

HIV/AIDS, Conflict and Displacement



CONFERENCE REPORT

on the

XVI International AIDS Conference Affiliated Event

HIV/AIDS, Conflict and Displacement

Toronto, Canada

August 12, 2006

Hosted by UNICEF and UNHCR

unicef 



UNHCR
The UN Refugee Agency

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Canadian International
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développement international





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ACRONYMS

ADB	African Development Bank
AIDS	Acquired Immune Deficiency Syndrome
ART	Antiretroviral Therapy
AVSI	Association of Volunteers in International Service
CBO	Community Based Organization
CIDA	Canadian International Development Agency
DOT	Directly Observed Treatment or Directly Observed Therapy
FAC	Foreign Affairs Canada
FDC	Fixed Dose Combinations
HAART	Highly Active Anti-Retroviral Therapy
HIV	Human Immunodeficiency Virus
HIV -	Human Immunodeficiency Virus (HIV) negative
HIV+	Human Immunodeficiency Virus (HIV) positive
IASC	Interagency Standing Committee
IDP	Internally Displaced Person(s)
INGO	International Non-Governmental Organization
IRC	International Rescue Committee
ISS	Institute for Security Studies
MISP	Minimum Initial Service Package
MSF	Médecine Sans Frontière / Doctors without Borders
NAC	National AIDS Commissions
NSP	National HIV Strategic Plans
OVC	Orphans and Vulnerable Children
PEP	Post Exposure Prophylaxis
PHC	Primary Health Care
PLWHAs	People Living with HIV and AIDS
PMTCT	Prevention of Mother-to-Child Transmission
STI	Sexually Transmitted Infection
TB	Tuberculosis
UNAIDS	The Joint United Nations Programme on HIV/AIDS
UNGASS	United Nations General Assembly Special Session
UNHCR	United Nations High Commission on Refugees
UNICEF	United Nations Children's Fund
WB	World Bank
WFP	United Nations World Food Programme
WHO	United Nations World Health Organization



EXECUTIVE SUMMARY

In affiliation with XVI International AIDS Conference held in Toronto in August 2006, the HIV/AIDS, Conflict and Displacement session hosted by UNICEF and UNHCR, turned the focus of discussion on the challenges of addressing HIV/AIDS in emergency settings and allowed for the sharing and discussion among conference participants of an array of topics. The following key messages and recommendations were the outcome of the day's meeting:

1. EPIDEMIOLOGY OF HIV/AIDS IN CONFLICTS AND EMERGENCIES

- HIV/AIDS and emergencies are importantly interlinked; it is extremely important to factor HIV and AIDS in emergency preparedness and response;
- More research has to be undertaken and information gathered on the linkages between and impact on emergencies and HIV/AIDS;

2. MULTI-SECTORAL PROGRAMMING FOR HIV/AIDS IN CONFLICTS AND EMERGENCIES

- Vulnerability to HIV in emergencies must be addressed multi-sectorally, in order to tackle the range of factors that contribute to increased vulnerability and risk.

3. PROTECTION AND GENDER-BASED VIOLENCE

- Protection, power relations, stigma and discrimination are critical factors when addressing HIV prevention in emergencies. HIV prevention, responses to sexual violence and child protection are all essential elements of a multi-sectoral response.

4. FUNDING FOR HIV AND AIDS

- Progress has been noted in three key areas: improved funding mechanisms, integration of HIV/AIDS programmes in emergency programming, and humanitarian concern in national AIDS programmes. Despite these improvements, there is still a great deal of advancement to be made.

5. IMPLEMENTATION OF ARV-BASED PROGRAMMES

- ARV-based treatment services (in particular PEP, PMTCT and ART) can and should be provided in emergency situations to a range of recipients and in a range of circumstances – this includes providing therapies to infants, guidance and information on childcare to HIV+ parents.

The following report provides a detailed outline of the main outcomes listed above along with an overview of the conference presentations and discussions.





BACKGROUND

The HIV/AIDS, Conflict and Displacement session was held on August 12, 2006 in Toronto, Canada, on the eve of the XVI International AIDS Conference. The one-day session allowed HIV/AIDS programming in conflict settings to take centre stage, and echoed the theme of the XVI Toronto AIDS Conference: Time to Deliver. The subject matter, HIV/AIDS, conflict and displacement, is both urgent and evolving, evidenced both by the very high numbers of refugees and internally displaced persons, the number of people who are vulnerable to or affected by conflict, humanitarian crisis or displacement, and also by the complexity of factors and actors involved. The relationship between humanitarian crises and HIV/AIDS is contentious: emergencies can increase risk factors for HIV transmission (for example, when rape is used as a weapon); but they can also play a “protective” role vis-à-vis HIV infection, by limiting population mobility and isolating communities, and by limiting the range of health and other services available to them. Emerging policies and programmes therefore need careful calibration and continuous evaluation. This session was part of that effort.

The conference brought together a diverse group of people, including the humanitarian community, academia, human rights advocates, policy makers, implementing agencies, donors, civil society, persons living with and those affected by HIV and AIDS. Working through the agenda, participants took stock of their collective experience, discussed lessons learned, and debated the way forward.

Some of the research findings presented during the various sessions were eye opening for many of the participants. Certain findings were also counter-intuitive and thought-provoking. This report follows the day's agenda, outlining the main points and issues raised by the speakers, and the discussion points raised following those presentations. Annexed to this report are the PowerPoint presentations



KEY MESSAGES AND RECOMMENDATIONS

1. EPIDEMIOLOGY OF HIV/AIDS IN EMERGENCIES

A number of linkages between emergencies and indicators for the HIV pandemic were addressed during session presentations; in particular, presenters noted the complexity of the linkages between conflict and population-level prevalence of HIV, as well the issue of the burden of HIV on emergency-affected populations.

Globally, a significant proportion of people living with HIV/AIDS (between 8% and 10%) are affected by conflict, humanitarian crisis and/or displacement. Children living with HIV/AIDS and orphans due to AIDS are similarly affected (12%-17%, and 11%-15% respectively) [2].

The relationship between HIV prevalence and conflict is quite complex and involves a range of considerations; for example, when we discuss HIV and refugees, we must consider the prevalence of HIV in the affected communities, in the host country, in communities immediately surrounding the refugee camps, and the degree of interaction between surrounding communities and refugee population. [2]. Unfortunately, when we look at internally displaced persons (IDPs), there is not enough data to come to firm conclusions about the relationships between conflict and prevalence of HIV/AIDS. More data on IDPs is needed before conclusions can be drawn.

The effectiveness of community-level mobilization is negatively affected when targeted populations are on the move. Other factors that can be negatively impacted by population mobility include voluntary testing and counselling efforts [7].

The HIV pandemic is not discriminatory -- high levels of HIV infection are apparent in some militaries.

Recent research in Botswana, Zambia, Tanzania, Swaziland and Zimbabwe show that there appear to be lower infection rates among young people (age 17–19) when compared to national rates (the challenge being to maintain HIV-negative recruits). Military personnel identified as HIV+ are taken off active duty, some being diverted to national health institutions, in an effort to maintain and sustain HIV- status among other recruits.

Problematically, ART supply in the military is often insufficient and inconsistent. When available, treatment/therapies generally target military personnel only -- not their families. In some cases, peacekeeping and deployed forces are issued limited quantities of ARVs, which often run out before the end of the mission [3]. Experience also shows that it is sometimes the same military personnel meant to ensure the protection of conflict-affected populations who become an obstacle and danger; taking medicines and funds for their own use, and committing sexual acts of violence against and exploitation of women and children [7].



Slide 1
Source: [2]

Although counter-intuitive, one proposed idea was that, in some cases, refugees in camps may actually have advantages over other conflict-affected populations. They are relatively easily targeted by UN agencies, specifically UNHCR (Office of the United Nations High Commissioner for Refugees) and international NGOs, and are more easily provided with information and services on HIV and AIDS. More money may also be spent (per capita) on them than on people in the surrounding communities. Research shows that refugees who repatriate often have better knowledge of HIV/AIDS and adopt less risky behaviours than those who were not displaced, because of their participation in HIV prevention programmes while in asylum. The result is that displaced persons and returnees should not be considered simply as vulnerable groups, but as potential change agents who might facilitate HIV prevention programmes upon their return [2].

In order to more fully understand the complex factors that impact on the epidemiology of HIV/AIDS in conflicts and emergencies, much more and better data needs to be compiled. Analysis needs to be undertaken in a site-specific manner. Compilation of strong data like this could then be used for policy decisions, advocacy and programming purposes. Implementing evidence-based, site-specific interventions will require an investment in research and monitoring [2, 4]. Good data would also help aid organizations better understand the links between various emergency-related risk factors and HIV infection, the extent to which those factors affect specific populations such as adolescents, and would help in disentangling the pre-post conflict HIV prevalence rates. This type of data could tell us whether emergencies cause a shift in the prevalence of HIV among vulnerable groups.

2. MULTI-SECTORAL PROGRAMMING FOR HIV/AIDS IN CONFLICTS AND EMERGENCIES

The interaction of so many distinct factors that impact on different populations' vulnerability to HIV infection calls for a multi-sectoral, collective approach [4, 6, 11]. The HIV/AIDS needs of

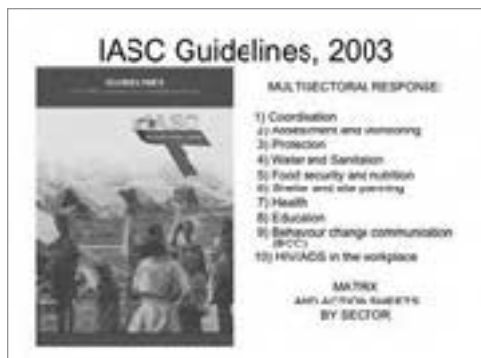
vulnerable populations should be incorporated into existing frameworks; humanitarian populations should be provided with basic services packages in accordance with the IASC Guidelines for HIV/AIDS Interventions in Emergency Settings; and underlying sexual and gender-based vulnerability factors (including sexual violence) need to be clearly addressed [10]. Many presenters commented on the need to develop, update, standardize or simplify common guidance tools. To help achieve this, advocacy and dissemination of experiences need to be strengthened.

Clear direction to national HIV/AIDS programming, in the form of a comprehensive and clear National HIV Strategic Plan (NSP) for asylum countries could alleviate many of the concerns or ambiguities that are felt

at the field level. Often, though, National Strategic Plans do not reference refugees (35% of countries do not directly specify refugee populations), and of those that do mention refugee populations, more than half do not actually include them in state activities[11].

When developing humanitarian programming, HIV and AIDS considerations should be reflected within the overall plan and should be given the same attention as other "traditional" relief interventions [1, 4, 10]. Activity-development should anticipate people moving from one country to another, or within countries and regional and sub-regional initiative should be considered from programme design [4, 11]. Broad initiative might make more sense with increased inter-agency coordination - opportunities for working together, and sharing sources of funding, should be explored.

Importantly, though, one presenter reminded session participants that unequal health services offered to refugees, compared to those offered to host communities, can have negative impacts on both



Slide 2
Source: [4]

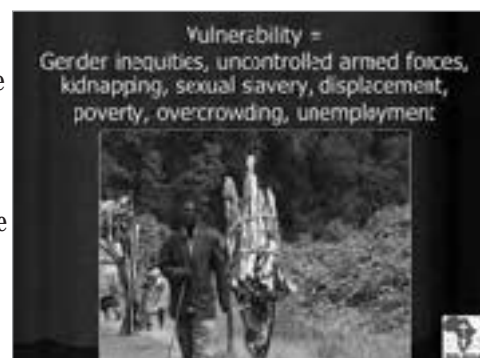
communities. Care must be taken to ensure that services offered to refugees match those offered to host communities [4, 11].

Access to healthcare, to education and protection services is critical to children's wellbeing, as is providing special attention for orphans and children separated from their families; it is important to remember that – whether or not they have been directly affected by HIV -- all children in conflict need additional care [6, 15].

More follow-up documentation and the employment of strict monitoring and evaluation methodologies were recommended by session presenters [4].

3. PROTECTION AND GENDER-BASED VIOLENCE

The main means of HIV transmission is sexual contact. Among all possible forms of sexual contact, rape would seem to be the most risky for individual transmission [5]. However, presentations indicated that there is no evidence that rape affects HIV prevalence at population level. At individual level, many social, behavioural and biological factors increase the risk of transmission of HIV to girls and women who are raped. Some case-studies suggested that conflict does increase the risk of HIV infection for individuals, albeit reiterating the challenge of getting solid figures. [7] There are many important dynamics at play in HIV transmission, including ongoing displacement, poverty and unemployment all of which create environments which place women and children at risk.



Slide 3
Source: [7]

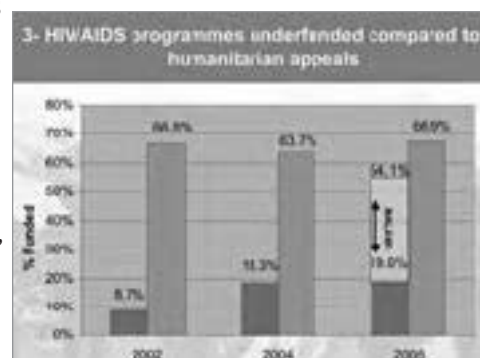
Other factors contributing to women and children's risk of contracting the disease include their vulnerability to uncontrolled local armed forces, and small arms proliferation [5, 7]. Studies have shown that women and children are at increased threat of rape by armed gangs and militiamen [7].

Post Exposure Prophylaxis (PEP) has been shown to be an essential part of a comprehensive strategy to address gender, violence and HIV prevention. To date, high compliance rates show that integration of PEP into medical responses to rape is feasible in emergency settings [4, 11, 13].

4. FUNDING FOR HIV AND AIDS.

Effective programming for HIV/AIDS in emergency settings requires that “traditional” humanitarian actors understand the threats to and needs of vulnerable groups, and that they design appropriate responses; it also requires that adequate resources are allocated to HIV/AIDS programming.

In 2002 only 8.7% of HIV/AIDS programming requests were funded; this percentage more than doubled, rising to 18.3% in 2004 and to 19% in 2005. Still, when compared to funds being requested and granted for humanitarian aid, HIV/AIDS programmes are well under-funded when compared to humanitarian appeals which remained stable over time at approximately 67%. [1].



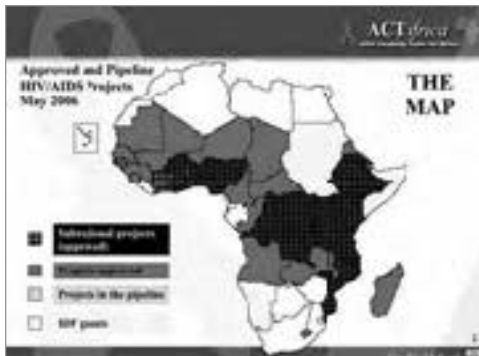
Slide 4
Source: [1]

Despite images of children being used to fundraise for humanitarian needs, not even 10% of money raised for emergencies is spent on children [6]. Appallingly, 70% of resources for HIV/AIDS do not reach children.

Close coordination among local and national AIDS initiatives, so as to avoid a duplication of efforts, is acknowledged as a means of adding value to programming. The fact that important patterns of financial flows, for both emergency and non-emergency related sources,

co-exist in nearly all settings affected by complex emergencies further supports this point.

Clear direction to national HIV/AIDS programming, with the aim of also directing interventions at populations of humanitarian concern, might work towards assuaging many of the concerns or ambiguities felt at the field level. Current National Strategic HIV Plans (NSPs) indicate that concern for and clear strategies outlining actions to be taken for helping humanitarian populations are limited [11].



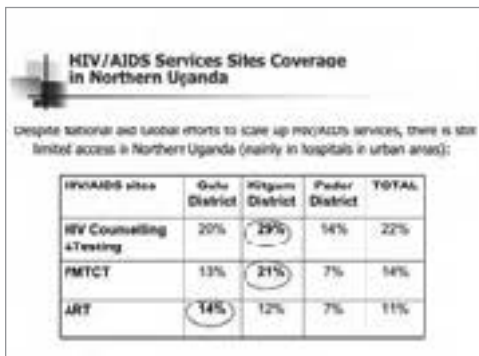
Slide 5
Source: [8]

Still, more effort is needed to integrate HIV/AIDS into programming responses and humanitarian frameworks; this could be done with increased dialogue with donors [1].

Many donors are used to donating to one country, rather than to thematic programmes or regions; reorienting funding to respond to the HIV and AIDS needs might prove challenging. Regional approaches, though, allow for increased programming flexibility - both in design and implementation - which could help respond to factors such as refugees who leave host countries to return home. Regional approaches were among the most engaging subject to emerged from the conference discussions. [8, 9] The importance of ensuring the commitment of governments in the region to endorse cross-border initiatives was also acknowledged [9].

Working through the cluster approach, and with a needs assessment of each, would go a long way to help donors direct money flows to the regions that face the most need. It is essential for the cluster approach to effectively integrate the perspective of HIV and AIDS related risks and vulnerabilities.

5. IMPLEMENTATION OF ARV-BASED PROGRAMMES



Slide 6

Source: [15]

One of the main findings of the session was that the implementation of ARV-based treatment services is possible during emergency settings. Momentum that has been gained in providing ART to PLHA, through activities such as the ongoing discussions at UNGASS, the 3 by 5 initiative - which aimed to put 3 million people living with HIV/AIDS on treatment by 2005 - and the push towards universal access. [11]

Despite the forward-moving momentum, though, only 20% of the global population who need ART are receiving the treatment; the majority of the unmet need is in the developing world. Refugees account for only 0.2 - 0.3% of the need (about 20,000 refugees need ARTs out of 10 million) [11].

It has taken some time to acknowledge the unique challenges to addressing HIV/AIDS in conflict and post conflict settings, including risk of insecurity, population instability, and challenges to providing ART and follow-up of people on the move. However, data suggest that the average length of stay for refugees in host countries is 17 years - indicating that refugees are not as mobile as one would first assume -- making effective treatment a viable option [4, 11].

PMTCT interventions have already been successful, even in emergency-affected settings, though there are still many challenges (including limited assisted delivery rates, need for simpler protocols, adherence, and fear of stigma) [12]. Indicators of acceptance of counselling and testing have shown that the PMTCT programme in Uganda was widely accepted by the communities, especially by internally displaced women [15]. PMTCT services have proven to be a possible means of treatment and prevention even in rural and conflict-affected areas; however coverage remains low in most regions and scaling up is urgently needed [15]. Similarly, in conflict affected areas, ART-coverage is

lower than the national ART-coverage. This inadequacy is compounded when paediatric ART needs are taken into account [12, 15].

ART clinical outcomes in conflict and post conflict settings, though limited in scale, compare favourably to those found in non-conflict settings and show that with adaptation and resources, HIV comprehensive care can be effectively administered in both post conflict and chronic conflict settings [13, 14]. An essential ingredient for successful provision of ART in conflict settings lies in being prepared for the disruption brought about by the complex emergency. These findings will have to be integrated into updated versions of the IASC Guidelines for HIV/AIDS Interventions in Emergency Settings.

ART Outcomes		
	TRC - Rakwa	TRC - Kisumu
Median 4 pill weight (kg) (95% CI)	2.8 kg (1.8-5.5) N = 36	2 kg (1.6-5) N=133
Median 4 pill EB4 rate (95% CI) (95%)	83 (82-83) N = 111	106 (98-103) N=358
Stability Rate (95% CI) 1 month	4.9% (2.6%-7.0%)	14.7% (12.6-16.1)
12 month	7.3% (3.7-12.2)	18.6% (14.2-20.5)
Loss to follow up Rate (95% CI) 1 month	3.3% (1.8-5.3)	1.8% (1.1-2.5)
12 month	5.4% (3.2-7.5)	2.0% (1.7-4.9)

Slide 7
Source: [13]

RECOMMENDATIONS

Data gathering: More and better data is needed. Evidence-informed programming must be based on solid understanding of the processes and contexts in place. Myths must be dispelled in order to most effectively use the limited resources available. The collection and dissemination of programmatic experiences, best practices and analyses of successes and challenges to the implementation of HIV/AIDS-related programmes in emergencies can further help programming.

Programming approach: The relationship between HIV/AIDS and emergencies is not univocal, and cannot be treated as such. It requires specific regional fine-tuning for interventions to be effective. Protection issues are inextricable elements of successful HIV prevention in complex emergencies. Cross-border and regional approaches may best address the challenges and concerns in settings characterized by significant mobility of affected populations. Implementation of ARV-based services is possible within emergency settings.

Resources and advocacy: More proactive, collaborative work is needed in order to secure greater funds; but then, assets can best be utilized if resources are focused on specific actions. Close coordination of international humanitarian-related HIV/AIDS programming with local and national AIDS initiatives, so as to avoid a duplication of efforts, is essential. Advocacy efforts need to be matched to the magnitude of the problem, through transitional recovery and developmental phases.

Accountability and division of labour: Coordination of response is essential. This includes the successful mainstreaming of HIV/AIDS within the cluster approach, the use of joint frameworks and tools - such as the IASC Guidelines for HIV/AIDS Interventions in Emergency Settings - and joint programming.

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7. Ciza Nakamina. Presentation 2.3.
8. Davanger. Presentation 3.2.
9. Youssouf. Presentation 3.3.
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11. Petros. Presentation 4.1.
12. Madraa. Presentation 4.4.
13. Tu. Presentation 4.2.
14. Evans. Presentation 4.3.
15. Ojom. Presentation 4.5.



PRESENTATIONS AND DISCUSSION

INTRODUCTION

Conference purpose, proceedings, structure and expected outcome

NIGEL FISHER

UNICEF CANADA

Statistics and the Real People Behind Them; The Role of Gender; Bravery; Time to Deliver

Nigel Fisher's introductory remarks touched on themes that would be raised and debated throughout the day.

*We don't need to invent new laws.
We have to implement them.*

NIGEL FISHER, UNICEF CANADA

After welcoming everyone to Toronto, Fisher recounted a recent trip to the Democratic Republic of Congo (DRC) where the near decade-long conflict has killed more than 4 million people—many not in direct combat, but by conflict-related diseases, including HIV/AIDS. He noted that 47% of the casualties were children, and over 600 children are dying daily. Despite these astonishing statistics, the world and the media seem not to notice. DRC is a “land the world forgot.”

