = 8% in some border districts, 2002

China: Kachin military recruits = 9%, 2006

Thailand:
Mae Tao Clinic
ANC = 2.2%, 2005

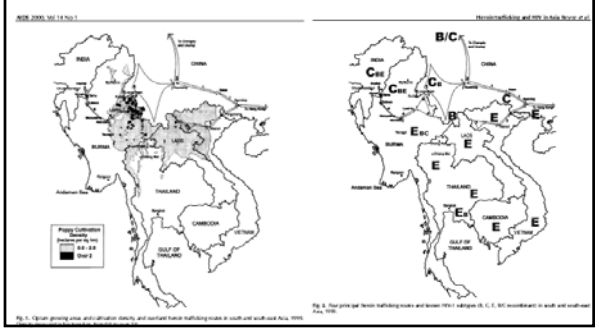
Shan migrants = 4.9%, 1999





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

Heroin Trafficking and Spread of HIV



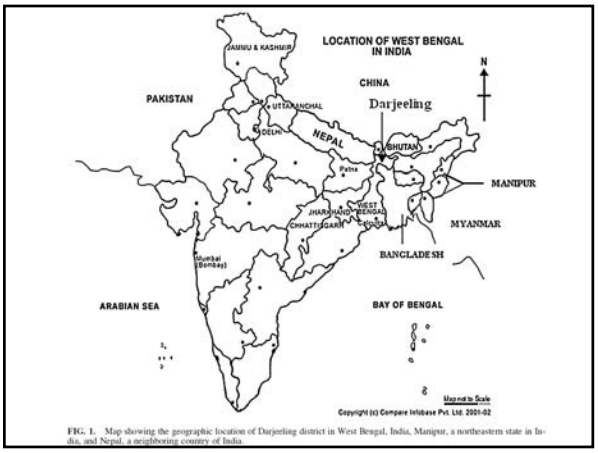
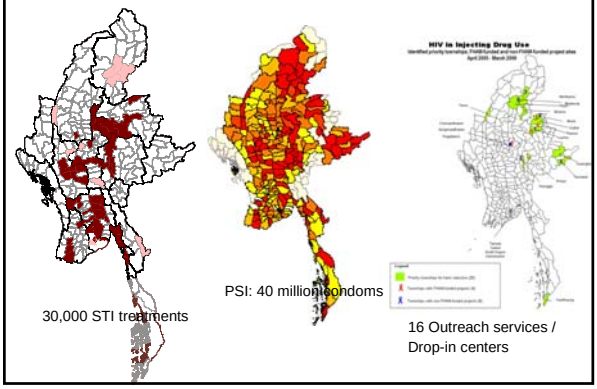


FIG. 1. Map showing the geographic location of Darjeeling district in West Bengal, India, Manipur, a northeastern state in India, and Nepal, a neighboring country of India.

Government & Agencies

- National Aids Control Program budget 2004: US$22,000
- UN Joint Program on AIDS (FHAM US$26 million 2003-2006) – prevention and care
- 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



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)

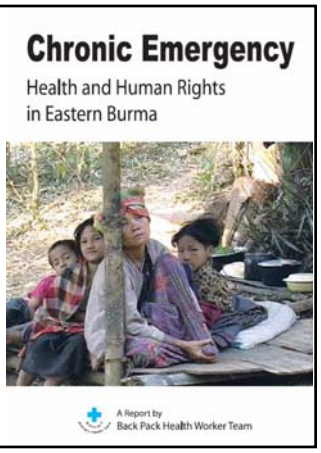
- 76 back pack teams
- Target population: 160,000 IDPs (Karen, Karenni, Mon)
- 2-4 health workers per team
- Total back pack workers: 300
- 80,000 cases per year

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)



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

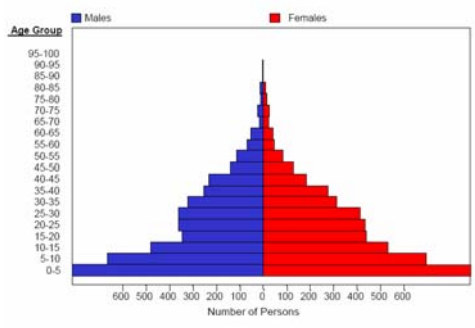
- **Retrospective household surveys**
  - **Reporting of vital events, 12 month recall**
  - **Seven rounds 2000 – 2006, 2006 surveys currently being analyzed**
  - **Census**
- **Sampling (latest)**
  - **Two stage village-based cluster design**
  - **100 clusters, 20 households / cluster**
  - **Random selection proportionate to village population (PPS)**
  - **Household selection: interval sampling**