Fisher noted that while statistics are vital to understanding the larger context, they can dull the senses and obscure the individuals captured in them. Behind every statistic is a person— often a woman or child. Fisher said we cannot disentangle the impact of conflict and HIV/AIDS from women and girls' societal status. HIV/AIDS is not only a health issue: it is a social issue, just like gender-based violence.

Brave groups and even braver individuals are pushing for justice on several fronts. Noting that girls and women who had been raped and/or captured are often blamed for their fate, Fisher recalled an NGO in DRC that negotiated with families to take back their daughters. In Beni near Uganda, groups of people—many of whom have been raped and/or are HIV positive—are taking on a corrupt justice system, rapists, and the institutions that protect them. In Goma, Fisher met doctors with a medical outreach programme who go to communities where very few health workers can be found.

Mr. Fisher noted that the normative frameworks are already in place, including international refugee laws, human rights law, the UN Convention on the Rights of the Child. We need to apply the laws we have. It is time for practicalities and action.

Mr. Fisher welcomed those working on the frontlines and thanked them for their courage. He urged those working in high-income countries to educate their fellow citizens and political leaders, and to

advocate. It is time for leaders to meet their political responsibilities, he declared. He reminded participants that all of us have a duty to support and advocate for solutions to conflict situations. It is time to deliver.

PAUL SPIEGEL

UNHCR

Keeping It Practical; Keeping an Open Mind

In outlining the day's topics, Paul Spiegel echoed Fisher's message to ground the discussions on facts and real-world practicalities. He named four general topics:

1. Latest thinking – emphasizing practicalities
2. Protection and gender violence
3. Funding
4. Antiretroviral therapy (ART) – a very neglected and controversial issue.

Noting many misconceptions among media, researchers and policymakers, he encouraged people to be blunt and open-minded in their discussions. The day's agenda deliberately left considerable time for questions. He drew attention to the guidance materials contained in the CD-ROM that had been provided to each participant, and re-iterated a thank you to CIDA and to the European Commission Humanitarian Aid Office (ECHO).

There are numerous misconceptions about HIV, AIDS, conflict and displacement— whether in Northern Uganda or DRC — and we need to address them.

PAUL SPIEGEL, UNHCR

Introducing the next speaker, Noe Sebisaba - a refugee in Tanzania, originally from Burundi - Spiegel called him a personal

“hero.” Spiegel heralded Sebisaba's courage for being the first known refugee in Africa to declare his HIV positive status, and for his activism in founding STOP SIDA NKEBURE UWUMVA to help raise awareness of HIV/AIDS in refugee camps.

NOE SEBISABA

STOP SIDA NKEBURE UWUMVA

Live and Go Forward; Harnessing the Power of the Community

More than anyone, Noe Sebisaba embodied the focus of the day's session: as a refugee in a refugee camp, as an HIV+ person, and as a pioneering HIV/AIDS activist for refugees.

Sebisaba expressed the desire to share his experience as a refugee, and the problems of living with HIV in refugee camps. He told of being an administrator in his native Burundi, where he witnessed barbarities. His wife was raped at gunpoint by military forces. In 1996, they fled their home and found themselves in a Tanzanian

After I was told I was HIV+ [in a Tanzanian refugee camp], I asked myself what should I do? I decided I was not going to weaken or break down. I must reconstruct and do something with my life. I decided to love the world. I must speak to refugees and raise awareness in the world. This is why I am here.

NOE SEBISABA

We cannot divorce the issues of conflict, displacement, HIV/AIDS, and sexual violence towards women and children.

NIGEL FISHER, UNICEF CANADA

refugee camp. Both his wife and child subsequently died in the refugee camp. Still in the camp in 2001, he was informed he was HIV+ after trying to donate blood.

Sebisaba felt his life was at an impasse. His HIV+ status was yet another major hurdle, one with the added risks of stigmatization and discrimination. In the camp, it was believed that HIV/AIDS brought dishonour upon individuals and their families. Even churches treated them as outcasts. Tanzanians blamed the refugee community at large for bringing HIV/AIDS to their country.

Instead of giving up, Sebisaba vowed to rebuild his life and do something with it. He decided to “love the world,” and to choose “the path of struggle.”

Rather than hide, he publicly declared his HIV+ status, becoming the first known refugee in Africa to do so. At this point he also began working with STOP SIDA Nkebure Wuumva, a non-profit group which organizes HIV/AIDS-related activities in camps. Sebisaba said that the purpose of his work was to make the refugee community understand that despite many problems, “we must be hopeful and do something.”

Early on, HIV/AIDS was thought to be a problem that must be addressed by humanitarian organizations alone. But we showed that the job must also be done by the community at large.

NOE SEBISABA

Modest means notwithstanding, the STOP SIDA activists were able to garner support from and influence authorities to help in awareness-raising and they caught the attention of international organizations. But for Sebisaba, a key lesson was the role of the community, which acts as an “umbrella.” Together, they worked on HIV prevention, using sports, discussion groups and seminars to transmit information. They also tried to foster a sense of communal responsibility towards those living with HIV and children orphaned by AIDS. They worked directly with HIV infected people, supporting them in ways such as helping them to grow their own vegetables and providing psychological counselling.

In closing, Sebisaba reiterated that refugees are in a dangerous situation. Policy-wise, they are considered neither by their country of origin nor their host country. He has now returned to Burundi to raise awareness about refugees and advocate for their inclusion in local programmes.



TOPIC 1: HIV, CONFLICT AND DISPLACEMENT: THE LATEST THINKING

MODERATOR: MICHEL SIDIBE, UNAIDS

PAUL SPIEGEL, UNHCR

FATOU MBOW, International Rescue Committee (IRC)

MARTIN RUPIYA, Institute for Security Studies (ISS)

Moderator Michel Sidibe, Director of Department of Country and Regional Support, UNAIDS (*Joint United Nations Programme on HIV/AIDS*), expressed appreciation for Noe Sebisaba's presence, and for "bringing us the reality of what we are facing," as the "voices of the numbers" are often missing from the debate.

Sidibe identified three objectives of this portion of the agenda:

1. to take stock of the latest research in the subject of conflict/displacement;
2. to learn from experiences, both good and bad, as we plan ahead; and
3. to examine policies that could move us forward.

He then introduced the three panellists for this session, each of whom is an expert in their field and who clarified different aspects of AIDS and conflict.

PAUL SPIEGEL, UNHCR

HIV Epidemiology among Conflict-Affected and Displaced Populations



No One Size Fits All

[PowerPoint presentations, Topic 1, slides 1—15]

In presenting data from conflict-affected areas across Africa, Paul Spiegel challenged conventional thinking regarding a simple correlation between conflict and HIV prevalence. Spiegel argued that there is no evidence that conflict leads to increased incidence of HIV prevalence at the population level. The relationship, Spiegel argued, is much more complex.

In his view, people speak somewhat glibly about refugees' increased risk of HIV/AIDS without considering in detail:

- Prevalence rates in the country of origin
- Prevalence rates in the host country
- Prevalence rates in communities immediately surrounding the refugee camp
- Degree of interaction between surrounding communities and refugee populations

A key but often overlooked determinant is HIV prevalence in communities that immediately surround refugee camps. Contrary to popular belief, researchers have consistently found that refugee populations have similar or lower prevalence than surrounding communities.

He added that there is no evidence that conflict increases HIV prevalence at the population level,



For the most part, refugees do not “bring” HIV, despite what the media says. In some cases they might “bring back home” higher HIV rates if there were higher rates in the surrounding host community and their interaction with these populations was high. To a large extent, refugees benefit from dedicated programmes and good practice in countries of asylum, and bring back awareness and become assets once repatriated.

PAUL SPIEGEL, UNHCR

citing examples such as Northern Uganda where HIV prevalence has actually gone down. Much more, and better, data is needed, such as Behavioural Surveillance Surveys (BSS), which measure knowledge, attitudes and practices. Analysis should be site-specific. Good data can and should be used for advocacy and programming purposes, he argued.

He cautioned anyone presenting statistics—media, NGOs and UN organizations—to do so with great care, ensuring the data’s accuracy and providing adequate context. Statistics must be transparent and truthful, otherwise facts and

figures risk becoming unclear or erroneous.

In closing, Spiegel asked participants to consider the possibility that in some cases, refugees in camps actually have advantages. International NGOs work with them, providing them with information and services. Per capita, more money is spent on them than on people in the surrounding communities.

FATOU MBOW, International Rescue Committee

HIV and Emergencies: The Response



The Need for Integrated, Coordinated, Local, National and Regional Programmes
• Working with Humanitarian Efforts • Sustainable Interventions
[Power Point presentations, Topic 1, slides 16–33]

Fatou Mbow broadened the discussion of HIV programming beyond conflict settings to include natural disasters and humanitarian responses. She reminded participants that in 2005, four times more people were affected by disaster than by conflict. Judging by trends, the number of disasters and peoples displaced by those disasters will continue to increase.

Under the 1951 *Convention Relating to the Status of Refugees* (“UN Refugee Convention”) refugees should be accorded the same basic services – including health care – as is provided to local, indigenous communities. This is not only a need, but a right. Having said that, Mbow also noted that services offered to refugees often do not match those available in host communities—and often favour refugees.

It is very rare to have studies done on refugees’ perception of the care they are receiving.

FATOU MBOW, IRC

Mbow cited some milestone efforts in HIV/AIDS service delivery to emergency-affected populations, and in particular refugees. The Sphere Project (1997) reviewed the results of humanitarian work in Rwanda and explored how to set standards for future work; the *Minimum Initial Service Package* (MISP) identified the minimum elements of reproductive health services for refugees; the International Rescue Committee (IRC) studied field interventions; the Inter-Agency Standing Committee’s (IASC) *Guidelines for HIV/AIDS Interventions in Emergency Settings*

recommended a set of programmatic interventions before, during and after an emergency, which include HIV/AIDS in the workplace.

What has yet to be adopted, according to Mbow, is a multi-sectoral, collective approach. To

improve accessibility of HIV/AIDS healthcare to people in conflict and humanitarian situations she noted:

- HIV/AIDS strategies must be mainstreamed into programmes
- HIV/AIDS activities should cover people moving from one country to another
- Opportunities for working with humanitarian efforts, and sharing funding sources should be sought
- More documentation on patient follow-up is needed.

If there is one message I would like to give, it is that we need a multi-sector approach and we haven't managed to do this yet. How many will mainstream HIV in their programmes?

FATOU MBOW, IRC

Discussing Antiretroviral Therapy (ART) in conflict-affected settings, Mbow remarked that it has taken some time to acknowledge the unique challenges posed by people on the move, especially in follow-up. Conversely, some statistics suggest that the average length of stay for refugees in host countries is 17 years, making effective treatment viable.

UNAIDS THREE ONES:

- *one national framework to coordinate the work of all partners*
- *one national AIDS coordinating authority with a multi-sectoral mandate*
- *one country-level monitoring and evaluation system*

Mbow closed her presentation by endorsing the following recommendations from humanitarian groups:

- Implementing evidence-based, site-specific interventions – which requires an investment in research and monitoring; and
- Working within the “Three Ones” principles from the outset to ensure sustainability of interventions.

It is very rare to have studies done on refugees' perception of the care they are receiving.

MARTIN RUPIYA, Institute for Security Studies

What We Know about HIV/AIDS vs. Militaries in Southern Africa



International & National Dynamics Play Out in Military Subculture • The Role of Food Security

[PowerPoint presentations, Topic 1, slides 34–45]

While militaries have well-defined environments that are distinct from civil society, Martin Rupiya noted that their values and dynamics often reflect those of the wider societal culture. This mirroring includes the stigmatization (sometimes criminalization) of homosexuality, related difficulties in education efforts about transmission methods because of denial (“it does not exist”), the shortage of ARVs, and issues of food security.

The armed forces have been combating HIV/AIDS for 25 years. Very gradually, the “head-in-the-sand” attitude, with respect to HIV/AIDS, is being replaced by acknowledgement and treatment. There is greater awareness, and HIV prevalence rates in 2006 seem to have stabilized or decreased slightly.

Rupiya said that until the 2006 UNAIDS Global AIDS Report there had been a policy vacuum in international and national frameworks addressing HIV/AIDS. To date, there still is not a single

HIV/AIDS policy framework that covers military, peacekeeping and deployed forces. In some cases, peacekeeping and deployed forces are issued limited quantities of ARVs (some countries give out 3 month supplies), which run out. Some of the issues involved, including access to health care, are basic human rights.

To understand more about HIV/AIDS in military culture, ISS conducted research in Botswana, Zambia, Tanzania, Swaziland and Zimbabwe. He explained the difficulty in accurately determining comparative prevalence rates with civil society. He said that militaries have begun to test new recruits. Generally, it has been found that:

- there appears to be lower rates among young recruits (age 17–19) compared to national rates – the challenge is to keep and maintain HIV- recruits
- those identified as HIV+ are taken off of active duty; some being diverted to national health institutions (not stigmatized)
- ART supply is insufficient and inconsistent.

Rupiya identified an opportunity for supportive services to be developed, including counselling, nutrition, home-based care, drug distribution, and spousal/survivor support.

Issues of food security and agricultural subsidies are strongly at play and affect how rations are doled out. Likewise, less affluent African countries, and the militaries that operate within them, need help with accessing generic drugs without having to fight the major drug companies. Persons living with HIV and AIDS often survive on herbal and traditional medicines as drugs are not readily available in these countries.



TOPIC 1: QUESTION AND ANSWER

DAVID TU, MSF:

Can we get an estimate of the number of people living in conflict-affected regions with HIV/AIDS?

SPIEGEL AND ZUCCA

According to preliminary data compiled by UNICEF/UNHCR, which does not include natural disasters, in 2003:

- Out of the total population living with HIV or AIDS, 2.7 million people have been affected by crisis or displacement (8–10% of the global total),
- This percentage is higher among youth (under 15 years), where 14% of children are living with HIV or AIDS have been affected by crisis or displacement,
- 11 – 15% of the global total of people living with HIV and AIDS have been affected by conflict, humanitarian crisis or displacement.

FOREIGN AFFAIRS CANADA:

What does sustainability mean? Can you discuss the issue of interface between IRC and local health services?

MBOW

We need to work within the “Three Ones” principles. Obviously when there is conflict or disaster, we need to respond quickly and appropriately. But let’s remember there is a government and we should not duplicate its efforts. That is not sustainable. We should go to the national AIDS council to work together. I know NGOs want to work efficiently and quickly, but to be sustainable we need to work with the national government.

SPIEGEL

For UNHCR, there are policy implications.

1. Advocacy. We wanted to show that refugees were not bringing in HIV/AIDS, and we hope we have changed governments’ opinions of refugees entering their borders. We have also succeeded in having refugees included in national strategic plans.
2. Integration. Our best practice is joint programming with NGOs and government. Sexual violence and sexual interaction between refugees and host populations is very high.
3. Sub-regional initiatives. This can be difficult for donors who are used to donating to one country. Programmes have to be flexible as refugees leave host countries for home.
4. ARTs funding and refugees. Out of 10 million people who need ART, only about 20,000 are refugees. They should be included in national programmes of host countries, not treated separately. Otherwise they are subject to donor funding interests.

PARTICIPANT:

Could we revisit the issue of conflict and HIV/AIDS levels. Do we have accurate information regarding refugees? We see a lot of acts of violence within camps. The IASC guidelines have been well-developed, but the situation is complex. On one hand, we are “unlinking” emergencies from acts of violence; on the other we need more programming to end the violence and reduce HIV.

SPIEGEL

These are important questions. A paper I have recently written looked at seven countries in conflict, IDPs and refugees. Although the paper contains important information drawn from rigorous data analysis, it has not yet been accepted. We are looking at data from Angola, southern Sudan and Burundi, and for the most part, the findings are consistent in conflict-affected countries: whether HIV+ prevalence is high or low (pre-conflict), rates go down during conflict, and this is difficult for many people to believe.

Many peer-reviewed articles are simply not correct. One example is misinterpretation of rape data from the Rwanda genocide in 1994. The study methodology at the time was good; however the interpretation of the data was less reliable. There is no data whatsoever that shows large-scale rape affects HIV prevalence at the population level significantly.

With internally displaced persons, there is not enough data to come to any conclusions about the relationships between conflict and incidence of HIV/AIDS. We need more data on IDPs before we can draw conclusions.

MBOW

In some instances, the prevalence of HIV/AIDS is sometimes higher in the host country than the refugee population.

KATE BURNS, OFFICE OF COORDINATION FOR HUMANITARIAN AFFAIRS, NY:

Regarding coordination, do we know what exists in terms of services provided and gaps for all countries that receive interventions? Is the coordination functioning? How can it be improved? Some countries do not have national action plans. Do we have some good examples of coordination?

MBOW

So far, coordination has been triggered by the willingness of people to work together. This has been the case in East Africa and the Horn of Africa. It has really been an effort at an individual level to share experiences between government, organizations, agencies and NGOs – this helps at an agency level. We don't have a cluster approach, but we should structure an intervention after the cluster approach.

SPIEGEL

UNHCR does have some data on this in its 2005 report. It seems coordination is not widespread. UNAIDS did a division of labour into 17 technical support areas and the UNAIDS secretariat is designated as the lead on uniformed services, security and HIV/AIDS, while UNHCR is the lead on HIV/AIDS for refugees and IDP issues.

RUPIYA

With regards to the military, there is a policy gap. We don't seem to have a rollout of the

UNAIDS focus—it's there in theory, but it hasn't engaged the armed forces. If an epidemic takes place, a national committee is established. Then they start moving towards sector-specific initiatives.

Sometimes countries work bilaterally. UNAIDS' Division Of Labour approach has not been embraced on the ground.

TOPIC 1: CLOSING REMARKS

MICHEL SIDIBE

Concerted efforts have been put into data collection and guideline implementation. However, some important gaps were identified in this session.

- Local adaptability: this is not a homogenous epidemic, and cannot be treated as such. It requires local fine-tuning to have effective interventions.
- Accountability and division of labour: there are gaps in defining who does what, as people are moving from and to different regions and countries.
- Resources and advocacy: we need more proactive, collaborative work to secure funds, and then to focus on specific actions that we can mobilize resources around. We need to match advocacy efforts to the magnitude of the problem, through transitional recovery and associated phases.
- Data gathering: we still need more data. However, there's a challenge when we need more aggregated data, but also need information that is localized
- Services: we need to look at sustainability and continuity in service delivery during a crisis (the Three Ones). This might involve the establishment of a single committee and one monetary mechanism to direct activities.



TOPIC 2: PROTECTION, GENDER-BASED VIOLENCE AND HIV/AIDS

MODERATOR: ROBIN JACKSON, WFP

JENNIFER KLOT, SSRC

GOPA KUMAR, SAVE THE CHILDREN, UK

JOSEPH CIZA, DOCTORS ON CALL, DRC

*Gender-based violence
is not just about women.*

ROBIN JACKSON, WFP

Recalling the previous series of presentations, Robin Jackson introduced the “Protection, Gender-Based Violence and HIV/AIDS” session by saying that Paul Spiegel had “dropped a bombshell” regarding the relationship between HIV/AIDS and gender-based violence. She maintained that issues of gender-based violence and protection strike at the core of much of WFP’s (United Nations World Food Programme’s) work. The continuing challenge to organizations like WFP is how goods and services can be delivered to victims of conflict without placing them at greater risk of violence including rape and HIV/AIDS. WFP has undertaken a decade-long effort to incorporate protective measures for women.

JENNIFER KLOT, Social Science Research Council

Sexual Violence and HIV Transmission: Pathway or Fork in the Road?



A Different Starting Point: Tracking Gender-Based Violence and HIV/AIDS Before, During and After Conflict

[PowerPoint presentations, Topic 2, slides 1-14]

Jennifer Klot challenged participants to reframe the day’s discussion, taking the focus from a simple equation of the role of conflict in HIV transmission to an expanded consideration of the contributing role of sexual violence and gender inequalities—before, during and after conflict—to transmission rates.

She called sexual violence the most significant link between HIV/AIDS and conflict; gender inequality, she argued, is fuelling the pandemic. It is also one of the least researched in terms of data concerning HIV risk and transmission rates.

Citing a disconnect between many epidemiological studies and the actual role of sexual violence, Klot pointed to many social, behavioural and biological risk factors that increase transmission rates among girls and women who are raped — factors that should be more fully integrated into studies. Problematically, assessing risk factors is challenging because there is no one agreed upon definition of sexual violence.

Risk factors include females’ lack of power and control in choosing sexual risk behaviour (including

condom use, where and when available), coital and other abrasive injuries that increase transmission risk, the number of perpetrators as well as their STI/HIV status, and traditional practices such as female genital mutilation. Adolescent girls are at even greater risk because they are more likely to receive abrasions during rape (68% compared to 10% in consensual sex.) Klot argues that the presence of small arms in the local community is known to increase violence against women.

Klot further cited risks to girls and women outside conflict arenas, such as intergenerational relations between older infected men who marry young women, child/elder rape and incest, among others.

An organizational frame is badly needed if we are to address this significant means of HIV transmission, Klot said. Currently sexual violence is addressed as a health issue, but there are no budget line items or technical support. The direct link between conflict and infection ignores the factors that are creating the risk: it is in the transmission, the interactions, and sexual violence, she argued. If this is as significant a transmission factor as needles, she asked why this has not entered the global response to AIDS.

She acknowledged the funding challenges in translating this issue into actions that result in safer environments, by giving the example of funding a bus to provide safe transport to women with a view to decreasing sexual violence and transmission. Who leads, who funds, and who implements are questions not easily answered.

Challenges notwithstanding, Klot echoed the remarks of Pam Delargy of UNFPA: "HIV/AIDS prevention is more likely to be a first-line response to sexual violence, than sexual violence is an entry point for HIV/AIDS prevention."

The Continuum: Before, During and After Conflict

"During conflict it can be addressed as violence associated with the war, as a humanitarian issue, but afterward, it becomes more private. It is the same violence, and often the same people committing the crimes, but now we're forced to call it 'civilian' or domestic violence rather than a war crime. We received death threats for even offering services in part, we think, because the perpetrators fear redress."

GOPA KUMAR, Save the Children, UK

Children, Conflict & HIV/AIDS



Protecting Children's Rights; HIV/AIDS and Children; Responses to Children in Conflict

[PowerPoint presentations, Topic 2, slides 15-21]

Gopa Kumar, from Save the Children UK, reminded participants of an important and often forgotten group: millions of children are affected by conflict and HIV/AIDS. Where, he asked, is the international funding and access to resources for children? Seventy per cent of resources for HIV/AIDS do not reach children. Despite images of children being used for fundraising, not even 10 per cent of money raise for humanitarian crises is spent on children. He echoed earlier remarks about the risk of numbers obscuring actual lives, and creating a kind of inertia.

Protection systems need to be in place to ensure that the most vulnerable are not further victimized by conflict and disasters. Recognizing that this takes time and patience, he pleaded with all parties to

When we talk about children, we are talking about millions of children and we have seen their lives destroyed – we have seen lives affected by conflict and HIV; we have seen ... violence directed towards children and we have seen neglect by communities and governments. Why are we ignoring children's rights?

GOPA KUMAR, SAVE THE CHILDREN, UK

act now. He described his organization's global response, which includes:

- Mobilizing political will
- Integrating HIV programming into conflict situations
- Trying to ensure children's access to healthcare, education and protection services
- Protecting and caring for orphans and children separated from their families – reminding participants that all children in conflict need care, whether or not they have been directly affected by HIV.

To illustrate child-focused activities, Kumar cited Save the Children UK's work in southern Sudan. There, Save is seeking the release of children from armed groups, tracing and reunifying children and families, reintegrating them, supporting victims of sexual violence, training staff, supporting prevention and care activities—including giving out condoms—and monitoring outcomes.

Kumar concluded with three recommendations. When planning responses during conflict situations, organizations should:

- Uphold children's rights as set out in the Convention on the Rights of the Child
- Devote adequate resources to fighting the HIV/AIDS pandemic – engineer budget mechanisms to track donations, and ensure funds are reaching the children
- Include HIV/AIDS programming in emergency responses – with children at the centre.

JOSEPH CIZA NAKAMINA, Doctors on Call, Democratic Republic of Congo Constraints and Opportunities



Linking Security & Protection to HIV Prevalence • Community-Based Solutions [PowerPoint presentations, Topic 2, slides 22-40]

Joseph Ciza Nakamina, from Doctors on Call in the Democratic Republic of Congo, addressed the issue of protecting vulnerable populations during armed conflict. He began by reminding participants that concerns regarding protection, or lack thereof, extend to relief workers in the area, in addition to the people who live in the area. To whom should we appeal to protect vulnerable people during conflict? Problematically, Ciza Nakamina tells us, experience shows that it is sometimes the same personnel meant to protect us who are stealing NGOs' and relief workers medicines and funds, and who are raping women and children.

Vulnerability equals gender inequities, uncontrolled armed forces, kidnapping, sexual slavery, displacement, poverty, overcrowding, and unemployment.

JOSEPH CIZA NAKAMINA, DOCTORS ON CALL

Showing maps of DRC where Doctors on Call is operating, it was clear that another related challenge is geographic: the huge scope of the region to be covered, and within that there are mountainous areas that have impassable roads, areas where it is difficult to transport good and supplies; in some areas women and children walk miles to get water – which further increases their risk of attack. Some areas are so dangerous humanitarian aid workers cannot pass, for fear of their safety.

Ciza Nakamina laid out the raw materials that comprise

vulnerability. The fallout from gender inequities (lack of respect, sexual slavery, an utter disregard for human rights) contributes significantly. Also very important are the dynamics at play in an environment of continual displacement, poverty and unemployment. Other factors contributing to vulnerability are uncontrolled local armed forces, kidnappings, and overcrowding.

Noting the difficulty of collecting data in areas of conflict, Ciza Nakamina said HIV/AIDS prevalence was difficult to determine. The

preliminary studies he presented confirmed that conflict does increase the risk of HIV. This is more so in rural areas, where there is less security and services. Women and children are at greater vulnerability to rape by militiamen—roughly 43 per cent of whom have STI, and 12 per cent are HIV+. More than 2/3 of the rapists in the region are armed gangs and militiamen.

While the studies yielded some data, he reiterated the challenge of getting factual figures. In one 2005–06 study, the majority of respondents – almost 74% -- abstained from being tested because there was a lack of trust. Isolated areas have also not been documented. Another barrier to taking part in studies is social realities, where HIV+ women and children are stigmatized, where women cannot refuse sexual relations with their husbands, and where life -- more often than not -- is unstable. Dr. Ciza Nakamina recounted a programme run by a local NGO in an area populated by more than 3000 people, but which could only reach 200 because of local instabilities.

Ciza Nakamina presented a provisional six-pillar national policy for HIV/AIDS service delivery. The base is community-level mobilization for awareness. The missing links, he argues, are safety, security and stability.

The effectiveness of community-level mobilization is challenging for populations on the move. Similarly challenging are voluntary testing and counselling efforts in mobile populations. Social service providers prefer to stay where security is in place. Secure testing and transfusion sites are a must in these settings. A militia presence can often curtail community efforts.

We need to fight against impunity. Sexual violence should be treated as a warm crime, as a crime against humanity.

JOSEPH CIZA NAKAMINA, DOCTORS ON CALL

Combating impediments would necessitate viable clinics with qualified doctors able to prescribe treatments; clinics that are capable of supplying voluntary counselling and testing; they must be able to reach all their patients, keeping in mind that 80% of women have not attended school, can't read and would have problems providing written consent to treatment. Clinics and treatment programmes should be integrated into the community with the help of

counsellors and advisors. Importantly, men must also be included to secure their commitment.

Ciza Nakamina closed by suggesting the following recommendations.

- increase accessibility of post-exposure prophylaxes (PEPs) by trained nurses where there are no doctors;
- mobilize faith-based communities for palliative and home based care; and
- talk about problems in the DRC and get DRC on the international agenda.

6 Pillar National Policy for HIV/AIDS Service Delivery:

1. *Provide ART*
2. *Prevent Mother-to-Child Transmission*
3. *Secure blood transfusions*
4. *Treat Sexually Transmitted Infections (STI)*
5. *Provide safe places for voluntary testing and counseling*
– *ensuring women and children are protected and safe*
6. *Mobilize communities to establish awareness campaigns*



TOPIC 2: QUESTION AND ANSWER

Comment [Susan Purdin, IRC].

I appreciate the passion, advocacy, and solutions that were presented. The issue around sexual and gender violence is a driver to the HIV pandemic. If we limit gender based violence to that definition that only includes rape, it won't be enough. Gender-based violence in conflict is an offence that we don't know how to measure yet. What is the incidence, prevalence, quantifying of gang-rape? Some of the data that Dr. Ciza showed indicates that there is high HIV prevalence among rape-survivors. We describe these acts as unspeakable and inhuman, but indeed, they are human because they are created by humans.

NORWEGIAN RED CROSS:

Prevention and peer education are central to Red Cross work. Jennifer Klot, could you please elaborate on 'Say No to ABC'?

KLOT:

17 out of 20 programmes enforce the 'ABC' strategy – Abstinence, Be Faithful, Condoms. In some cases, the programmes increased risks of sexual violence, but overall these outcomes were localized in effect. We have talked about women's ability to negotiate safer sex. But, these strategies – abstinence, faithfulness – don't factor in when we are talking about rape. We need a multi-sectoral approach to sexual violence to decrease the risks to women – something that we don't currently have.

Comment [Eric Mercier, UNICEF]:

When discussing gender-based violence, we need to discuss a multi-sector response; too often we see many NGOs responding to crises, but we don't see this happening on a multi-sectoral basis. We need to make sure there is cooperation and coordination, perhaps organized by a central ministry. We have to scale up gender-based programmes in the DRC, or most of the work being done there right now will disappear.

Right now, UNICEF is focused on preventing mother-to-child transmission; but within this programme, all emphasis is on 'saving' the child. There isn't a commitment to 'saving' the mother. We have to give credit to UNICEF for implementing this type of programming; but do the math: if we are saving the children, but no one is saving the parents, then you are creating more risk! With respect to issues of international development coordination, each of these bodies – Department for International Development (DFID), United States Agency for International Development (USAID) – have their own executives, mandates and goals. We need to prepare emergency instruments that will allow us to respond faster and in a unified manner. Of course, this creates difficulties in ensuring that plans are developed multi-sectorally.

KUMAR:

Problematically, in the field we see a huge emphasis being placed on “A” and a huge emphasis being placed on “B”, but very little emphasis is placed on “C” – on actually providing condoms for people to use. Another problem is when humanitarian aid doesn’t address the needs of sex-workers – especially during times of conflict; sexual violence happens within this industry as well, and we need provide these women with support and services aimed at decreasing their risk factors.





LUNCH TIME PRESENTATION

CORNEILLE, UNICEF Canada National Ambassador

Children as victims, children as actors; Finding Hope in the face of all obstacles

"They don't have much ... but they still smile and have dreams"

CORNEILLE,
UNICEF CANADA AMBASSADOR

The moderator began by introducing Corneille, UNICEF Canada's National Ambassador. Corneille is a Canadian citizen of Rwandan descent and the sole survivor in his immediate family. Corneille promotes a simple message: children are not only the victims of conflict, but also actors; young advocates amongst young people; young people taking action on their own behalf.

Corneille began his presentation by recounting past visits he has made internationally, and how, despite his own Rwandan roots, he still can't really relate to the impetus for conflicts, and the harrowing ordeals faced by the peoples of other African countries in conflict.

As Westerners, he says, we have to ask ourselves, where does our help go? What do we do when armed people are raping young girls? How can we tell those girls to defend themselves? What solution can we bring to that problem? How do we take a country going through political turmoil and help to make it right? How can we avoid these wars? Simply put, we need to help the people of these countries. We need to use our own platforms, our own strengths, to raise awareness of these issues and to encourage an end to war.

Returning from a recent visit to Malawi, a country which Corneille noted is not currently at war but is in the middle of a food crisis, he told conference participants of the "critical situation" there, the immense poverty, and of the people - mothers, children, and AIDS-orphans - he met who have nothing left. But, he remained hopeful, because the people he met were filled with determination and will.

FORWARD-LOOKING REFLECTION AND DISCUSSIONS:

Roxanne Bazergan, the Department of Peacekeeping Operations (DPKO): I think a key aspect is to integrate gender violence training into other programmes, such as Disarmament, Demobilization and Reintegration (DDR) programmes. How that will be implemented remains to be seen.

Tom Sears, Rotary International: I have tried to follow the issue of rape and violence against women. I think it is larger than this; we look at the issue of gender equality from our own cultural perspective: we need to look at the relative equality of women in our own societies, to that of women in societies of conflict. Much of our judgement is culturally based.

Annie Sparrow, Catholic Relief Services: Such as when we discussed how FGM (female genital mutilation) was used as a means of protection in Sudan.

Klot: Yes, I heard an anecdotal story of a case in Sudan where FGM was used as a means of a barrier, to prevent others from having sex with girls.

Laurie Bruns, UNHCR Regional HIV/AIDS Coordinator in Southern Africa: This brings up other protection-related issues that are of concern, for instance, community level stigma and discrimination. Often, this can create within communities a real stumbling block to any programmes you want to put in place. In Darfur, if a woman is raped and becomes pregnant, she will be jailed for having a child out of wedlock. Community level and cultural barriers are tough to tackle, but we do need to address them. We need to be able to ensure confidentiality, because if we can't do that, nobody is going to come forward.

We also need to talk about issues of mandatory HIV/AIDS testing, and refoulement of refugees who are HIV+.

Ciza Nakamina: Regarding a multi-sectoral approach, we should have more partners come aboard this issue and there should be a forum where different funders can come together to streamline funding options. This would allow us to prioritize projects ... the population is not stable, and this is something that needs to be addressed.



TOPIC 3: FUNDING FOR HIV/AIDS PROGRAMMES IN CONFLICT AND POST-CONFLICT SITUATIONS

MODERATOR: CATHERINE BRAGG, CIDA

MASSIMO ZUCCA, UNICEF

FRODE DAVANGER, WORLD BANK

YOUSSEF MOHAMED, AFRICAN DEVELOPMENT BANK

MUKESH KAPILA, IFRC

MASSIMO ZUCCA, United Nations Children's Fund (UNICEF)

HIV/AIDS Programmes in Emergency Funding Mechanisms



HIV Prevalence is not an Indicator of a Programming Response •
Global Reach of HIV/AIDS

[PowerPoint presentations, Topic 3, slides 1-16]

Massimo Zucca, from the United Nations Children's Fund, brought the very practical issue of funding HIV/AIDS programming within the broader context of humanitarian aid. In discussing the issues of both humanitarian aid and HIV programme funding, Zucca first reviewed global incidences of conflict – often an indicator of funding needs.

In 2005, 21 countries were engaged in armed conflict, and another 26 were facing destabilizing political tensions and high-risk disputes. In comparison, there were almost as many countries facing humanitarian crises, as were facing armed conflict in that same year.

Zucca then linked conflict, humanitarian aid and HIV/AIDS, and demonstrated the impact that these events have on the lives of affected children. To this end, he told the group that in countries in conflict or facing humanitarian crises in 2005:

- 8 – 10% of the population were people living with HIV/AIDS (PLWHAs),
- 10 – 14% of the population were HIV+ children, and
- 11 – 15% were children who had been orphaned due to AIDS.

When planning funding for international aid – both aid targeted towards conflicts and towards humanitarian crises – Zucca outlined a number of main points.

1. Funding of humanitarian appeals is stable through time.
2. An increase was observed in HIV/AIDS programming requests and funds received.
3. HIV/AIDS programmes are still under funded when compared to overall humanitarian appeals' funding.
4. HIV prevalence is not a predictor for funding of HIV/AIDS programmes in emergency funding mechanisms.

5. “Usual suspects” (that is, countries with high prevalence of HIV) received a relatively lower funding coverage.

The funding of humanitarian appeals for aid have remained stable over time. In 2002, 66.8% of funds requested within humanitarian appeals were covered, and levels of funding in 2005 are at 66.9%.

Conversely, in the same period, HIV/AIDS related programme requests within humanitarian appeals have increased significantly, unlike, their funding level. According to Zucca, in 2002 only 8.7% of HIV/AIDS programming requests were funded; this percentage essentially doubled, rising to 18.3% in 2004 and to 19% in 2005. Still, when compared to funds being requested and granted for humanitarian aid, Zucca clarified, this means that specific HIV/AIDS programmes are under-funded when compared to more general humanitarian appeals.

The national prevalence of the disease is often taken as an indicator of the level of effort that will be necessary in emergency. The financial response to HIV/AIDS programmes within humanitarian appeals would be expected to be higher in countries where HIV prevalence is high, and therefore the problem represented by HIV is more “obvious”. Zucca outlined that:

- In 2005, the greatest amount of humanitarian funding requests were from mid HIV-prevalence countries;
- The proportion HIV/AIDS specific projects that received any funding was greater in low-prevalence countries than in middle and high prevalence countries; and
- The proportion of HIV/AIDS funds received out of those requested was greater in low prevalence countries.

In order to illustrate this trend, Zucca indicated that in countries with HIV prevalence lower than 1%, the HIV/AIDS components of humanitarian appeals were funded up to 37%, whereas in countries with an HIV prevalence of more than 5%, humanitarian appeals were only funded up to 8% (after excluding an “outlier” given by a WFP project in Malawi’s appeal) Zucca demonstrated.

Zucca concluded his presentation by reminding us that AIDS is getting on the humanitarian agenda. In 2002, proposals were focused on the “usual suspects”, but in 2005, there was greater diversity in regions that were covered by AIDS programming. While more effort is needed to integrate HIV/AIDS into programmatic responses and humanitarian frameworks, he argued that this can be done through open channels of dialogue with donors.

Why are HIV/AIDS funding requests being granted for those countries with lower prevalence on a greater ratio than for those countries which have higher prevalence rates?

MASSIMO ZUCCA, UNICEF

FRODE DAVANGER, World Bank

World Bank Africa: HIV/AIDS Programme, Conflict and Displacement



Multi-Country AIDS Programme (MAP) • Development Cooperation and Conflict
• The Great Lakes Initiative on AIDS (GLIA) Support Project
[PowerPoint presentations, Topic 3, slides 17-35]

Frode Davanger provided the audience with a sketch of the World Bank’s (WB) multi-sectoral response to HIV/AIDS programming within a conflict context, how the WB is able to involve communities in programming, and their strategic targeting of gender-based violence. WB currently has 3 main projects that address HIV/AIDS and conflict being implemented in Africa.

WB now recognizes the link between AIDS and conflict; previously attention was given after conflict, not during. This shift took place during the Balkans conflict

Frode Davanger, WB

Davanger began the presentation by discussing the Bank's support to HIV/AIDS affected Africa, through their Multi-Country AIDS Programme (MAP). MAP is a far-reaching programme through which \$1.12 billion has already been committed and targeted towards 29 countries and 4 sub-regions in Africa.

The MAP project has been able to lay the groundwork for national action on HIV/AIDS, has been able to successfully promote the 'Three Ones,' has had positive results regarding the substantial quality of their resources, as well as being able to adapt and streamline their assets. Davanger also pointed out that WB and the MAP have had success engaging civil society, in stimulating multi-sectoral involvement and have had success with iterative programming.

Despite its success, Davanger outlined several areas where WB is looking to strengthen MAP:

- Accelerate project implementation (variable)
- Strengthen and clarify the National AIDS Commissions' (NAC) role
- Deepen political commitment/leadership
- Strengthen public sector response
- Better sector programmes; greater Ministry Of Health engagement
- Simplify civil society procedures
- Use full scope of MAP flexibility
- Substantially strengthen Monitoring & Evaluation
- Better accountability and governance to make the money work
- More strategic national frameworks
- Design the programme to respond to specific country epidemic
- Link financial disbursements to performance and results
- Scaling up good practices
- Expand civil society involvement
- Balance prevention and treatment components
- More explicit gender dimension
- Targeted approach to vulnerable or neglected groups and high risk groups
- Improve health sector support
- Integrate services with RH and TB programmes

WB is also committed to supporting areas facing conflict – such as WB's Support in Conflict Affected Areas programme. Through this programme, WB has been able to assist countries suffering from violence and conflict by restoring asset and production levels that disrupt economies (as opposed to many aid organizations, which target relief or consumption). Additionally, WB recognizes the link between AIDS and conflict; they now target aid for HIV/AIDS programming during (not after) conflict. This type of innovative programming was used in Bosnia-Herzegovina, thereby laying the groundwork for what has become current operational policy on conflict and development.

WB leads a wide range of activities in war-torn countries, including:

- Institutional support in economic management
- Demobilization and reintegration of ex-combatants (Sierra Leone, Angola, Dem. Rep. of Congo)
- Community-based social and economic reintegration of displaced persons (Angola, Burundi, Georgia, Colombia)
- Community driven development, building capacities and social capital (Timor Leste, Indonesia, Angola, Northern Uganda)

- Infrastructure (Liberia)
- Basic service support, e.g. education, health (Iraq)
- Mine Action (Croatia, Bosnia, Sri Lanka)

Most recently, Davanger told the group, WB has partnered with Burundi, DRC, Rwanda, Tanzania, Uganda, UNAIDS and UNHCR in support of the Great Lakes Initiative on AIDS (GLIA) Support Project, which was launched this past summer (2006), and focuses on refugees, IDP, returnees, networks for transport workers, and PLWA.

This project supports 4 main objectives, namely 1) HIV/AIDS support – prevention and care - to refugees, IDPs and returnees; 2) Support to HIV/AIDS related networks; 3) Support to regional health-sector collaborations; and 4) Strengthening Project management via capacity strengthening, monitoring and evaluation, and reporting.

MOHAMED YOUSOUF, African Development Bank

HIV/AIDS: A major development concern for the African Development Bank



Mainstreaming HIV/AIDS programming • Displaced Populations • A Way Forward
[PowerPoint presentations, Topic 3, slides 36-58]

Mohamed Youssouf provided a presentation that highlighted African Development Bank (ADB) strategies and experiences in developing and implementing HIV/AIDS programmes in Africa. This type of HIV/AIDS programming supports the ADB's mandate of poverty reduction, as the two are closely linked.

In 2001, ADB approved “HIV/AIDS Strategy Paper for Bank Group Operations”, which focuses on assisting countries to develop and implement multi-sectoral approaches to HIV/AIDS programming, and supporting programmes currently implemented by countries.

ADB's guiding principles assist the Bank in outlining and focusing on key priority areas, such as:

- The promotion of political commitments at all levels;
- Supporting sectoral responses in reducing vulnerability and risk; and
- Strengthening coordination and synergy of HIV/AIDS prevention and control programmes.

Youssouf told the group that ADB meets its priorities by channelling energies into advocacy and policy dialogue; by mainstreaming of HIV/AIDS in ADB operations; and by undertaking partnership development. He stressed the importance of mainstreaming HIV/AIDS into the most basic programming aspects – such as the project proposals – through to project reviews and documentation (such as analyses and Country Strategy Papers) and also in impact assessments of local areas and populations.

Youssouf further explained to participants that ADB has more than 60 projects with HIV/AIDS components, each of which strives towards reaching MDG #6: “halt by 2015, and begin to reverse the spread of HIV/AIDS” by preventing the spread of new infections of HIV/AIDS/STIs among refugees, IDPs, and their host communities. To do this, each project seeks to strengthen HIV/AIDS/STI prevention, control and treatment; promote multi-sectoral and sub-regional coordination and to build the capacities of communities, leadership and partnership.

Youssouf outlined 3 examples of ADB funded programming:

HIV/AIDS falls within [the African Development Bank's] mandate, as it is linked to poverty reduction

MOHAMED YOUSOUF, AFRICAN
DEVELOPMENT BANK

- Support to sub-regional HIV/AIDS programming for refugees, IDPs and host communities in the Mano River Union Basin countries and Côte D'Ivoire
- Support HIV/AIDS initiatives of countries along Rivers Congo, Ubangi and Shari
- Support to Lake Chad Basin Initiative to reduce vulnerability to and risks of STIs/HIV/AIDS, which includes Niger, Chad and Cameroon

Youssouf summed up the experiences gained from those projects, namely the necessity for strong partnerships among donors, government and community; the need for regional integration; the importance of harmonizing efforts between donors, government and NGOs to avoid duplication of activities; and the importance of having the commitment of governments in the region to endorse cross-border initiatives.

Youssouf closed his presentation by indicating future direction of ADB programming, noting that the Bank was looking to accelerate research to end the epidemic; to expand and sustain human resources to scale up prevention and treatment; to intensify involvement in affected communities; to build new leadership to advance the response; and to scale up the lessons learned coming out of the field.