Eastern Burma IDP mortality

	2002*	2003	2004
Mid-Year Populations			
< 5 years old	1423	1890	1856
>= 5 years old	7450	8994	7890
Vital Events			
Live Births	275	392	408
Infant Deaths	37	48	37
Under-5 Deaths	80	108	90
Overall Deaths	184	189	195
Mortality Rates	*Estimate (95% CI)*	*Estimate (95% CI)*	*Estimate (95% CI)*
Infant (IMR)	135 (73-196)	122 (70-175)	89 (49-129)
Child			
U5MR	291 (209-373)	276 (190-361)	218 (135-301)
ASDR-5	56 (37-75)	57 (40-75)	49 (32-72)
Overall (CMR)	25 (18-31)	21 (15-27)	19 (15-24)

Lee et al. Mortality rates in conflict zones in Karen, Karenni, and Mon states in eastern Burma. Tropical Medicine and International Health. July 2006.

Population pyramid



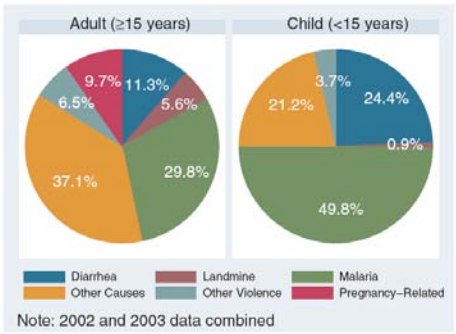
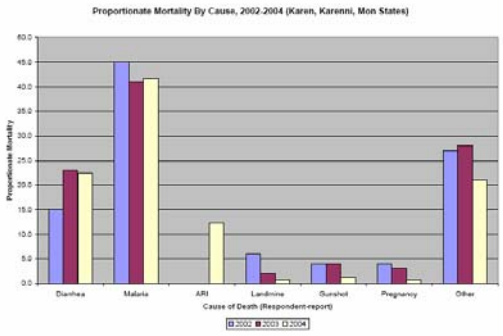


Figure 3 Reported cause of death, by age group.



Selected Morbidity Indicators

Morbidity Prevalence	N	Positive (%)
- *Pf* positive (respondents only)	1739	216 (11.2)
- children 1-5 years old (n=1462)		
Malnutrition (MUAC)		
- mild [12.5 cm -13.5 cm)	1335	147 (10.8)
- moderate [11.0 cm– 12.5 cm)		36 (2.6)
- severe (< 11.0 cm)		25 (1.6)
any malnutrition (< 13.5 cm)		208 (15.0)
- child diarrhea in previous two weeks	1830	252 (13.5)
- landmine injuries reported in household	1818	13 (0.8)

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

Mullany LC, et al. Population-based survey methods to quantify associations between human rights violations and health outcomes among internally displaced persons in Eastern Burma. [In Press J Epidemiology & Community Health, 2007]

Sample Questions

- **In the past 12 months, how many people, from your household:**
  - **were forced to work against their will**
  - **were shot at, 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?**

Prevalence of human rights violations, 2004, Households in Eastern Burma

Forced labor	32.6%
Forced displacement	8.9%
Theft/destruction of food	25.2%
Landmine injuries/deaths (13.3 / 10,000 per year)	1.3%
Multiple rights violations	14.4%

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)

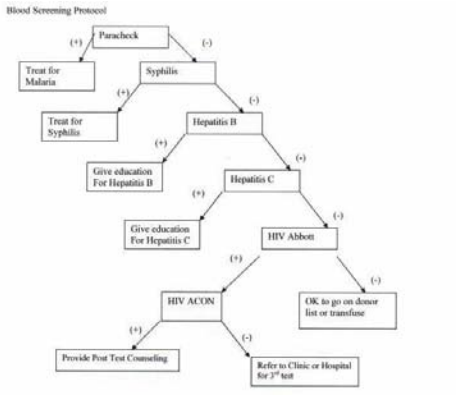
- Address High Maternal Mortality
- Address High Neonatal Mortality
- Mobile providers of Basic Emergency Obstetric Care and other essential RH services
- Provide training for local health workers and Traditional Birth Attendants (TBAs)
- Support from Gates Institute for Population and Reproductive Health

Adapt evidence-based interventions for IDPs

- Maternal
  - Antenatal Care
    - Deworming, ITN, Malaria Screening
    - Fe/Folic 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 – ex) 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