MUKESH KAPILA, International Federation of the Red Cross

Scaling up HIV/AIDS Services for Populations of Humanitarian Concern AN UNITED NATIONS SYSTEM-WIDE PROGRAMME



Mainstreaming HIV/AIDS programming • Displaced Populations • A Way Forward
[PowerPoint presentations, Topic 3, slides 59-71]

Mukesh Kapila began his presentation by discussing the importance of helping populations of concern as two-thirds of the global burden of HIV occurs in countries affected by emergencies. These are countries that face an ongoing threat of conflict or crisis, in addition to countries facing an active, violent conflict. Our assistance, Kapila stated, must go principally to refugees and IDPs, but we must also consider and assist other affected groups, such as those whose livelihood has been disrupted due to high HIV prevalence – which could further exacerbate crises.

HIV/AIDS programming can meet a range of needs, including easing the effects of displacement of peoples with differing levels of HIV prevalence; strengthening humanitarian, human rights and protection to reduce the burden among the most neglected groups facing increased vulnerability in emergencies; allows us to modify and adapt programming; and importantly, provides us the opportunity for social transformation.

The HIV/AIDS framework allows us to open the door to address social and development issues such as sexual based violence.

MUKESH KAPILA, IFRC

Kapila suggested re-orienting our thinking to consider the opportunity to work in these areas as opportunities for change, and that we can look at these aspects through a more positive lens. Within this structure the critical features would be to expand access to treatment, to care, to prevention and -- importantly -- to expand coverage.

To do this, Kapila maintained that we should include HIV/AIDS needs of humanitarian populations into existing frameworks; humanitarian populations should be provided with basic services packages in accord with the IASC Guidelines; and underlying sexual and gender-based vulnerability factors (including sexual violence) need to be clearly addressed.

Aside from his work with the Red Cross, Kapila also represents UNAIDS, a multi-agency

Donors don't always throw the most amount of money where the greatest problem is.

MUKESH KAPILA, IFRC

organization committed trying to contribute to bettering the global situation by following principles of best practices outlined by the UN development system, following the “Three Ones” approach to HIV/AIDS prevention and treatment, working towards a more predictable and accountable UN system so as to better meet the needs of people living with or affected by HIV/AIDS, and to encourage a good humanitarian donorship initiative. What this means, he told us, is that donor initiatives will be more harmonized

– reducing duplicated or conflicting programming initiatives – and will better coordinate efforts made by the various bodies.

UNAIDS seeks to promote key strategies in 3 key areas:

Planning

- Development of planning and financial mechanisms
- Mainstream HIV/AIDS into thematic planning and funding mechanisms
- Harmonization of humanitarian planning and financing mechanisms

Expanding Services

- IASC Guidelines and implementing best practices
- Address marginalization through information and media
- Address strategic data and information gaps

Gender Based Violence

- Build capacity on HIV/AIDS interventions in emergencies
- Tracking and assessing sexual and gender based violence and exploitation
- Expanding SDBV service delivery
- Reduction of vulnerability

Typically donors are resistant to become involved in HIV/AIDS programming in conflict situations: donors question why this group and not another? AIDS prevention or treatment is not important during emergencies when there are other life-saving things to do. Donors often maintain that we're already doing this type of programming within another context. Yet, despite these challenges, Kapila argues that positive results have been achieved: in the 13 countries in conflict that UNAIDS is working in, baseline testing has been established and minimum indicators have been set. With on-going focus and a maintained dedicated focus, real change can be made.

The opportunity to work in these areas [displaced persons, HIV/AIDS programming, humanitarian aid, etc] are crucibles for change; we need to look at this positive aspect.

MUKESH KAPILA, IFRC



TOPIC 3: QUESTION AND ANSWER

ED MILLS, CENTRE OF INTERNATIONAL HEALTH AND HUMAN RIGHTS STUDIES:

Regarding accountability, the Global Fund had to pull funding from Burma. There are a number of instances suggesting that funding is being used by governments/regimes to support states sponsored violence. What kind of mechanisms are in place to ensure that funding doesn't get into the hands of such regimes?

Davanger declined to respond to the question.

PARTICIPANT:

We speak about prevention and treatment, but where has the care giving issue gone? This usually falls on women to care of the ill. We talk about the resilient family and women, but how many post-conflict societies have we walked through and talked about re-employment and other economic programmes? In terms of reconstruction, when we look at works programmes we look at creating human capital, but is there a single discussion around public works programmes that doesn't consider care as low-skilled work? This has to do with funding. I know it's difficult for sectors to cooperate, but how possible is it? I would be interested in hearing from WB and other perspectives.

FRODE:

I will try to answer this by looking at community initiative programming. Communities come up with their own initiatives, and in many areas there are programmes that provide orphan care, etc. There are examples here where such initiatives can be scaled up. There is some flexibility, and the potential to have larger programmes.

KAPILA:

This is a really important issue. It might be helpful to see care as a welfare issue, or as an investment issue. If it is seen as a welfare issue, funding will remain on an ad-hoc basis, but if it is looked at as an investment issue, then we can get sustainable funding because it will be seen as a public good that supports economic development.

YOUSSOUF:

As a funder we also have to keep in mind the goals of government. We can't fund something that isn't a government priority or government supported.

OPEC FUND FOR INTERNATIONAL DEVELOPMENT:

We have a small window for grant operations, and in 2001, we established a small programme to combat HIV/AIDS. We now work with UNAIDS affiliated organizations;

we started with WHO and now with UNICEF. We have the biggest programme with UNAIDS. In the target area, assistance is directed to prevention care and treatment. The issue of priorities of donor agencies like us is that each organization sets its own priorities and objectives. We leave assessing priorities to specialist organizations; unless we are given the correct picture, we can not identify priority areas. When we get proposals for a sub-region, we need to know exactly what is going to be done. Giving us general information - on gender for example - we have to ask ourselves, what exactly does this mean? Donor agencies are not just cashiers; we have to know all of these details, as they are important.

ZUCCA:

I would like to respond to your comment with a question: would an instrument for programmatic initiatives vis-à-vis HIV/AIDS in emergencies be useful for a donor to monitor the breadth of the situation? In that case, the IASC Guidelines for HIV/AIDS Interventions in Emergency Settings and their multi-sectoral framework could be useful for donors.

OPEC:

Of course this would be a useful benchmarking tool. We have some ideas as to what countries we would like to go to, but this would go together with the information to help decide where to direct resources. We should also consider fair distribution geographically – Africa, South Asia, Central America. Real priorities, latest priorities, we need to have this information.

MBOW

If we were able to link money to performance and results, as indicated by the mechanism and resulting data, then we will of course steer donors to low prevalence countries, since then they will look like better performers.

ZUCCA:

Countries that asked for smaller amounts of money for HIV/AIDS programmes tended to receive bigger proportions of funding. This kind of data may suggest that countries might be expected to be better able to absorb resources and they could be funded to a greater degree. Otherwise, it could be that such HIV/AIDS related requests are small amounts in absolute terms, compared to 10s of millions of dollars within the overall humanitarian appeals, and this might make it easier for the donors to chip in the money for HIV/AIDS as well.

DAVANGER:

When we say 'performance results', I didn't mean that lower HIV prevalence is an indicator of results. I think there needs to be some results and good measurements. In some countries, we are seeing that vulnerable groups, marginalized groups are not receiving enough attention.

KAPILA:

We need to see patterns of financial flows in order to determine the whole picture. Donors are saying that some high prevalence countries don't receive humanitarian funding for AIDS, because they might be receiving the greatest amounts of funding from the AIDS funding stream. Unless we can see both streams, then we can't analyze Massimo (Zucca)'s data entirely.



ELIZABETH, MANAGER FOR A MULTI-COUNTRY AIDS PROGRAMME, UNDER THE WB:

Let's talk about corruption. Many of you have been following Paul Wolfowitz, the new president of WB and he is demanding accountability. Some of the things that the WB is trying to do with respect to accountability, we track via the CPIA index, which shows policy frameworks that are not supportive of government. Another area is to demand accountability through civil society. In some countries we are seeing an increase in demands from civil society that the government be more responsive and act. In Uganda, we did a study and only 13 cents from each dollar received actually benefited the intended beneficiary (education sector). Media can also help up track corruption issues. In conflict situations, this is especially a concern.

KUMAR:

Children have been hugely affected by corruption. Does WB have disaggregated information on spending? Are there funding targets?

DAVANGER:

WB works with government to develop strategies on spending. In Burundi there is a larger component on orphans. There isn't a spending target, but it is extremely important to include them.

OXFAM:

WB provides funding for HIV/AIDS in Zimbabwe. This is one of the few countries that is showing decreasing rates of prevalence. In 2000, it was 30%, and now in 2005, it is closer to 20%. They have only received \$10 million from the Global Fund. They have done this with very little money and now they are experiencing a food crisis. Why are they not receiving more money?

ZUCCA:

UNICEF is not a donor. My reply is mainly on your statement regarding Zimbabwe's advancement. You are using decreasing prevalence as a marker of success. But how much of that has been due to deaths, as opposed to other gains made?

DAVANGER:

We don't have a specific programme in Sudan; but there are programmes in all of sub-Saharan Africa through the MAPs programme.

OXFAM:

We know that user fees create huge problems. Can any of the panellists tell us how post-conflict countries can have free health care? Can this be made a condition of funding?

KAPILA:

This is not a question of user charges, but about who pays the bill. Certainly, with populations in crisis, it is immoral for them to be charged fees.

PAUL SPIEGEL:

Many of the people we are dealing with, the governments don't wish to support. They don't want to take money from their own citizens. How do funders deal with that?

YOUSSOUF:

The way out of that for the African Development Bank is to take a sub-regional approach. They come up with an initiative, and rather than donating to one country, funds go to institutions and it is purely a grant thing.

BRAGG:

I am going to take a cop-out because I have a humanitarian budget and it is never directed to government (i.e. bilateral funding)

Massimo, you asked the question as to why funding does better in less expected sectors. We don't deal with funding through a sector-approach; we look at it from a crisis-approach to decide where we are going to fund and then we finally go into detail on which sectors need to be funded during a particular crisis.

There are instances where funding is not determined on greatest need. Tsunami victims were funded at \$7000 per person, as opposed to Bangladesh which was \$3 per person. How do we get more predictability for funding in this area as well as funding for humanitarian crisis in general?

A few things were informative for me this morning, like realizing that there isn't much good data for evidence-based decision making. We need to know where the needs are. This is far from the case at the moment. We need better information and donors will find it easier to establish priorities for funding. This is not an excuse: we need to do this together. The second thing that was mentioned this morning was the cluster-approach. For some that don't live and breath humanitarian work, this might be new. I feel it is one of the best ideas to have come along in a long time. Working through a protection cluster and a health cluster, and with a needs assessment within each, will go along way to helping donors ensure that money flows to where the needs are.

DAVANGER:

Some countries target IDP and refugee work more than others, such as Sierra Leone working with refugees in Liberia. We are in dialogue with some countries in the Horn of Africa, which is the larger approach to reaching vulnerable groups if their needs haven't been addressed already.

IOM:

This issue goes beyond refugees and IDPs. Some are mobilized by conflict, some become slum dwellers, some cross borders without status and are not recognized as refugees. I don't see this concept being addressed. Is it the WB's intent to address these broader migration issues?

DAVANGER:

In the Horn of Africa, it goes beyond IDPs and regular migration, and is therefore an extremely difficult question. We don't have the answer yet, but it is being discussed. GLIA Secretariat is looking into these issues. The countries are working together on other development areas, and are talking about the issues that you raise. Unless you address the regional dimension, you can jeopardize any national efforts. We are looking at Ethiopia's experience of monitoring and evaluation.

DAVID TU, MSF:

I want to take issue with the idea that HIV is not a great concern in areas of conflict. 750,000 people are in need of treatment. Dr. Spiegel is looking at transmission, not prevalence. So are we saying that the many vulnerable people already living with HIV do not need funding or support because they are not contracting HIV because of conflict or migration?

BRAGG:

We don't really know the relationship with respect to HIV/AIDS. Donors find it easier to fund rapid emergencies; it is the difference between protracted emergencies and quick on-set conflicts.



TOPIC 4: CONSTRAINTS AND OPPORTUNITIES TO PROVIDE ART FOR DISPLACED POPULATIONS AND IN CONFLICT / POST-CONFLICT SITUATIONS

MODERATOR: CHARLIE GILKS, WORLD HEALTH ORGANIZATION (WHO)

GEBREWOLD PETROS, UNHCR

DAVID TU, MSF

EVAN LYON, PARTNERS IN HEALTH

ELIZABETH MADRAA, NATIONAL AIDS CONTROL PROJECT (NACP), UGANDA

LAWRENCE OJOM, ST. JOSEPH HOSPITAL/AVSI, UGANDA

Moderator Charlie Gilks opened the afternoon session, by welcoming participants and panellists.

GEBREWOLD PETROS, UNHCR

Antiretroviral Therapy for Displaced and Conflict-Affected Populations



ART as a Human Right • Opportunities and Constraints • National Strategic HIV/AIDS Plans

[PowerPoint presentations, Topic 4, slides 1-11]

Gebrewold Petros, the UNHCR Liaison Officer to UNAIDS, spoke to the conference participants about the global need for Antiretroviral Therapy (ART) for populations in displacement and conflict settings. He explained to the audience that globally only 20% of those who need ART are receiving it. This being the case, the majority of the 80% of unmet needs for ART is in developing countries. Refugees compose only 0.2 – 0.3% of that need.

Petros made the link that as ART is now considered to be as lifesaving and essential medicine, populations affected by conflicts, refugees and other displaced populations living with HIV/AIDS should be provided ART as part of their broader human rights. Many host countries – those who provide asylum to refugees – should see the advantages of providing ART to these populations when available to the surrounding host population, both in terms of cost and mitigating the progression of the disease; the consequences of exclusion are both costly and detrimental.

KEY ART INTERVENTIONS

1. *Post exposure prophylaxis*
2. *Prevention of mother-to-child transmission*
3. *Therapeutic long term ART*

Petros outlined some of the key strengths and opportunities associated with ART delivery to persons affected by conflict. He stressed that “evidence and possibilities for ART access do exist in conflict and post-conflict settings.” In support of this theory, he reminded the participants of a point made earlier in the day – refugees often remain in refugee camps for prolonged periods of time in stable



conditions. It is not logical and has a negative public health impact he argued, to exclude refugees in those circumstances from ART treatment.

Other opportunities Petros highlighted, include the momentum that has been gained in scaling up ART; the ongoing discussions at UNGASS (United Nations General Assembly Special Session), the experience from the 3 by 5 initiative – which proposed to treat 3 million people living with HIV/AIDS by 2005 – and the Political Declaration of UN High Level Meeting on HIV/AIDS in June 2006, that called for scaling up towards universal access on HIV prevention, treatment, care and support. In addition, regional initiatives and the creation of an enabling environment will prove to be crucial. Most importantly, now there is a wide body of experience among organizations like MSF, UNICEF, UNHCR, and others on the ground.

We are faced by certain limiting factors, with conflict itself being at the top of that list. Conflict impedes logistics and distributions of goods, which can then further exacerbate conflict. Other key constraints include incorrect assumptions – misconceptions that refugees always have higher HIV prevalence rates, or from physicians who say that refugees do not have a right to treatment or are hesitant to initiate refugees on ART because of their uncertainty of refugee access to/rights to health care. As stated in 2005 UNAIDS Global report, of the 18 countries surveyed, about half reported that they have restrictive policies in place that negatively impact treatment, or worse, that specifically deny refugees access to ART. Such policies further exacerbate the social exclusion of refugees.

Other areas of constraint are insufficient resources, capacity and logistics; restrictive policies; insufficient political will; concentration of treatment facilities/ sites in urban areas; and discrimination and exclusion.

ART are now considered lifesaving and part of broader human rights.

GEBREWOLD PETROS, UNHCR

Clear direction to national HIV/AIDS programming, in the form of a straight-forward and comprehensive National HIV Strategic Plan (NSP) in asylum countries in Africa could alleviate many of the concerns or ambiguities felt at the field level. However, NSPs do not always reference refugees (35% of countries in Africa did not mention refugee populations in their NSP in 2004), and of those that do mention refugee populations, more than half do not actually specify activities for refugees.

In order to ensure the most efficient and effective treatment delivery to all populations – both host and refugee – UNHCR works within certain key delivery principles. Those principles are:

- Inclusive and integrated programmes;
- Adherence to policies and protocols ;
- Minimum package of services;
- Continuity and sustainability.

So as to realize the principles that UNHCR has set out, and to work towards meeting the unmet need for ART, Petros outlined a number of recommendations. First we need to design optimal strategies. This would then allow us to more fully take advantage of our strengths and opportunities, while limiting constraints. Furthermore, this process would be helped if we were able to remove all barriers – this would require both legal and policy reforms. Additionally, he pointed out the need to increase resources, which would allow practitioners in the field to more fully develop and augment technical capacities. Another area that Petros pointed to was the need for inclusive policies, strategies, proposals, funding mechanisms and initiatives.

Further recommendations included the need to expand sub-regional initiatives; develop, update, standardize and simplify guidelines (such as IASC) and programmes; dissemination and implementation of experiences; advocacy; and employing strict monitoring and evaluation methodologies.

In closing, Petros reiterated key considerations when considering HIV/AIDS within a refugee context: first, this is a global endeavour – not only the responsibility of the host country, but also a responsibility of donors, activists and people living with HIV/AIDS. Second, he pointed out that we must provide treatment equally to host populations and to refugees alike – there is no point in establishing parallel systems or in providing ART to refugees when it is not available for the surrounding populations. Other considerations should include scaling up technical support; providing proper tools and collecting good evidence; the need for available treatment in areas of return; and the provision of care and treatment – a core priority outlined in the IASC guidelines. However, the most important consideration is the ongoing inclusion of ART in upcoming discussions and meetings.

It is not logical and has detrimental public health impact to exclude refugees in stable and long term situations from ART.

GEBREWOLD PETROS, UNHCR

DAVID TU, MSF

MSF & ART in Conflict and Post-Conflict Settings



Insecurity and instability • Clinical Outcomes • Adaptation and Flexibility
[PowerPoint presentations, Topic 4, slides 12-25]

David Tu, HIV consultant to Médecin Sans Frontière (MSF), presented a more medically focused review of HIV/AIDS and ART within conflict situations.

Currently, MSF is working to provide care to more than 100,000 people living with AIDS, of whom 57,000 receive ART. ART programmes are being implemented in 30 countries, where 65 projects are specifically tackling HIV and AIDS. There are 7 MSF projects being implemented in 3 countries in conflict; as a result of those projects, 467 people are on ART. Another 7 projects are being implemented in 6 post-conflict countries, where 2317 people are receiving ART.

The obstacles to providing ART in conflict and post-conflict settings, though, are wide-spread; Tu divided the challenges into three distinct areas: 1) obstacles due to medical programming (or lack thereof); 2) obstacles due to population; and 3) obstacles caused by conflict.

While each of these three areas provides multi-faceted challenges, the most complex is medical programming wherein both health infrastructure and human resources (both in terms of persons and in terms of skills) are limited or totally absent. In addition, Tu emphasized the lack of financial resources available to health service providers; worsening the situation is the limited political leadership and/or political will to competently coordinate services and service providers.

Specific to challenges to conflict settings are population-related issues, specifically migration. Persons living under the shadow of conflict are most often impoverished, which Tu connects to limited HIV awareness or understanding. Conflict situations themselves lead to a further set of conflict-specific obstacles, including lack of security which can interrupt programme continuity, and unstable populations– either those leaving conflict settings or those seeking to repatriate after conflict has subsided – both leading to interruptions in treatment.

Despite all of the challenges, Tu provided the audience with a clear set of advantages to ART in conflict settings. The most significant advantage of ART treatment is the obvious reduction of HIV related illnesses and death. However, the delivery of ART also works to improve morale of health care providers and PLWHA and to transform social stigma associated with HIV/AIDS into a more

supportive and caring environment. The provision of ART services also allows health care infrastructure to begin to re-build, which in turn can allow for more rapid response and scale-up post-conflict.

In order to better provide treatment, MSF supports 7 Core Principles for providing ART:

1. Comprehensive HIV Care Model
2. Simplified treatment regimens (e.g. Fixed Dose Combinations or FDCs) and protocols
3. Decentralizing care and delegating greater responsibility to clinical officers, nurses, and community health workers
4. Emphasis on patient centred treatment literacy and adherence support
5. Community involvement and mobilisation
6. Free access to treatment
7. Preparing for disruption/instability

Tu then highlighted some of the major successes of two MSF ART programmes in the DRC - East Bukavu and Kinshasa. Together the two project sites support almost 2300 patients. At both sites, patient survival rate is over 80% (almost 90% in Bukavu). Despite destabilizing events – conflict, mobilization or migration – MSF has found that there is a very small drop-out rate (4.7% in Bukavu and 1.9% in Kinshasa); even when stability is interrupted because of conflict – such as the most recent event in Bukavu - most patients manage to continue their treatment. In fact during that period of acute instability, only 5 (of the 66 patients at the time) experienced a significant interruption of their ART. Those 5 eventually returned to treatment.

4.7% and 1.9% drop out rates [from the ART programmes] might be shocking to some of you. You would assume that, due to conflict and the instability of mobilization and migration, that numbers would be much higher ...

DAVID TU, MSF

The key to a successful ART programme is to have a contingency plan for disruption, including providing adequate education to patients so that they understand the risks and consequences of treatment interruption; to outline human resources capacities, so that a competent skeleton staff can be selected, who will keep things running during times of conflict; to establish communication networks to be able to contact patients; to prepare emergency drug stocks that provide patients with enough medication to get them through to either the next medical facility or to their next treatment; to secure drug storage to prevent potential looting; decentralize care facilities; and to prepare treatment information cards for patients.

In summary Tu restated some of the most salient points of the MSF experience:

- The risks of insecurity and population instability do offer additional challenges in providing ART in conflict/post-conflict settings;
- MSF ART clinical outcomes in conflict and post-conflict settings, though limited in scale, compare favourably to those found in non-conflict settings;
- The MSF experience has shown that with adaptation (and the resources of an international non-governmental organization) comprehensive HIV care can be effectively administered in both post conflict and conflict settings;
- An essential ingredient for successful provision of ART in conflict settings is preparation for disruption

EVAN LYON, Partners in Health (PIH)

Providing Health Care in an Undeclared War: HIV and Primary Health Care in Haiti



Hospital closings • Stability Amidst Chaos • The 4 Pillars *[PowerPoint presentations, Topic 4, slides 26-62]*

Partners in Health is a community based health care NGO that has worked in Haiti for the past 25 years; because they have been working in an undeclared “war zone,” PIH has amassed a range of unique and challenging experiences to share with the group. Evan Lyon, a medical doctor with PIH, specializing in HIV and TB, began his presentation by first introducing the work that PIH has been doing in Haiti.

PIH has 7 clinical sites where they treat more than 1900 patients a day. Lyon explained that these facilities have helped to provide primary care throughout the Central Plateau. In addition to primary care, the clinics provided over 2200 patients with Highly Active Antiretroviral Therapies (HAART) and Directly Observed Therapy (DOT) treatments. In 2005 alone, the PIH provided HIV tests to just under 40,000 people; and direct services to 8,564 HIV+ people. Nationally, Haiti has surpassed its Global Fund goal for HIV testing, treatment, PMTCT and prevention efforts.

PIH works in four main areas, which they call “Pillars”; the 4 Pillars are:

1. HIV Prevention and Care: Integration into primary health care services.
2. Screening and treatment for tuberculosis.
3. Prenatal care and women’s health.
4. Screening and treatment for all STIs.

Lyon further explained that in providing these services, their clinics have experienced major expansion. He provided an example of the town of Lascahobas near the Haiti-Dominican Republic boarder. The small local clinic there saw approximately 20 patients a day, and found absolutely no cases of HIV and only 9 cases of TB (when epidemiology suggested there should be 180). Patients paid for services out of their own pockets. The clinic had little access to drugs. After PIH and the 4 pillars were implemented, the clinic was expanded and the pharmacy was stocked with over 30 essential and 100 common medications; human, financial and material resource capacities were developed and expanded; a laboratory was operationalized, providing medical personal with the resources to perform HIV testing, TB microscopy, RPR testing, manual haematology, radiology, and several other basic services. As a result TB and HIV+ patients were properly identified and were appropriately treated.

*No security. Heavy conflict.
And yet, our organization was
able – not only to survive – but
to expand!*

EVAN LYON, PIH

Lyon explained that by establishing a proven principle of health care during times of relative stability, his organization has been able to continue functioning and practicing medicine during the all-to-frequent times of instability. Political instability in Haiti has been very damaging. At PIH clinics, there were movements of personnel – even kidnapping – and supplies and vehicles were stolen. Lyon explained that the situation was actually much worse than the outside world saw: the humanitarian mission absolutely failed to provide security.

Following the 2004 coup, most hospitals closed; but Partners in Health is an oddity, said Lyon. It has unusual stability, and has never shut its doors, nor had them shut. PIH does not have a team of volunteers, but a paid Haitian staff, which gives employees as sense of pride, accountability and a paid job during times when a little money can make all the difference for them. Lyon did not think



that, during the coup, anyone missed their medical treatments. Significantly, Lyon reported that PIH had nearly 100% compliance with treatment programmes because they were able to continue offering services, regardless of the coup.

In order to continue this tradition, PIH seeks to strengthen the public sector, as well as train and retain local medical staff. To do this, all clinics are joint public-private ventures that provide a comprehensive residency training and professional development component. In order to encourage medical staff to take rural placements, they are financially compensated for their transportation, housing, internet and for tools of the trade. Additionally, all medical staff are encouraged to take part in research, conferences, continued formal education, and teaching within the healthcare sector.

The successes of this project have been noted. The Clinton Foundation has asked that this Haitian model be used in Rwanda, and clinicians have already traveled to Rwanda to lay the ground work.

Lyon notes, though, that the Partners in Health project in Haiti is backed by impressive political will and financial support.

ELIZABETH MADRAA, NACP, Ministry of Health, Uganda

Constraints & Opportunities to Provide ART for Displaced Populations in Conflict and Post-Conflict Situations



Indicators • Opportunities • Constraints

[PowerPoint presentations, Topic 4, slides 63-77]

Elizabeth Madraa explained that she would approach the main issues – HIV/AIDS and conflict – from a broad national perspective, providing a country-specific example of the challenges to and opportunities for ART provision. The Ugandan population is composed of 28 million people, of which, more than half are under 15 years old. Uganda has high maternal and child morbidity rates, a total life expectancy of 47 years and a GDP of \$312 per year. A 20 year-long war – 25 years in the Mid-north -- and 24 years of the AIDS epidemic are both partially responsible for this pronounced poverty.

Other results of this prolonged war, Madraa explained, have been displaced peoples, the disruption of social services, and the destruction of infrastructure.

HIV is among the 5 leading causes of morbidity and mortality in Uganda, and accounts for 12% of deaths annually. The first case was documented in 1982; currently, there are approximately 900,000 people living with HIV/AIDS, with more than 100,000 more being infected each year. Of those, approximately 150,000 to 200,000 are in need of ART treatments, 10% of whom are children. Madraa told us that she expected that 47,220 people in North Uganda are HIV+. Since the on-set of the pandemic, over 1 million Ugandans have died and 2 million children have been orphaned.

Madraa explained that in Uganda ART is provided within a comprehensive HIV/AIDS Care package, and implemented within the National Health Care System. Counselling is available in 22% of treatment sites in Northern Uganda, and PMTCT services are available in 14% of sites. ART has been available since June 2006. Currently ART is provided to about 80,000 people, which accounts for only about 40% of those who need it. In some regions – such as Mid-North -- as little as 10% of the population who need antiretrovirals are able to access treatment.

Despite the incredible need for ART and other HIV related treatments and services, Madraa

explained that there are serious constraints that limit its provision. Chief among those constraints is a human resources gap – mostly as a result of understaffing; in addition, there are problems associated with the logistics supply management chain and with poor monitoring and follow-up of patients. All of these problems, she explained, are multiplied during periods of conflict.

Other constraints that Madraa pointed to included:

- Displaced populations
- Lack of access to existing infrastructure
- Inaccessibility of health services
- Difficulty in providing certain services (laboratory diagnostics, counselling, monitoring patients, etc)
- Presence of unexploded ordinance makes roads difficult to travel
- On-going war affects adherence to ART
- Unwillingness of humanitarian workers to work in conflict situation and IDP camps
- Lack of or poor access to electricity, water, sanitation, and food

Yet, Madraa explained to the audience, the situation is not without hope: the conflict situation in Uganda has drawn the attention and support of local and international organizations – UN bodies, and international and local NGOs have all begun to coordinate relief and rehabilitation efforts. IDP camps have been strengthened to provide basic care and specialized HIV/AIDS services (such as ART and PMTCT), as well as TB and reproductive health services; they have provided support in collecting and organizing accurate multi-level data and recruiting extra human resources; they have assisted in instituting effective follow-up programmes, especially with HIV+ mothers and newborn babies; new paediatric ART sites have been implemented; and personnel and community-based-groups have received training on all aspects of HIV/AIDS. The result has been an incredible improvement in infrastructure and equipment, and hopefully a durable solution.

Madraa highlighted the work that UNICEF contributes to in Uganda, citing special child-formula ARTs that have been successful. In addition, she explained that ART patients meet with the community to discuss such subjects as home-care and other issues of importance. These gatherings help to reduce social stigma associated with HIV/AIDS.

In conclusion, Madraa told the conference participants, “there are many challenges in providing ART in a conflict and post-conflict situation, [but] it is possible given the available opportunities.”

We need to look at a holistic approach to HIV (and) AIDS care
ELIZABETH MADRAA, NACP

LAWRENCE OJOM, St. Joseph’s Hospital, Kitgum Uganda

Constraints & Opportunities to Provide ART for Displaced Populations in / Post-Conflict Situations



Lack of access • Civil War • Grassroots efforts
[PowerPoint presentations, Topic 4, slides 78-101]

Lawrence Ojom provided a focused medical perspective of the activities in Uganda. After briefly re-visiting the overview of Uganda’s political and socio-economic situation, Ojom provided insight into the government’s first reaction – almost 25 years ago -- to the AIDS pandemic: the government was open about the disease, and provided political commitment and support to research for treatment and a cure. A multi-sectoral approach was taken to HIV/AIDS prevention and control. Since 1992 –

MODERATOR: CHARLIE GILKS, WORLD HEALTH ORGANIZATION (WHO)

GEBREWOLD PETROS, UNHCR

DAVID TU, MSF

EVAN LYON, PARTNERS IN HEALTH

ELIZABETH MADRAA, NATIONAL AIDS CONTROL PROJECT (NACP), UGANDA

LAWRENCE OJOM, ST. JOSEPH HOSPITAL/AVSI, UGANDA

Moderator Charlie Gilks opened the afternoon session, by welcoming participants and panellists.

GEBREWOLD PETROS, UNHCR

Antiretroviral Therapy for Displaced and Conflict-Affected Populations

ART as a Human Right • Opportunities and Constraints • National Strategic HIV/AIDS Plans

[PowerPoint presentations, Topic 4, slides 1-11]

Gebrewold Petros, the UNHCR Liaison Officer to UNAIDS, spoke to the conference participants about the global need for Antiretroviral Therapy (ART) for populations in displacement and conflict settings. He explained to the audience that globally only 20% of those who need ART are receiving it. This being the case, the majority of the 80% of unmet needs for ART is in developing countries. Refugees compose only 0.2 – 0.3% of that need.

Petros made the link that as ART is now considered to be as lifesaving and essential medicine, populations affected by conflicts, refugees and other displaced populations living with HIV/AIDS should be provided ART as part of their broader human rights. Many host countries – those who provide asylum to refugees – should see the advantages of providing ART to these populations when available to the surrounding host population, both in terms of cost and mitigating the progression of the disease; the consequences of exclusion are both costly and detrimental.

Petros outlined some of the key strengths and opportunities associated with ART delivery to persons affected by conflict. He stressed that “evidence and possibilities for ART access do exist in conflict and post-conflict settings.” In support of this theory, he reminded the participants of a point made earlier in the day – refugees often remain in refugee camps for prolonged periods of time in stable conditions. It is not logical and has a negative public health impact he argued, to exclude refugees in those circumstances from ART treatment.

Other opportunities Petros highlighted, include the momentum that has been gained in scaling up ART; the ongoing discussions at UNGASS (United Nations General Assembly Special Session), the experience from the 3 by 5 initiative – which proposed to treat 3 million people living with HIV/AIDS by 2005 – and the Political Declaration of UN High Level Meeting on HIV/AIDS in June 2006, that called for scaling up towards universal access on HIV prevention, treatment, care and support. In addition, regional initiatives and the creation of an enabling environment will prove to be crucial. Most importantly, now there is a wide body of experience among organizations like MSF, UNICEF, UNHCR, and others on the ground.

We are faced by certain limiting factors, with conflict itself being at the top of that list. Conflict impedes logistics and distributions of goods, which can then further exacerbate conflict. Other key constraints include incorrect assumptions – misconceptions that refugees always have higher HIV



TOPIC 4: QUESTION AND ANSWER

CHARLIE GILKS

Are there any examples of midwives and birth attendants trained in prevention of mother-to-child transmission? And second, what sort of follow-up has been provided to refugees who have returned to their country of origin?

ANNA MILLER, CPAR:

Is there a place for two levels of national policy for ART? One for normal situations and another for conflict situations. In DRC, there are very few medical doctors, and over 3000 rapes.

UNDERGRADUATE STUDENT:

Dr. Tu, could you please go through your recommendations?

OJOM:

Community based organizations (CBOs) are trained so that they can effectively refer patients [to PMTCT services]. Right now, in camps that are far off, there is no effective supervision. But they are deeply involved in all of these activities.

MADRAA:

They [midwives and birth attendants] were trained to have a clean delivery, but only 40% of women in Uganda deliver in health facilities. Now we are moving from a single dose to a multiple dose. Now it is more difficult to train and ensure that mothers of taking their doses. We need to encourage mothers to declare their status so that they can get the needed treatment.

In terms of two policies, the gap affects the normal situation and the conflict situation. There is a burden of the workload and this affects people both in time of conflict and not.

LYON:

Birth attendants are given supplies for clean birth, but are not given prophylaxis, but they can make referrals. Use and proper oversight on community health workers ... the infrastructure that is built when community health workers are trained is great considering the lack of infrastructure that these workers have to work around; for example, the lack of cell phone coverage.

TU:

In terms of decentralization, you need mobile support and training for staff members that are doing things beyond that which they were trained for.

With regards to recommendations, other than to just re-emphasize that there is a huge need- up to 3.5 million people with HIV are living in conflict situations- ART is feasible in stable and in conflict settings. It is possible and we have no choice but to go there.

MSF:

It strikes me that only in the context of conflict do we think we can talk about the problems that exist at all times, like the shortage of doctors. Access problems occur in non-conflict settings as well. Remaining on treatment in your community should be the baseline. Perhaps conflict settings are the way that we have to discuss access to health care in rural settings.

We spent a great deal of time to run after the train, to catch up with prevalence, but we didn't talk about prevention; so that we don't have to keep pouring in resources.

What are UNICEF and WHO doing to ensure proper nutrition for children?

PARTICIPANT:

PMTCT can be an access point for women who receive ART. How well are women treated or followed up with after they have been identified as HIV+?

UNHCR:

There were some great MSF programmes. What are the MSF strategies for handover and sustainability in terms of HR capacity? Handover is a difficult issue.

If there is a good model there, it would be interesting to learn how you get people in earlier stages of HIV.

PARTICIPANT:

In terms of sustainability ... if we say that there is a health worker coming into your home everyday, how is this sustainable? And what of confidentiality ... what will the neighbours say?

When I was in a refugee camp in 2003, I visited a doctor when it was time for me to start ART treatment ... but the doctor was far from where I was. The doctor told me to go to a nearby hospital. I came from the camp to the hospital and asked about ART; they told me that follow-up might not be possible in my country once I become repatriated. I was in a situation where I couldn't receive follow-up in my county of origin. So since 2003, I haven't started ART treatment, and I have friends that are in the same situation.

SPIEGEL:

If there is an imminent repatriation, then there is no way for a refugee to access ART. UNHCR advocates for regional initiatives because of this issue. Proper coordination has to exist between country of origin and that of asylum. I don't think there is a ready answer on this. If repatriation is not going to take place within 6 months, then [it is feasible that] ART should start. This can be explained in terms of human rights, and also to the stigma regarding refugees. The stigma will follow them home as well, because they are sometimes perceived as bringing HIV home – this might also impact their access to treatment, even once back in country of origin.

TU:

Regarding handover: I think your comment that MSF is a 'mobile population' is warranted. We recognize our limitations; we wouldn't be able to provide the coverage that is needed, but we want to become role models and agents for change. There is a responsible method for handover. There is an abstract about handing over project in Guatemala. There are some positive examples of handover in Thailand and Ukraine, so that basic standards of care are established and this can translate into national best practices and push national coordination systems to take action.

As I said before, it is not clear in each circumstance what the handover strategy should be. In Angola, with the prevalence so low, there was a clear willingness so that facilitated the early handover.

Some other projects will be more challenging. We see need in many places throughout Africa. Yes we do plan to hand over our projects, but we will do what is possible within our limitations so as to do so responsibly.

You also have to look at origins of the programme. It started in 2000 as a prevention programme. Sex trade workers, fishers, taxi drivers, and doing outreach work with them. It evolved into a programme to prevent STIs; the evolution to provide treatment was organic. It was from that infrastructure that the treatment centre evolved. There is some hypothesis in that region about the generalization of the epidemic ... there are more patients at an earlier stage of infection. The main method of enrolment is through voluntary testing. Once we start working with hospital structures, we will meet with people in more advanced stages

We have taken that on by providing a package of nutritional support, and prenatal care. For us that includes milk supplements. Supply the milk and access to clean water. It is trivial compared to life long treatment for HIV. The cost is not terrible. The question of 'is the mother in PMTCT' is about standards of therapy. PMTCT means that the mother has a relationship with a community health worker. All mothers get CD 4 testing. If they are positive, they start treatment for long term therapy, if they are a fit: we hope that allows for better health for both mother and child on long term

LYON:

First of all I would propose that sustainability is a matter of perspective. We have people asking us for employment as community health workers. Everybody gets a stipend. They receive about \$40-45 per month which is about double the national average wage. Our system would not function without those actors. Small outbreaks of diarrhoeal disease, etc. are treated by these workers.

Confidentiality is an issue. We recognize that within the HIV theatre. So there is a lot of talk in the community about who is getting treated and for what. Every condition receives follow up treatment in the home for other diseases. So this diffuses the spotlight for those who are receiving treatment for HIV. They can say that they are being treated for TB or diabetes. This works and allows for constant feedback. We don't use pill bottles. So there are no labels involved. The worker hands out daily pills and labels aren't an issue. Really, it is less than 5% of patients who won't accept a community health worker into their homes.

PARTICIPANT:

If I may add to that, the question raised about prevention. .. Uganda has been successful ... it has worked very well because patients get their two week dose. Sometimes it is even the children who make sure of their parents' compliance to treatment; the children look to make sure that the mothers take their pills. Then the health workers go to ensure that all pills were taken that week. This helps, because they don't have to go to health facilities to get their pills. They visit each other to ensure that pills are taken. We have to normalize HIV/AIDS. Confidentiality is going to be an issue unless we can increase normalization. Without normalization it will be difficult to scale up treatment in the community. The issue of prevention is very important. ART is used as an entry point for addressing prevention. Unless we reduce new infections, we are not going to be able to successfully address HIV. Many countries are looking at drivers of the epidemic. We need to know what the drivers are, and then the national strategies can be developed; could be risky sexual activity; or when we come to



PMTCT, do we wait until the woman is pregnant, or do we prevent it when she is a teenager. Condom use alone has not prevented infection because women might not have decision making power to make use of condoms. So what are we saying? We need to look at all efforts.

With nutrition, those mothers who are positive are given the treatment. We are encouraging peer education. Preparation of baby formula has been a problem, because if a woman chooses not to breast feed, it is a very expensive solution to sustain. Many mothers who are positive do refuse to breastfeed. But, the sick children are still living and the healthy ones are dying.

OJOM:

To provide supplements for mothers, it is difficult. For at least 2 years these children are going to be tested and many become malnourished and die on the way. Normally over 90% of the children are negative, so that eventually they are able to stand on their own. But for all of them, there is a normal assessment, and treatment support is critical. They make the daily follow up trip. We work with community groups, community support groups also offer support in the home; especially for children ... because they normally come with other complications. At the centre where I work, in the nutrition centre, the prevalence of AIDS is about 20% in children above age of 18 months. So whenever children come in with other health issues, such as malaria, they should be tested so that we can identify when the disease is in its early stages.

Access to land is important, but with this situation of conflict, it is difficult to support. But education and follow up ... it is a dream to say that health workers can do it all. Community support groups will need to play a greater role. The problem is we also have soldiers in Uganda. What do we do? When do we start treatment? If a soldier/patient is in northern Uganda and is then re-assigned to a different region, what will happen to treatment? Of course they should get access to treatment, but how do we manage these issues?



FINAL WORDS

RIMA SALAH

DEPUTY EXECUTIVE DIRECTOR, UNICEF

Rima Salah's closing remarks touched on the themes of the day: namely HIV and conflict, and how our efforts have contributed to improving the global HIV situation. She reminded us that in 2003, 1 in 7 HIV+ children were living in a conflict or in an emergency situation.

Conflict leads to a range of problems – the disruption of social and economic norms, broken families, risks of sexual violence and non-consensual sex. Salah also pointed out that a number of women are driven to engage in sex for survival. Many girls do not even know if they are positive or not. Many women and children cannot go to school or access health care and are more vulnerable. People often need to liquidate their resources – including selling their meagre belongings or their homes. Salah reminded the group that conflict places increased burdens on children.

Salah led the group through the salient points of the IASC Guidelines. She pointed out that these guidelines have been compiled from best practices, and that even in the midst of conflict, these guidelines call us to action. But even these guidelines miss the importance of ART. From an HIV/AIDS programming perspective, we are beginning to understand the need for programming in complex emergencies; but the degree of funding within consolidated appeals still remain relatively low. Salah hopes that donors will use today's discussion to inform their funding decisions for HIV programming in humanitarian responses.

Salah closed her final remarks by thanking CIDA, ECHO, UNHCR, and UNICEF Canada. "Together, united," Salah concluded, "we will achieve our goals."

These issues – conflict, HIV and AIDS – affect children as well as adults.

RIMA SALAH, UNICEF

STEFANO SEVERE

REPRESENTATIVE, GUINEA, UNHCR

Stefano Severe admitted to conference participants that he represented a different perspective than the majority of the presenters they had seen during the day: that of the country manager. But, he felt that this perspective was an important one. Ideas and theories might work on paper, but he mentioned that in the field, there are many things that simply do not work.

Severe shared an idea with the group that has met with some success: a working group, with a rotating presidency, allowing for a multi sectoral approach and investment in the important issue of coordination in implementing both the UN's integrated plan, but also Guinea's national plan. The challenge that this group has come to is that, in many respects, the previous national structure established through a presidential decree is quite far behind where the group is working from. This leads to competition between this working group and the Ministry of Health. In other countries, Severe recounted, this type of working group has additional problems when the Ministry of Health sees the group as a source of funding, and they "spend more time looking for funding than on

activities directed towards the fight against AIDS.”

In many cases, Severe elaborated, refugees are seen to be the cause of higher HIV prevalence. This means that an approach is needed that will focus on IDPs and refugees, and will work with them towards prevention and treatment.

LOUISE HOLT

DIRECTOR, SOCIAL DEVELOPMENT POLICIES, CIDA

Louise Holt began her final words by stressing that this conference provided a very important opportunity to move forward, but she asked the group – what was the essential message and how will we take that forward? She pointed out that the challenge for policy makers is to translate all the important issues they heard today into sustainable actions.

Ms. Holt also pointed to the messages of the day: that conflict does not lead to an automatic heightened prevalence of HIV; that there are a number of new models for reintegrating HIV/AIDS within host country situations; and that we should look at HIV/AIDS and conflict as a “double emergency”. “I think that is a really important model and image that should resonate with all of us,” she said to the group.

Holt ended her remarks by recalling Corneille’s talk earlier in the day. Youth are an important group to engage. “I think,” she stressed “we should all pick up on the challenge to meaningfully engage youth in finding the solutions.” There is much to be done to address HIV/AIDS, Conflict and Displacement. Today we have touched on issues ranging from the technical to the personal and now we need to move forward with action. She closed her talk by thanking both UNICEF and UNHCR.

NIGEL FISHER

PRESIDENT AND CEO, UNICEF CANADA:

Fisher once again thanked participants for their interaction in the day’s proceedings and assured them that they would receive a copy of all presentations and a summary of the day’s talks.



ANNEX 1: AGENDA

HIV/AIDS, CONFLICT AND DISPLACEMENT
August 12, 2006
XVI International AIDS Conference Affiliated Event

TIME	AGENDA	MODERATOR	DISCUSSANTS
8:00-8:30	Registration		
8:30-8:50	Conference purpose, proceedings, structure and expected outcome	Nigel Fisher, President & CEO, UNICEF Canada Paul Spiegel, Senior HIV/AIDS Technical Officer, UNHCR	
	First hand introduction to the topic to set the stage for the days proceedings	Noe Sebisaba, Stop SIDA Nkebure Uwumva	
8:50-10:00	Topic 1 HIV, conflict and displacement; latest thinking	Michel Sidibe, UNAIDS	Paul Spiegel, UNHCR Fatou Mbow, IRC Martin Rupiya, ISS
10:00-10:30	Q & A		
10:30-10:45	Tea / coffee break		
10:45-12:00	Topic 2 Protection, gender based violence, and HIV/AIDS	Robin Jackson, WFP	Pam Delargy, UNFPA Jennifer Klot, SSRC Gopa Kumar, Save the Children UK Joseph Ciza, Doctors on Call –DRC
12:00-12:30	Q & A		
12:30-12:45	Corneille, UNICEF Canada National Ambassador		
12:45 -1:30	Lunch		
1:30-2:45	Topic 3 Funding for HIV/AIDS programmes in conflicts/post-conflict situations	Catherine Bragg, CIDA	Massimo Zucca, UNICEF Frode Davanger, World Bank Mohamed Youssouf, African Development Bank Mukesh Kapila, IFRC
2:45-3:15	Q & A		
3:15-3:45	Tea / coffee break		
3:45-5:00	Topic 4 Constraints and opportunities to provide ART for displaced populations and in conflict/post conflict situations	Charlie Gilks, WHO	Gebrewold Petros, UNHCR David Tu, MSF Evan Lyon, Partners in Health Lawrence Ojom, St Joseph Hospital/AVSI, Uganda
5:00-5:30	Q & A		
5:30-5:45	Final words	Rima Salah, Deputy Executive Director UNICEF Stefano Severe, Representative, Guinea, UNHCR Louise Holt, Director, Social Development Policies, CIDA	
6:00-8:00	Evening reception		





ANNEX 2: POWER POINT PRESENTATIONS

TOPIC 1 HIV, CONFLICT AND DISPLACEMENT; LATEST THINKING

Paul Spiegel, UNHCR (slides 1-15)

HIV Epidemiology among Conflict-affected and Displaced Populations

Paul Spiegel MD, MPH
United Nations High Commissioner for Refugees

1

Overlap between HIV and Conflict

More at: www.unhcr.org/refugees/1421.html

2

HIV Prevalence by Asylum Country and Country of Origin by Region

3

HIV Prev. of Refugees and Host Communities in Selected Sites, 1998-2005

Country/Camp	HIV prevalence (%)	Year	Host population (%)	Year
Burundian Refugees in Tanzania				
Mtaka and Hyamba camps	1.1, 4.2	2001, 2002	Expatrie region*	2.0
Saba and Shamba camps	1.1, 1.6, 1.7	2001, 2002, 2003	Expatrie region*	2003
Lobito Camp	4.1, 3.1, 1.6	2001, 2002, 2003	Expatrie region*	2003
DRC Refugees in Tanzania				
Ngazwa and Kinyanya camps	1.6, 2.5, 1.8	2001, 2002, 2003	Expatrie region*	2.7
DRC Refugees in Burundi				
Chibinda camp	1.7 (2.1+2.4)	2002	Expatrie site	4.7 (3.7-5.4)
DRC Refugees in Zambia				
Mwando camp	1.1	2002	Expatrie site	1.8
Lala camp	1.7	2002	Expatrie site	1.8

4

Table B: HIV prevalence of refugees and host communities in selected sites, 1998-2005

Country/Camp	HIV prevalence (%)	Year	Host population (%)	Year
Burundian Refugees in Tanzania				
Mtaka and Hyamba camps	1.1, 4.2	2001, 2002	Expatrie region*	2.0
Saba and Shamba camps	1.1, 1.6, 1.7	2001, 2002, 2003	Expatrie region*	2003
Lobito Camp	4.1, 3.1, 1.6	2001, 2002, 2003	Expatrie region*	2003
DRC Refugees in Tanzania				
Ngazwa and Kinyanya camps	1.6, 2.5, 1.8	2001, 2002, 2003	Expatrie region*	2.7
DRC Refugees in Burundi				
Chibinda camp	1.7 (2.1+2.4)	2002	Expatrie site	4.7 (3.7-5.4)
DRC Refugees in Zambia				
Mwando camp	1.1	2002	Expatrie site	1.8
Lala camp	1.7	2002	Expatrie site	1.8

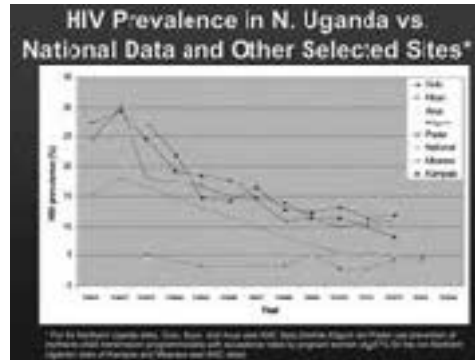
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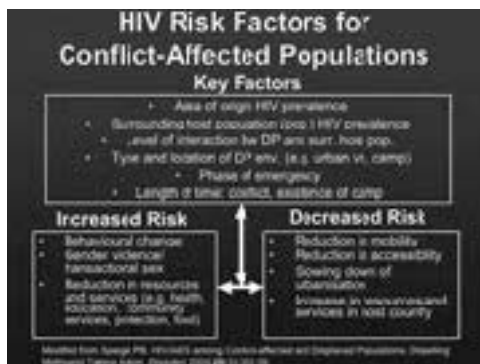




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8



9

Behavioural Surveillance Survey (BSS) Study: Objective and Methodology

- To evaluate quality of BSS in HEs and post conflict situations and provide recommendations to NGOs and Gov'ts on how to improve quality
- 31 BSS evaluated between 1998-2005 in 14 countries classified as reproducible if:
 - pop. based sampling:
 - Defined sampling frame
 - Used probabilistic sampling (incl. PPS for cluster sampling)

10

Results

- Settings
 - Conflict: 8 (25.8%)
 - Post-conflict: 6 (19.0%)
 - Refugee settings: 14 (45.2%)
- Organisations
 - NGOs: 23 (74.2%)
 - CDC: 4 (12.9%)
 - UN agencies: 3 (9.7%)
 - Gov'ts: 1 (3.2%)
- Sample size
 - Mean: 1,261, median: 549, range: 148-7,184

11

Results cont

Sampling Method	Frequency (%)
Random sampling	23 (74.2)
Convenience	4 (12.9)
Not mentioned	4 (12.9)
31 (100)	
Random what type?	
Simple random	4 (12.9)
Systematic	7 (22.6)
Cluster sampling	8 (25.8)
Not mentioned	4 (12.9)
25 (100)	
All eligible person in household surveyed	yes: 31 (100)
Sampling frame	yes: 23 (74.2)
reproducible	yes: 14 (45.2)

12

Behavioural Surveillance Surveys (BSS) for Displaced Persons (DP) and Host Communities

- Modified questionnaire incl. pre-displacement, displacement and post-displacement/interaction modules with strong gender-based violence component developed*
- Undertaken in both DP and host communities
- Development of BSS manual to improve quality of BSS undertaken in field

13

Knowledge and Risk Behavior among Refugees, Surrounding Populations, and Persons in Country of Origin, Southern Sudan, 2002-04

	Eastern zone (incl. IDP, ACPs, DP)	Western zone (incl. IDP, ACPs, DP)	Urban zone (incl. IDP, ACPs, DP)	Urban zone (incl. IDP, ACPs, DP)
Characteristics	Host towns (%)	Host towns (%)	Host towns (%)	Host towns (%)
Level of HIV/AIDS	113/1000 (11.3)	144/1000 (14.4)	114/1000 (11.4)	114/1000 (11.4)
Knowing HIV spread via sex	523/524 (99.8)	179/180 (99.4)	324/325 (99.7)	439/439 (100)
Know correct details about AIDS	109/104 (104.8)	102/102 (100)	109/111 (98.2)	109/111 (98.2)
Thought sex safe	109/111 (98.2)	102/102 (100)	109/111 (98.2)	109/111 (98.2)
Higher risk	109/111 (98.2)	102/102 (100)	109/111 (98.2)	109/111 (98.2)


*2 components

14



Conclusions

- Complex relationship between HIV and conflict
 - Findings not support contention that conflict increases HIV transmission regardless of magnitude of prev. when conflict began
 - Refugees had lower or similar prev. than surr. pop.
 - Analysis is context-specific and no assumptions should be made
- Need to examine (and program for) interactions between DPs and host pop. as well as returnees and those persons in area of return
- Need for improved biological and behav. data
- Data can and should be used for advocacy and programming purposes



15

HIV & EMERGENCIES: THE RESPONSE

Dr Fatou Mbow, MRCGP, DFFP

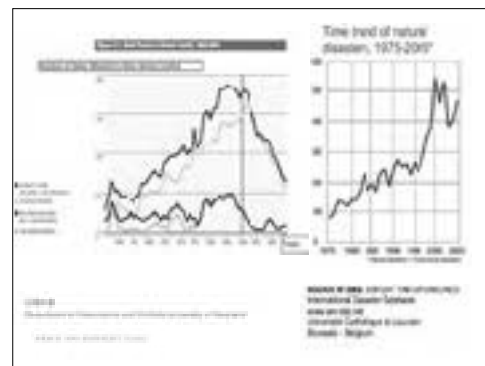
16

Caseload

Conflict-affected, 2005	Disaster-affected, 2005
<ul style="list-style-type: none"> • Refugees (13.4M) (9.2M UNHCR 4.2 UNRWA) • Internally displaced people (25M) • 50% under 18 	<ul style="list-style-type: none"> • 157M affected (floods, droughts) • 245,000 deaths (90% tsunami) • 159 billion USD in damage (125 billion USD Katrina)

Source: UNHCR and UNRWA, 2006

17




18

Framework

19


Refugee Convention, 1951



Article 23:
States parties shall accord to **refugees** lawfully staying in their territories access to **the same "public relief and assistance"** as their nationals, including medical care.

20

The Sphere Project, 1997



- Humanitarian Charter
- Universal minimum standards in core areas of humanitarian assistance

Aim:

- quality of assistance
- accountability of the humanitarian system

21

MISP, 1997



- Coordination
- GBV prevention and management
- HIV prevention (condoms, universal precautions)
- Maternal and child morbidity and mortality prevention (delivery kits, referral systems)
- Planning for comprehensive RH services

22



IRC Field Manual, 2003



- Protecting the Future
HIV Prevention, Care and Support Among Displaced and War-Affected Populations

23

IASC Guidelines, 2003



MULTISECTORAL RESPONSE:

- 1) Coordination
- 2) Assessment and Monitoring
- 3) Protection
- 4) Water and Sanitation
- 5) Food security and nutrition
- 6) Shelter and site planning
- 7) Health
- 8) Education
- 9) Behaviour change communication (BCC)
- 10) HIV/AIDS in the workplace

MATRIX
AND ACTION SHEETS
BY SECTOR

24

Post-emergency, 2005



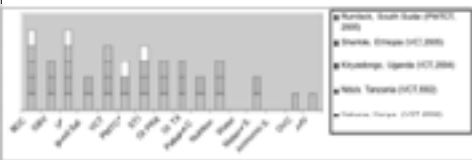
- Integrate refugee issues into national HIV programs and policies
- Implement sub regional (cross border) initiatives
- Combine humanitarian and development funding

25

The response

26

HIV activities in 5 IRC sites, 2006

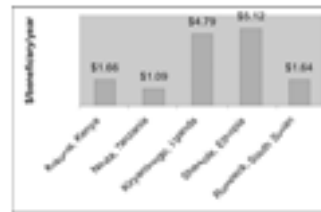


Issues of note:

- Host communities: access to services.
- Referral systems: follow up and documentation.

27

HIV program budget in 5 IRC sites, 2005



Mean: 2.86 US\$/beneficiary/year

28

ART in conflict-affected settings

UNHCR, 2005

RATIONALE	INTERVENTIONS
<ul style="list-style-type: none"> • Life saving, essential treatment available (universal access) • Shown to be feasible in conflict-affected settings • Average length of stay of refugee in host country in 2004 was 17 years 	<ul style="list-style-type: none"> • Post Exposure Prophylaxis (PEP) • PMTCT • Therapeutic, long term ART

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ART in conflict-affected settings- cont.

UNHCR, 2005

KEY STRATEGY COMPONENTS	ART access in 63 countries with more than 5,000 refugees, 2005	
	# of countries	%
• Advocacy/ Funding		
• Technical assistance		
• Integration of services within national initiatives and sub-regional initiatives		
• Monitoring and evaluation (M&E)		
• Clearly defined roles and responsibilities		
Available data	44	70%
ART access for hosts and refugees	26	59%
ART access for hosts only	7	16%
ART access for refugees only	0	0%
ART access for neither hosts nor refugees	11	25%

30

“We are happy with health services now; **even** the HIV/AIDS problem is being addressed”

Rutta E. et al, Refugee perceptions of the quality of healthcare: findings from a participatory assessment in Ngara, Tanzania. Disasters, 2005, 29(4):291-309

31

Recommendations from humanitarian agencies in the field

- Invest in monitoring and evaluation/ research
Implement evidence-based, site-specific, interventions
- Aim for sustainable interventions
Work within “the 3 ones” from the outset

32

Martin Rupiya, ISS (slides 34-45)

Acknowledgements

- United Nations High Commissioner for Refugees (UNHCR)
- International Rescue Committee (IRC)
- United Nations Children’s Fund (UNICEF)
- Regional (East Africa & Great Lakes) HIV Humanitarian Working Group (based in Nairobi)
- Conflict affected populations

33

What We Know About HIV & AIDS vs Militaries in Southern Africa

Martin Rupiya
MilAIDS Project Manager
Institute for Security Studies



Project supported by the Rockefeller Brothers Foundation (RBF)

34

Caveat on HIV & AIDS in the MILITARIES

- History of suspicion, stigma - associated with search for scapegoats
- Events in militaries intricately linked to national trends and challenges
- International dynamics affect and reflected in the institutions

35

Research methodology

- Worked with 5 militaries - 3 formal agreement and 2 with colleagues from civil society with a working relationship with security sector in their own countries: Botswana, Swaziland, Zambia and Tanzania and Zimbabwe
- Conducted and attended HIV & AIDS related workshops and conferences with the sector at which the issues were freely debated
- Engages in Lectures/debates Staff Colleges and National Defence Colleges

36

National Prevalence Rates and those in the militaries - methodology

- Drawn from sources:
 - Ante-Natal Clinics (ANC)
 - Blood transfusion services analysis, Volunteer assessments
 - Commentary - Flawed methodology for Angola and DR Congo
 - Southern African mean 10.6% (??)
 - Transmission modes
 - a) homosexual behaviour, b) sharing needles/ syringes
 - c) mother-to-child-transmission, d) unsafe sex, inappropriate condom use/alcohol abuse and
 - e) heterosexual relations
- Culture of ‘political’ and vocal stigmatization as well as legislated criminalization -

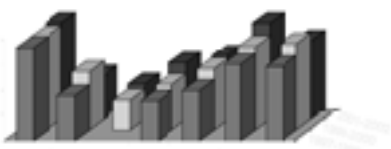
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HIV/AIDS in Sub-Saharan Africa, 2005	
New Infections	32 000 vs 49 000
Deaths	24 000 vs 31 000
People living with HIV/AIDS	25.8 m vs 40.3 m

UNAIDS/006
Estimate of situation in 2005 in the epicenter of the global epidemic

38

Trends in median HIV prevalence in the same antenatal sites by country and period, Southern Africa, 1997-2002



The epidemic is leveling off at extremely high levels of prevalence

39

Specific sector challenges: Context

- Policy vacuum in international and national frameworks - WHO-transition to UNAIDS -
 - First policy direction in after presentation of 2006 Global AIDS Report - Peter Piot
- National reaction mid-1980s “just another pandemic” to be addressed by the Ministry of Health (MoH)
- National Commissions and calls to Sectors to fashion sub-policies
- Pressure from coal-face position -- 500 000 special category vs 230 million

40

What we now Know

- A) HIV & AIDS confirmed presence within Militaries- 21% SANDF
- B) All Militaries Test new recruits -
 - New Challenge - 17 - 19 year olds Negative
 - Incentive for Institution and Individuals
 - Human rights issues
- C) Serving members falling victim
 - Containment strategy -
 - Redeployment
 - Provision of medical support
 - Include spouses--burden sharing
 - New skills -
 - Counselors
 - Nutrition
 - Social/Chaplaincy
 - Drug control/Quarter-master

41

Continued....

- Containment - generic drugs - not readily available
- Scientific Medicines overwhelming role of Traditional-Herbal medicines & culture
- Home based care - special needs and
 - Long sick leave and early terminal benefits
 - Uniformed welfare organizations
 - Integral funeral services

42

continued

- Challenges - Policy vacuum - (??)
 - Peacekeeping and
 - Deployment - “Take-Aways” - poor cousins and availability of drugs [ARVs]
- Nutrition - Developed World Agriculture subsidies + Food AID = African Food Insecurity

43



Southern Africa Food Insecure States whose Armed Forces are also confronted with equally severe nutritional demands.

44

Conclusions

- Engage in impact studies to determine the exact impact of the epidemic? This must include paying attention to role/place of Traditional-Herbal-Medicines
- Address Containment short-comings-Generic Drug supply
- Abandon head in the sand attitude on the presence of homosexuality and its implications
- Receive recognition at national level for role over the last 25 years and increased constituency
- Serve as possible change agent?
- Operate within national guiding policy framework

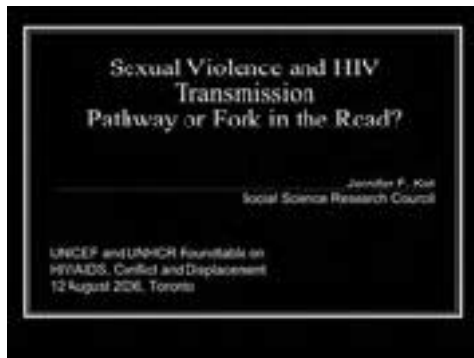


45



TOPIC 2 PROTECTION, GENDER-BASED VIOLENCE, AND HIV/AIDS

Jennifer Klot, SSRC (slides 1-14)



1

Sexual Violence and HIV transmission

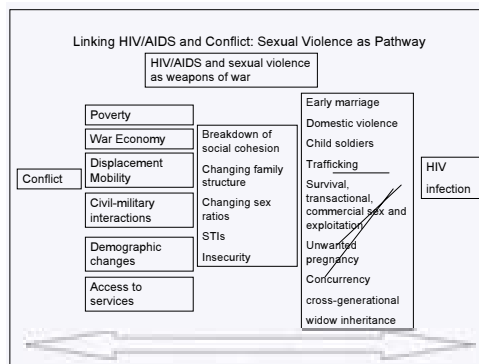
- Sexual violence most significant expression of how gender inequalities fuel the pandemic
- Vastly under-represented factor of HIV risk and transmission
- Disproportionate rates of infection among young women
- Dissonance between epidemiologic evidence and current orthodoxy about heterosexual transmission

2

Sexual Violence and Transmission Efficacy

- Social and behavioral factors
 - Determinant of condom use
 - Increase sexual risk behavior
- Biological co-factors
 - Most common cause of coital injury
 - Number of perpetrators
 - Incidence
 - Prevalence
 - Likelihood of anal penetration
 - Adolescent girls more vulnerable due to immature genital tracts
 - Traditional practices – FGM as protective measure
 - Infectiousness of perpetrator – mass rape
 - Likelihood of ulcerative STIs and HIV

3



4

The Continuum: Before, during and after conflict

"During conflict it can be addressed as violence associated with the war, as a humanitarian issue, but afterward, it becomes more private. It is the same violence, and often the same people committing the crimes, but now we're forced to call it 'civilian' or domestic violence rather than a war crime. We received death threats for even offering services in part, we think, because the perpetrators fear redress."

- Patterns, scale, and scope over time
- Interaction with multiple long wave events and crises
- Legal and political implications and remedies

5

Defining sexual violence and assessing HIV/AIDS risks

- Rape (child, 'virgin', elder, incest)
- Harmful traditional practices
- Prostitution, commercial, transactional, and survival sex
- Forced and coerced marriage and intergenerational relations
- Consent, desire, domestic violence

6

Circumstance?

7

Victim?

8



9



10

Measurement challenges

- Measuring the role of force/coercion in HIV/AIDS risk indicators in the context of heterosexual transmission
 - sexual debut
 - sexual experience
 - number of partners
 - condom use
 - age of marriage
 - age difference between partners
- Safety and ethical considerations
- Baseline data
- Incidence/prevalence
- No theoretical, legal or policy agreement across different settings

11

Sexual Violence and the Global HIV/AIDS Response: organizing frame or undercurrent?

"HIV/AIDS prevention is more likely to be a first line response to sexual violence, than sexual violence is an entry point for HIV/AIDS prevention."

— Pam Delargy, UNFPA Director of HIV/AIDS and Humanitarian response

- Transmission efficacy
- Who leads? Who funds? Who implements?
- Social movements
- What to do?

12

Preventing HIV by reducing risks of sexual violence

- Providing services/treatment and ensuring continuity
- Say no to 'ABC'
- Security, transportation, camps, return
- DDR
- Small arms/light weapons
- Gender justice
- Social protection

13

Other Anomalies

- Higher HIV prevalence in prenatal, postpartum and induced abortion
- Discrepancy between observed prevalence in women undergoing reproductive medical care
- HIV seropositivity in those denying coital exposure and those claiming a sole lifetime sexual partner who is reportedly negative
- HIV in infants 2-14 with seronegative mothers unexplained by maternal and sexual transmission

Brewer, Brody Gisselquist, et. Al International Journal of STD and AIDS 2003

14

Gopa Kumar, Save the Children UK (slides 15-21)



15

Double Emergency-Combined killers

- Vulnerable children
- Violence & exploitation
- Neglect-Low awareness
- Lack of focus on Children's Rights
- International financing?
- Access to resources for children?

16



War and Death

Failure of Protection Mechanisms
Violence
Sexual Health is not a priority
Inertia - Numbers-Not lives
Systems ??



17

The Right to Protection

- Promises: Article 22
- "Children receive appropriate protection and humanitarian assistance"

"I am not well I don't have a good life. Things have changed after the war. We are forced to sell sex"

Claudine, 13.

- Violence breeds violence:
- "Rape was occurring before the war but not as rampant as it is since the war"

Fatou, 16

- Humanitarian Responses?
- Community's role



18

Save the Children global response

- Mobilising political will & global attention
- Integrating HIV/AIDS programming into conflict situations
- Ensuring access to essential health, education and protection services
- Protecting and caring for orphans and children separated from their families



19

Save the children country response

Example: South Sudan

- Promoting the release of children from armed groups and their reintegration into their communities
- Family tracing and reunification of children separated by the conflict
- Supporting children who are victims of sexual violence
- Training staff
- Supporting prevention and care activities
- Monitoring impacts to strengthen operations




20

Joseph Ciza Nakamina,
Doctors on Call, DRC (slides 22-40)

Recommendations

Save the Children recommends that Governments, donors and humanitarian agencies:

- Uphold children's rights as agreed under the UN Convention on the Rights of the Child
- Devote adequate resources to fighting the AIDS pandemic
- Include HIV/AIDS into emergency responses



21

Protection, gender based violence and HIV AIDS

Constraints and opportunities

Ciza Nakamina
Supervisor, Gender Based Violence
HEAL Africa, Goma, DR Congo



22

I. Vulnerability in conflict



23

Who or what will protect you here?

United Nations?
Red Cross?
Police?
Government?



24



The areas we serve
30 000 km2 in North Kivu
50 000 km2 in Maniema

25

Vulnerability =
Gender inequities, uncontrolled armed forces,
kidnapping, sexual slavery, displacement,
poverty, over-crowding, unemployment

26

The human face behind the figures
3,705 victims of rape

Two thirds of the rapists are armed gangs

27

• Does HIV advance faster in situations of conflict?
North Kivu data

	Goma	Rutshuru + Masisi
Seroprevalence	5.3%	11.8%
Rapes 2003-2005	476	3229
% of population	0.1%	0.3%

28

First 100 WF patients treated at HEA, Africa in 2003
Kivumu, Misisi, HD, DRC

Rape by military
STI 43%
of which HIV+ 12%

29

Voluntary counseling and testing of
Gender Based Violence survivors
2004-2005

Value Label	Value	Percent
Negative	84	2.3
Positive	14	0.4
Absention	2723	73.5
Test N/A	881	23.8
Total	3705	100

30

The Missing Link

31

The constraints we face

- * Renegade military
- * Impunity for criminals
- * Impassable roads
- * Health structures destroyed
- * Rigid health policies
- * Inequity of aid

32



What protection can we offer?

Our opportunities




33

Fight against impunity

A united government will make the 2005 DRC Constitution a fact, not a wish!

Article 15 (summarised)
All sexual violence is a crime against humanity and will be punished by the law.



34

Post Exposure Prophylaxis (PEP) and post rape kits for STIs




35

Which preconditions can this clinic meet?



- Voluntary Counselling and Testing
- Qualified doctors able to prescribe treatment
- Written consent
- Assured adherence, if possible, Direct Observed Therapy



36

The Missing Link




37

Increase social capital

- Community committees caring for the vulnerable
- Community counsellors
- Football to reach men for protection of women and children




38

What must be done?

- Make PEP accessible – train nurses for places where doctors will not go
- Mobilise faith-based communities for palliative home-based care before VCT
- Keep Congo and GRV on the world's agenda
- Reinforce social capital for protection of vulnerable members of the community
- Promote a revolution in aid – send most resources where there is most need, not just where it is easiest

You have it in your power to help us



39



Thank you for your attention



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TOPIC 3

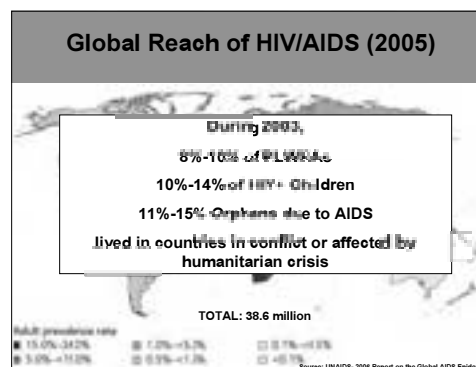
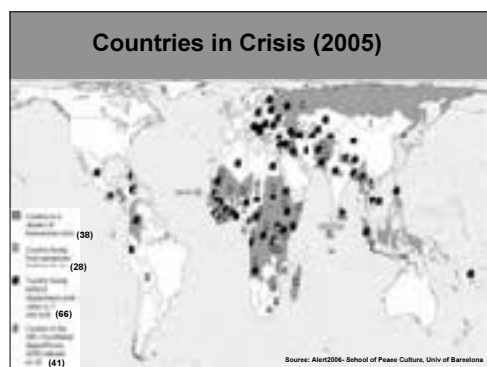
FUNDING FOR HIV/AIDS PROGRAMMES IN CONFLICT/POST-CONFLICT SITUATIONS

Massimo Zucca, UNICEF (slides 1-16)

HIV/AIDS Programmes in Emergency Funding Mechanisms

Massimo Lowicki-Zucca
Child Protection Section
UNICEF NY

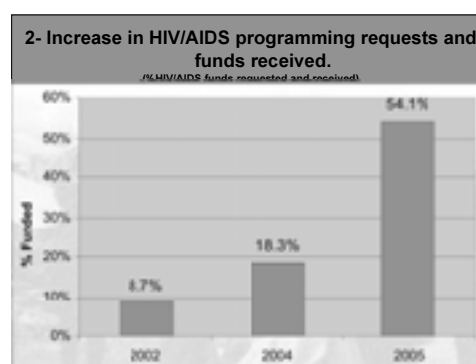
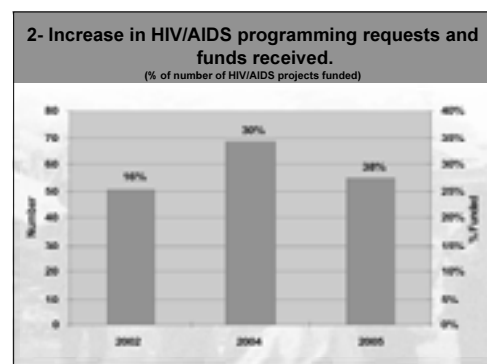
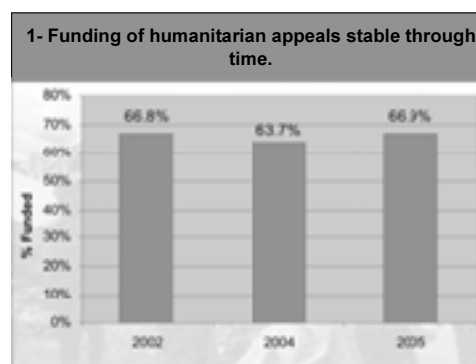
HIV/AIDS, Conflict and Displacement
August 12, 2006
Toronto Marriott Downtown Eaton Centre

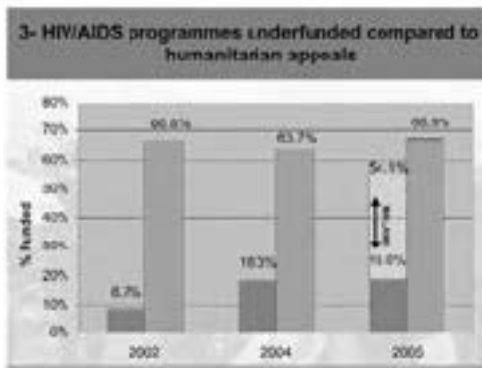


HIV/AIDS Programming in Humanitarian Planning 2002-2005

Highlights:

1. Funding of humanitarian appeals stable through time.
2. Increase in HIV/AIDS programming requests and funds received.
3. HIV/AIDS programmes still underfunded compared to overall humanitarian appeals' funding
4. HIV prevalence not a predictor for funding of HIV/AIDS programs in emergency funding mechanisms.
5. "Usual suspects" received a relatively lower funding coverage.





9

4- HIV prevalence not a predictor for HIV/AIDS appeals funding

- In 2005, greatest need for humanitarian funds in mid prevalence countries
- Proportion of number of HIV/AIDS specific projects funded greater in low prevalence countries than in mid and high prevalence countries.
- Proportion of HIV/AIDS funds received out of requested greater in low prevalence countries.

10

Proportion of humanitarian funds requested by range of HIV prevalence

Years	2002	2004	2005
<1%	44%	20%	3%
1%–5%	24%	51%	46%
5%>	6%	13%	6%
N/A*	26%	17%	45%

* Applies to both regional appeals and countries for which there are no prevalence estimates.

11

Proportion of HIV/AIDS funds requested.

Years	2002	2004	2005
<1%	1%	11%	3%
1%–5%	39%	54%	27%
5%>	50%	26%	65%
N/A*	10%	10%	5%

* Applies to both regional appeals and countries for which there are no prevalence estimates.

12

Proportion of HIV/AIDS funds received out of amounts requested.

Years	2002	2004	2005
<1%	0%	17%	37%
1%–5%	17%	17%	23%
5%>	0%	19%	8% w/o Malawi:
N/A*	17%	23%	34%

* Applies to both regional appeals and countries for which there are no prevalence estimates.

13

5- "Usual suspects" received a relatively lower funding coverage.

Composition of HIV/AIDS funds requested

Region	2002	2004	2005
Caribbean	-	8.9%	-
East Asia and Pacific	4.7%	2.5%	-
Eastern Europe & Central Asia	0.5%	6.9%	0.5%
Latin America	-	7.0%	20.1% SUDAN
Middle East and North Africa	5.2%	10.8%	-
Sub Saharan Africa	89.1%	63.7%	77.6%
South and South East Asia	0.5%	0.2%	1.8%

14

Proportion of HIV/AIDS funds received out of amounts requested: by region


Region	2002	2004	2005
Caribbean	-	2.9%	-
East Asia and Pacific	36.2%	58.3%	-
Eastern Europe & Central Asia	0%	19%	74.7%
Latin America	-	2.4%	-
Middle East and North Africa	0%	17.1%	26.9%
Sub Saharan Africa	7.8%	19%	12% w/o Malawi:
South and South East Asia	0%	0%	48.4%

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Conclusions

- HIV/AIDS is progressively getting on humanitarian response's agenda.
- More effort needed to integrate HIV/AIDS in programmatic response.
- More effort needed in dialogue to ensure donors "buy in" on HIV/AIDS in Emergencies' agenda.
- Why are HIV/AIDS funding requests comparatively better received in less obvious settings (lower HIV prevalence, outside SSA)?

16



World Bank Africa HIV/AIDS Program, Conflict and Displacement

HIV/AIDS, Conflict and Displacement
August 12, 2006 – Toronto, Canada

Frode Davanger
Operations Officer
ACTAfrica

17

Presentation Overview

- I. Introduction and update on the WB's AIDS Support in Africa (MAP)
- II. Overview of Bank's Support and Policy in conflict-affected areas
- III. Great Lakes Initiative on HIV/AIDS (GLIA), and Horn of Africa
- IV. Future Activities on HIV/AIDS and conflict

18

I. Multi-Country AIDS Program (MAP)

- Launched in 2000
- Focus on:
 - Multi-Sectoral Response
 - Exceptional and Flexible Implementation Arrangements
 - Community Initiatives
 - Bottom-up, top-down comprehensive approach
 - Learning-by-doing

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MAP Status Update

- ❖ 29 countries + 4 sub-regional projects
- ❖ \$1.12 billion committed so far
- ❖ \$625 million disbursed—\$250M in '05 alone
- ❖ > 50,000 civil society subprojects funded
- ❖ Laid the groundwork for other donors
- ❖ 2nd phase MAPs prepared in 5 countries – 3 approved

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Approved and Pipeline HIV/AIDS Projects: May 2006



THE MAP

- Disburse approved
- Project in the pipeline
- MAP green

21

Review: What's Working?

- ❖ Laying foundations for national action
- ❖ Promotes "The Three Ones"
 - National leadership, strategy, and M&E
 - Joint reviews in Ethiopia, Kenya, Rwanda
 - Multi-donor pooled support in Malawi
- ❖ Substantial, flexible, streamlined resources
- ❖ Engaging civil society
- ❖ Stimulating multisectoral involvement (NODs)
- ❖ Learning by doing informing new projects

22

Review: What Needs Work?

- ❖ Accelerate implementation (variable)
- ❖ Strengthen NACs and clarify role
- ❖ Deepen political commitment/leadership
- ❖ Strengthen public sector response (MOD)
 - Better sector programs; greater MOH engagement
- ❖ Simplify civil society procedures
- ❖ Use full scope of MAP flexibility (outsource)
- ❖ Substantially strengthen M&E
- ❖ Better accountability and governance to make the money work

23

Review: What to Improve

- ❖ More strategic national frameworks
 - Design the program to respond to specific country epidemic
- ❖ Link disbursements to performance and results
- ❖ Scaling up good practices
- ❖ Expand civil society involvement
- ❖ Balance prevention and treatment
- ❖ More explicit gender dimension
- ❖ Targeted approach to vulnerable or neglected groups and high risk groups (refugees, IDPs, ex-combatants, etc)
- ❖ Improve health sector support (HR, Supply chain, lab infrastructure, other health systems)
- ❖ Integrate services with RH and TB

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II. World Bank Support in Conflict-Affected Areas

- 1990s: International environment is increasingly complex. 80% of the world's 20 poorest countries suffered from major violent conflict in the past 15 years.
- 1995: OP/BP 8.50 on Emergency Recovery Assistance → focus on restoring assets and production levels in the disrupted economy, rather than relief or consumption.
- World Bank intervention in post-conflict Bosnia and Herzegovina laid framework for what has become current operational policy on conflict and development.

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OP 2.30 "Development Cooperation and Conflict"

- Recognizes that violent conflict affects the Bank's core mission of poverty reduction
- Shifts focus from rebuilding infrastructure to economic and social stability
- Shifts focus from post-conflict to conflict-affected
- Outlines levels of Bank engagement in different conflict settings:
 - all member countries vulnerable to conflict
 - countries in conflict
 - countries in transition from conflict

26

26

Tools for World Bank Engagement in Conflict-Affected Countries

- **Country Assistance Strategy:** standard World Bank instrument for the coordination of development assistance.
- **Watching Briefs:** can be initiated during conflict. Allows Bank to maintain a minimum level of engagement and builds knowledge base for future interventions.
- **Interim Strategy Note (previously Transitional Support Strategy)** short- to medium-term assistance strategy for countries emerging from conflict. Generally reflects objectives and sequencing of priorities in peace accords and recovery plans.

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Tools for World Bank Engagement in Conflict-Affected Countries

- **Poverty Reduction Strategy Papers:** Adaptation of PRSP processes to the special needs of conflict-affected countries.
- **Joint Assessment Mission:** determines funding needs and often serves as centerpiece for donor conferences and longer-term reconstruction plans.
- **Conflict Analysis Framework:** helps the design of conflict-sensitive approaches for Bank-supported strategies, policies and programs by:
 - systematically **identifying key factors** affecting conflict
 - providing **analysis** of each factor
 - highlighting **priority problem areas and opportunities.**

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World Bank Activities in Conflict-Affected Countries

- Institutional support in economic management
- Demobilization and reintegration of ex-combatants (Sierra Leone, Angola, Dem. Rep. of Congo)
- Community-based social and economic reintegration of displaced persons (Angola, Burundi, Georgia, Colombia)
- Community driven development, building capacities and social capital (Timor Leste, Indonesia, Angola, Northern Uganda)
- Infrastructure (Liberia)
- Basic service support, e.g. education, health (Iraq)
- Mine Action (Croatia, Bosnia, Sri Lanka)

29

29

III. The Great Lakes Initiative on AIDS (GLIA) Support Project

- Member states: Burundi, DRC, Kenya, Rwanda, Tanzania and Uganda (HQ in Rwanda).
- Officially launched in June 2006
- Close partnership among the member countries, UNAIDS, UNHCR and the Bank.
- The GLIA Support Project primarily focuses on refugees, IDPs, returnees, and networks for transport workers and PLWHA

30

30

GLIA Mission Statement

To contribute to the reduction of HIV infections and to mitigate the socio-economic impact of the epidemic in the Great Lakes Region by developing regional collaboration and implementing interventions that can add value to the efforts of each individual country.

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Project Components

- 1: HIV/AIDS Support to Refugees, Surrounding Areas, IDPs and Returnees
- 2: Support to HIV/AIDS related networks
- 3: Support to Regional Health-Sector Collaboration
- 4: Management, Capacity Strengthening, M&E and Reporting (Project Management)

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Component 1: Refugees, IDPs and Returnees

- Full range of prevention, care, treatment and mitigation services
- Assist 2 sites in each country, scaling up existing interventions
- Possible extension of coverage with additional resources/partners
- A contract has been signed between UNHCR and GLIA – annual work plan agreements through IPs
- Close coordination and collaboration w/NACs

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Horn of Africa Initiative

- Worked in partnership with the Inter-Governmental Authority on Development (IGAD) since 2003 (Djibouti, Eritrea, Ethiopia, Kenya, Somalia, Sudan and Uganda).
- Mapping Assessment recently completed of HIV/AIDS interventions for cross-border and mobile populations (CBMP)
- Preliminary discussions on “GLIA-like” initiative for the Horn of Africa

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Mohamed Youssouf, African Development Bank (slides 36-58)

IV. Future AIDS and Conflict Initiatives

- Identify future priority interventions
- Public Sector Response (MODs) Strengthening
- Develop guidelines on HIV/AIDS and conflict (MDRP/DDR)
- Ensure that vulnerable groups are addressed in conflict-affected areas
- Improve partnership and coordination with key stakeholders

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HIV/AIDS
a major development concern for the African Development Bank

August 2004

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OUTLINE OF PRESENTATION

- ROLE OF ADB
- EYU/ADB STRATEGY PAPER FOR BANK GROUP OPERATIONS
 - ✓ OBJECTIVES
 - ✓ GUIDING PRINCIPLES
 - ✓ PRIORITY AREAS
 - ✓ STRATEGIES
- BANK'S EXPERIENCE
 - ✓ MAINSTREAMING OF HIV/AIDS INTO BANK GROUP OPERATIONS
 - ✓ HEALTH SECTOR-SPECIFIC PRODUCTS
 - ✓ SUPPORT TO DISPLACED PEOPLE
- LESSONS LEARNED
- WAY FORWARD

37

ROLE OF THE AFRICAN DEVELOPMENT BANK GROUP

The Bank's assistance to the Regional Member Countries for HIV/AIDS prevention and control falls within its mandate for poverty reduction, as articulated in the vision statement approved by the Board of Governors in 1999.

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VISION


The African Development Bank Group strives to be the leading development finance institution in Africa, dedicated to providing quality assistance to African Regional Member Countries in their poverty alleviation efforts.

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HIV/AIDS STRATEGY PAPER FOR BANK GROUP OPERATIONS
(2001)

40






OBJECTIVES

- ❑ Assist the countries in their efforts to develop and implement multisectoral HIV/AIDS control activities; and
- ❑ Support the programmes prepared by the countries.


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GUIDING PRINCIPLES

- > Long-term action
- > Technical reliability
- > Stressing vulnerability
- > Principles of empowerment
- > Support and not rejection
- > Rights of the individual
- > Participation & partnership
- > National autonomy
- > Avoiding new structure


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PRIORITY AREAS

- ◊ Promotion of political commitment at all levels;
- ◊ Support to sectoral responses for a more efficient focus on vulnerability factors and on efforts to reduce risks; and
- ◊ Strengthening of coordination for greater synergy of the HIV/AIDS prevention and control actions.

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STRATEGIES

To support RMCs in their HIV/AIDS prevention & control efforts, the Bank focuses on the following strategies:

- ✓ Advocacy and policy dialogue;
- ✓ Mainstreaming of HIV/AIDS control in Bank operations; and
- ✓ Partnership development.

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MAINSTREAMING OF HIV/AIDS

The mainstreaming of HIV/AIDS into Bank Group Operations is promoted through:

- ❑ Analysis of HIV/AIDS in the PRSPs and Bank Country Strategy Papers;
- ❑ Assessment of the impact of HIV/AIDS on key sectors in the context of economic & sector work; and
- ❑ Screening of project & programme proposals so as to ensure that HIV/AIDS dimensions are fully taken into account and reflected in project design.


45



BANK'S EXPERIENCE

- ✓ Mainstreaming of HIV/AIDS into Bank Group Operations
- ✓ Health Sector Specific Projects
- ✓ Interventions Targeting Specific Displaced Population

46



MAINSTREAMING OF HIV/AIDS

The Bank's investment on HIV/AIDS prevention and control in Regional Member Countries (RMCs) has increased over time. To date its contribution in the fight against HIV/AIDS is estimated at over UA 500 million (approximately \$740 million).

47



HEALTH SECTOR SPECIFIC PROJECTS

- ◊ Currently the Bank is funding about 60 interventions throughout the continent for a total sum of UA* 505,00 million [USD 747,09 million].
- ◊ All the projects have either major HIV/AIDS components or sub-components

*UA = Units of Account; 1UA = 100 L.A.

48

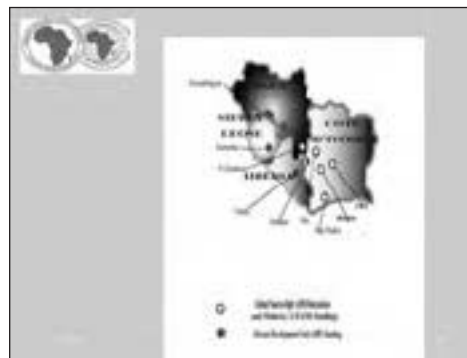


PROJECTS TO SUPPORT DISPLACED POPULATION

PROJECTS	BANK SUPPORT
SUPPORT TO THE SUB-REGIONAL HIVAIDS PROGRAMME FOR THE REFUGEES, INTERNALLY DISPLACED POPULATION & HOST COMMUNITIES IN THE MANGO RIVERS UNDOH BASIN COUNTRIES & COTE D'IVOIRE	UA* 5.00 million (29.09.2004)

TSU - ESB LAB

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50

PROJECTS TO SUPPORT DISPLACED POPULATION

PROJECTS	BANK SUPPORT
SUPPORT TO THE INITIATIVES OF THE COUNTRIES ALONG RIVERS CONGO, UBAHQI AND SHARI FOR STEWARDS CONTROL	UA 9.00 million (11.09.2003)

TSU - ESB LAB

51



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PROJECTS TO SUPPORT DISPLACED POPULATION

PROJECTS	BANK SUPPORT
SUPPORT OF THE LAGE SINDRABASI INITIATIVE TO REDUCE VULNERABILITY TO AND THE RISKS OF STEWARDS	UA 10.00 million (26.10.2003)

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54

PROJECTS TO SUPPORT DISPLACED POPULATION

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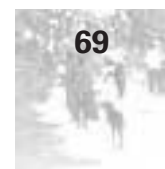
TSU - ESB LAB

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COMMON FEATURES : SUPPORT TO DISPLACED POPULATION

GOAL	MDG 1 : halt by 2015, and begin to reverse the spread of HIV/AIDS.
OBJECTIVE	to prevent the spread of new infections of HIV/AIDS among refugees, internally displaced populations, and their host communities
TARGET POPULATION	Refugees, internally displaced population and their host communities
GOVERNANCE	<ul style="list-style-type: none"> - Strengthening of HIV/AIDS prevention, control and treatment - Promotion of Multi-Sectoral and Sub-Regional Co-ordination - Building communities' capacities, leadership and partnership - Monitoring and Evaluation

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LESSONS LEARNED

- ◆ Strong partnership (donors, government, and community);
- ◆ Regional Integration
- ◆ Harmonization of efforts (donors, governments, NGOs, etc.);
- ◆ Coordination of efforts in order to avoid duplication of activities; and
- ◆ Commitment by governments in the region to endorse cross border initiatives.

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WAY FORWARD


- Accelerate research to end the epidemic;
- Expand and sustain human resources to scale-up prevention and treatment;
- Intensify involvement of affected communities;
- Build new leadership to advance the response; and
- Scaling Up: Lessons from the Field.

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Mukesh Kapila, IFRC (slides 59-71)

Scaling up HIV/AIDS Services for
Populations of Humanitarian Concern


AN UNITED NATIONS
SYSTEM-WIDE PROGRAMME



59

WHY?

- Two-thirds of global burden of HIV occurs in countries affected by emergencies.
- Populations of humanitarian concern have right to access HIV services on same basis as general populations.... BUT they also have special needs.



60

What are populations of humanitarian concern?

- *Principally:* refugees, internally displaced, and others whose well-being and livelihood are threatened or affected by armed conflicts and disasters.
- *Secondarily,* others whose well-being and livelihood are seriously disrupted due to high HIV prevalence combining with other factors...resulting in humanitarian crisis conditions in the community.

78 low or middle income countries hosting at least 5000 people of humanitarian concern.



61

WHY?

- Effects of displacement of people with differing levels of HIV prevalence
- Humanitarian, human rights, protection concerns to reduce burden among most neglected group facing increased vulnerability in emergencies
- Unique circumstances need modification to some of usual HIV interventions
- Opportunity for social transformation




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PURPOSE

To expand access to HIV prevention, treatment, care, and mitigation services to populations of humanitarian concern


*Three-year programme: started March 2006
Funded by DFID; other donors welcome to join.*



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Members of Consortium

- FAO
- OCHA (including IRIN)
- UNDP
- UNFPA
- UNHCR
- UNICEF
- WFP
- WHO, and
- UNAIDS Secretariat



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KEY OUTPUTS

- Include HIV/AIDS needs of humanitarian populations in *existing* assistance frameworks.
- Provide humanitarian populations with *basic service packages* in accord with IASC Guidelines.
- Address *underlying sexual and gender-based vulnerability factors*, including sexual violence.

12/19/06



65

Programming principles

- Joint programming guidelines of UN development system
- The UNAIDS "Three Ones" and Global Task Team division of labour.
- UN reform: predictability and accountability
- Good Humanitarian Donorship initiative

12/19/06



66

Output 1: key strategies

- ❖ mainstream into development planning and financing mechanisms
- ❖ Mainstream into HIV/AIDS thematic planning and funding mechanisms
- ❖ Mainstream into humanitarian planning and financing mechanisms
- ❖ Address marginalisation thru information and media

12/19/06



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Output 2: key strategies

- ❖ Build capacity on HIV/AIDS interventions in emergencies
- ❖ Address strategic data and information gaps

IASC Guidelines on HIV/AIDS Interventions in Emergency Settings

12/19/06



68

Output 3: key strategies

- ❖ Tracking and assessing sexual and gender based violence and exploitation
- ❖ Expanding SGBV service delivery
- ❖ Building capacity
- ❖ Vulnerability reduction

IASC Guidelines for Gender-based Violence Interventions in Humanitarian Settings

12/19/06



69

Showing Results

- 13 countries of focus
- Establishing baselines
- Minimum indicator set

12/19/06



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Excuses...

- What is special about them?
- "PHCs" are not important to achieving global targets.
- Not a priority in emergencies where other life-saving things to do.
- Already doing it as part of...etc... etc...

12/19/06



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TOPIC 4

CONSTRAINTS AND OPPORTUNITIES TO PROVIDE ART FOR DISPLACED POPULATIONS AND IN CONFLICT/POST-CONFLICT SITUATIONS

Gebrewold Petros, UNHCR (slides 1-11)

Antiretroviral Therapy for Displaced and Conflict-affected Populations

Gebrewold Petros, MD
United Nations High Commissioner for Refugees
12 August 2006

1

Current Situation

- Global coverage of antiretroviral therapy (ART) is approx. 20%
- Majority of unmet needs in developing world
- HIV/AIDS services often insufficient
- Refugees receiving ART in many countries but generally not in official manner
- 0.2-0.3% of global ART need is for refugees; unknown for internally displaced persons

2

Rationale

- Antiretroviral medications are lifesaving and essential
- Human right
- Public health benefit
- More efficient
- Consequences of exclusion are costly and detrimental

3

Key ART Interventions

1. Post exposure prophylaxis
2. Prevention of mother-to-child transmission
3. Therapeutic long term ART

4

Opportunities

- Evidence and possibilities for ART access exist in conflict and post conflict settings
 - Refugees often in stable environment
- HIV strategies exist for unforced services
- Momentum (UNGASS, "3x5", Universal Access)
- Regional initiatives
- Enabling environment and growing concern
- Experience (UNHCR, NGOs)

5

Constraints

- Conflict itself
- Incorrect assumptions
- Insufficient resources, capacity and logistics
- Restrictive policies
- Insufficient political will
- Concentration of treatment sites in urban areas
- Discrimination and exclusion

6

National HIV Strategic Plans (NSPs) in Asylum Countries in Africa*

Country	NSP Mentions Refugees (N=23)	NSP Mentions Refugees (N=23)	NSP Mentions Refugees (N=23)
Kenya	100%	100%	100%
South Africa	100%	100%	100%
Uganda	100%	100%	100%

7

Principles

- Inclusive and integrated programs
- Provision in hard-to-reach areas
- Adherence to policies and protocols
- Minimum package of services
- Continuity and sustainability

8

Recommendations

- Design optimal strategies
- Use existing and new opportunities
- Remove barriers: legal and policy reforms
- Increase resources; develop and augment technical capacities
- Inclusive policies, strategies, proposals, funding mechanisms and initiatives



9

Recommendations cont

- Sub-regional initiatives
- Develop, update, standardize and simplify guidelines (e.g. IASC) and programs
- Dissemination and implementation of experiences
- Advocacy
- Strict monitoring and evaluation



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David Tu, MSF (slides 12-25)

Considerations

- Global endeavor
- Availability to surrounding host pop.
- Technical support to scale up
- Proper tools and evidence
- Availability in areas of return
- Provision of care and treatment – core priority of IASC guidelines



11

MSF & ART in conflict and post-conflict settings: obstacles, strategies, outcomes & lessons learned



August 12, 2006
Dr. David Tu, MD
MSF HIV Consultant



12

MSF & HIV Care

- Humanitarian Medical NGO
- First HIV/AIDS programs started for scaling 1990s
- First Pilot ART programs 2000 [1]
 - Demonstrated feasibility in resource-poor settings (R.L.S.)
 - Demonstrated biological efficacy of ART
 - Demonstrated feasibility & efficacy of the project itself
- Initiation of Advocacy Campaigns (2000)
- Continuity...



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MSF HIV/AIDS TREATMENT PROGRAMMES



20 countries
10 low countries
87,500 people on ART treatment
100,000 people on ART treatment
100,000 people on ART treatment

Conflict Settings: 1 country, 7 HIV projects
Post-Conflict Settings: 6 countries, 7 HIV projects

85,7 people on ART treatment
85,7 people on ART treatment
85,7 people on ART treatment

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Country & Project Summary

Conflict Settings				Post-Conflict Settings				
Country	Project	No. People on ART	Year	Country	Project	No. People on ART	Year	
DRC (1st phase)	Basoko	14	2001	DRC (2nd phase)	Basoko	210	2001	
	Wit	15						
DRC (3rd phase)	Basoko	100	2002	DRC (4th phase)	Basoko	100	2002	
	Basoko	10			DRC (5th phase)	Basoko		10
	Basoko	5				DRC (6th phase)		Basoko
	Basoko	100			100			
DRC (7th phase)	Basoko	15	2003	DRC (8th phase)	Basoko	10	2003	
	Basoko	10			10			
Total		100		Total		100		

15

Obstacles to Providing ART

Medical Program

- Limited (or absent) Health infrastructure
- Limited (or absent) Human resources (personnel & skills)
- Limited financial resources
- Limited political leadership, will, coordination or competency

Population

- Poverty
- Limited HIV Awareness/Understanding

Context

- Instability of security
 - Interruptions in program continuity
 - Instability of populations
 - Interruptions in program continuity

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Advantages to ART in Conflict Settings

- Reduces HIV related sickness and death
- Improved morale of health care providers and PWAs
- Re-establish Health Infrastructures
- Allows for more rapid scale up during post-conflict period



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MSF Core Strategies to Providing ART

- Comprehensive HIV Care Model
- Streamlined treatment regimens (e.g. FDCs) and products
- Decentralizing care and delegating greater responsibility to clinical officers, nurses, and community health workers
- Emphasis on patient centered treatment literacy and adherence support
- Community involvement and mobilization
- Free access to treatment
- Preparing for disruption/instability

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ART Outcomes

	DRC - Bukavu	DRC - Kisumu
No. Initiating ART	494	176
Median duration on ART	4.1 Months (95% CI 3.7 - 4.7)	7.1 Months (95% CI 6.8 - 7.5)
Median Baseline CD4	233 cells/ml (95% CI 221 - 245)	317 cells/ml (95% CI 303 - 331)
No surviving to discharge (%)	40 (81%)	147 (82%)
No. at death (%)	75 (15%)	38 (21.6%)
No. lost to follow up (%)	0 (0%)	3 (1.7%)
No. of 37 base treatment failures (%)	1 (0.2%)	—

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ART Outcomes

	DRC - Bukavu	DRC - Kisumu
Median 6 week viral load (log copies/ml)	2.8 log (95% CI 2.7 - 2.9)	2.5 log (95% CI 2.4 - 2.6)
Median 6 week CD4 per follow-up (2000)	347 (95% CI 335 - 359)	386 (95% CI 374 - 398)
Stable Rate (95% CI) 0-3 month	14% (12.4% - 15.6%)	14.4% (12.9% - 15.9%)
Lost to follow up Rate (95% CI) 0-3 month	4.6% (3.2% - 6.4%)	4.6% (3.1% - 6.6%)

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Episode of Acute Insecurity in Bukavu May - June 2004:

- On May 29, 2004, Bukavu was the scene of intense fighting lasting into June 6
- Hundreds of civilians were killed, thousands fled into nearby Rwanda, and unknown numbers of women were raped



21

What happened to the patients on ARVs?

- Pre-conflict, 66 patients were receiving ART
- 5 patients had significant ARV treatment interruptions
- No patients were lost to follow up; all eventually returned to treatment

22

Preparing for Disruption-- Factors Supporting ARV Adherence:

- Advanced Planning
- Patient Education
- Human Resources Capacity
- Communication Networks
- Emergency Drug Stocks/Warehouse Medications
- Secure Drug Storage
- Decentralization of Care
- Cooperation with Neighbouring HIV Treatment Facilities
- Treatment Information Cards

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Summary:

- Risk of insecurity and population instability are additional challenges to providing ART in conflict/post-conflict settings.
- MSF ART clinical outcomes in conflict and post conflict settings, though limited in scale, compare favorably to those found in non-conflict settings.
- Our experience has shown that with adaptation (and the resources of an NGO) HIV comprehensive care can be effectively administered in both post conflict and chronic conflict settings.
- An essential ingredient for successful provision of ART in conflict settings is preparation for disruption.

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25

Providing Health Care in an Undeclared War

HIV and Primary Care in Haiti

Evan Lyon, MD
Partners in Health / Zanmi Lasante
Boston / Plateau Central

26

Overview

- Introduction.
- The latest 3+ coup years.
- Community-base and DOT. Stability amidst Chaos.
- Expansion in an “occupied territory.”
- Comprehensive HIV / TB care in the setting of Primary Healthcare.
 - “The Four Pillars.”
- Insuti Mu Buzima / PIH in Rwanda. Lesotho....
- Transnational Challenges: Haitians in the Dominican Republic.

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3 year campaign to the Coup, February 29, 2004

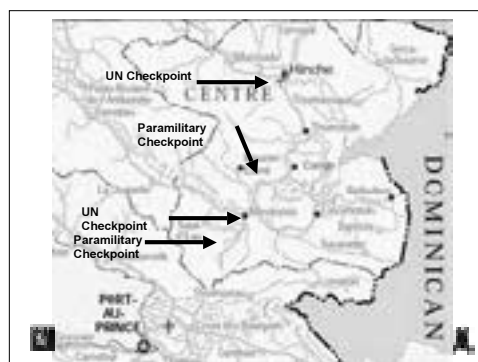
- December 12, 2001 Attack on National Palace in P-au-P.
- Serious fighting between Belledere and Lascahobas starting in early 2002.
 - Community work ground to a halt in this area.
- Human rights abuses systematically applied.
 - Brutal but infrequent → widespread intimidation.
- Paramilitary roadblocks and harassment universal in the Central Plateau from 2002 – 2005.
 - Humanitarian work – and the fact that several paramilitary are our patients – was our only protection.
- May 7, 2003 – Attack on Peligre, kidnapping and stolen vehicle.
- February 16, 2004 – Hinche taken by 30-50 men.
 - 30-50 “occupied” a city of 80,000.

29

“March to Port-au-Prince”

- 300-500 armed men “occupied” nearly half of Haiti.
 - Legacy of Duvalier, Tonton Makout, and the repressive, autonomous Haitian Military. Founded by act of U.S. Congress in 1915.
 - Aristide disbanded the Army on his return to power in 1994.
 - Paid for “10 years of back pay” in late 2004. 30 million US\$.
- Aristide taken out by a “kidnapping in the service of a coup d’etat” February 29, 2004
 - U.S. Marines said they could not assure his security.
 - Unmarked plane to Central African Republic.
 - Held incommunicado for a week.
 - Now in exile in South Africa.
- U.S. Troops out within weeks and UN under Brazilian command “occupied” Haiti.

30



31



32



Health Consequences of 2004 Coup

- Following coup most hospitals closed.
 - P-au-P General Hospital (largest public hospital, and only 'trauma' center in the Capital) closed a total of ~8 weeks.
 - **We remained open!**
 - 3 of our vehicles stolen by the paramilitary.
- Clinic visits dropped 40 percent, even with influx of patients from outside our region.
 - The health cost of this is unknowable.
- Food prices 2-3 times higher. 1 in 4 children with chronic malnutrition, 3-6% with acute malnutrition.
- Public Medical School at Tabarre Closed!
 - US Marines occupied the school as a military base in March 2004.
 - Joint Haitian – Cuban initiative to train doctors with a commitment to going back to their home communities.



33



34



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37



38

Community-base and Local Direction

- Unusual Stability.
 - In 24 years (and under 10 governments) PIH has never shut its doors or had its doors shut!
- 5 / 2500 = ratio of foreign volunteers to Haitian staff.
- Local decision making and priority setting.
- Social Justice / Human Right's Framework.
 - Schools, water projects, adult literacy, agriculture and environmental work, housing, job creation, etc.



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40



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DOT and Adherence

- Near 100 percent adherence to ARV regimens.
- Problems recognized early and reported back to clinic.
 - Clinical change, drug side effects, changing social dynamics, economic migration, contact tracking, etc.
- *Accompagnateurs* are employees.
 - Formal relationship increases accountability, cutting both ways.
 - Jobs are great where there is rural poverty.
- Travel Stipend and Food Assistance.
- Monthly *accompagnateur* meetings, bi-monthly HIV / TB patients meetings for ongoing education, psycho-social support, engagement, common cause.



42

HIV Prevention and Treatment: Expansion and Integration into Primary Health Care



43



44

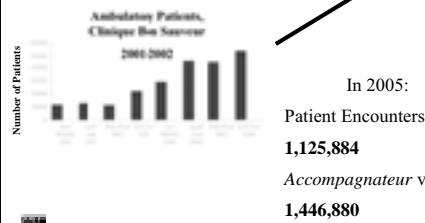
Four Pillars – and our *Chwal Batay*

1. HIV Prevention and Care: Integration into primary health care services.
2. Screening and treatment for tuberculosis.
3. Prenatal care and women's health.
4. Screening and treatment for all STIs.



45

Rapid Expansion



46

The Lascahobas Experience

- Town and outlying areas with 50,000 people. Near the DR border.
- Clinic saw 0-20 people per day.
- No cases of HIV detected.
- 9 cases of TB detected in an area where 180 should be according to epidemic.
- Very little access to essential drugs.
- All lab tests and medicines were paid out of pocket.



Stats and slides from:
 "Integrated HIV Prevention and Care Strengthens Primary Health Care: Lessons from Rural Haiti." D.A. WALTON, P.E. FARMER, W. LAMBERT, F. LEANDRE, S.P. KOENIG, and J.S. MUKHERJEE.

Journal of Public Health Policy, vol. 25, no. 2 (pp 137-158), April, 2004.



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Before and After

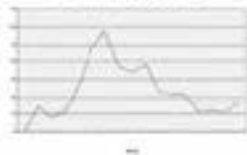
- 4 pillars structure in place.
- This meant a working pharmacy with 30 essential meds plus about 100 other regularly stocked medicines.
- Inpatient capacity – staff, supplies, and materials.
- Laboratory – HIV testing, TB microscopy, RPR testing, manual hematology, several basic chemistries.
- Radiology.
- Comprehensive coverage of communities with Community Health Workers (CHWs) and DOT workers.
- Systematic Community Health Education – HIV focused.
- 250-300 patient visits per day within one year.
- Improved access to "tertiary" care.



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Before and After – TB



- From 9 to 250 cases.
- Hundreds of smear positive contacts screened.
- Numerous HIV positive patients identified.



49

Before and After – HIV

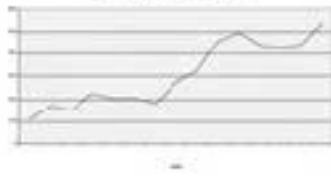


- 120 patients on HAART at one year.
- 20,000 HIV tests performed (VCT).
- Expanded STI screening and treatment.
- Decreasing HIV stigma, increased staff morale.
- “Lazarus Effect.”



50

Collateral Benefits



- Prenatal Care Visits
- One of the services available ‘free’ before scale-up.



51

PMTCT / PTME



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Measuring Success

- 7 clinical sites, each with inpatient capacity.
- Seeing on average > 1900 patients per day.
- 4 operating ORs. 300+ Hospital beds total.
- Expansion of primary health care services throughout the Central Plateau.
- Over 2200 patients on HAART triple therapy with twice a day DOT.
- 39,732 people HIV tested in 2005.
- Direct services to 8,564 HIV-positive people.
- Nationally, Haiti has surpassed its Global Fund goals for HIV testing, treatment, PTME, and prevention efforts.



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Strengthening Public Sector

- All health centers are joint Public-Private facilities.
 - Mixed staff.
 - Helping the State to achieve State goals.
- Residency training, professional retention, and continued development of local professionals.
 - Providing Stable Jobs – 80 percent of Haitian-trained MD’s leave the country.
- Political Stability - Cooperation despite regime change and within political chaos.
- Allows for a single standard where otherwise every NGO or church group would set their own agenda.



54

Training and Retention

- All Local Talent. Against “Brain Drain.”
- Few want to live and work in rural areas.
 - Transportation / rotation, housing, internet, tools of their trades.
 - Participation in research, conferences, further formal education, and teaching within healthcare and the community.
- Few nurses (and doctors, lab techs, pharmacists, accountants, etc) in Haiti.
 - On-site training and ongoing education.



55

Insuti Mu Buzima

- 10 years after genocide.
- Political will and significant international funding.
- South – South collaboration.
- Medical and nursing team from Haiti has laid foundation in Rwanda, ongoing oversight and staffing.
- Lesotho national program.



56

Haiti and the Dominican Republic

57

Transnational Challenges

- 500-650,000 Haitians living illegally in the Dominican Republic.
- No political, civil, social, or economic rights protections.
- No healthcare, let alone HIV care.
- Slavery conditions in *batays* and informal sector.
- Lynching common and ongoing.
- Mass deportations ongoing, up to 15,000 deported in 2005.
- Cross-border collaboration has been very slow starting.
- Haitian patients frequently lost to follow up across border, looking for economic opportunity.

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Ongoing Challenges

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60

Ongoing Goals

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Mesi Anpil Thank you

Evan Lyon
elyon@pih.org
www.pih.org

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Elizabeth Madraa, NACP, Ministry of Health, Uganda (slides 63-78)

Constraints & Opportunities to Provide ART for Displaced Population in Conflict and Post Conflict Situations

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Geography

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Demography, key health and economic indicators

- Uganda has a population of 28 million (Mid-North 2.47M)
- 90% of the population is in rural areas and living in absolute poverty
- Half of population less than 15 years
- Administratively divided into 80 districts (Mid-North 8 districts)
- Infant mortality rate; 88 deaths/1000 live births
- Maternal Mortality Ratio; 505 deaths/100,000 live births

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Key Indicators ... Cont.

- Life expectancy is 47 years
- GDP per capita of \$ 312 for the fiscal year 2004/05

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Conflict Areas in Uganda

- Mid-northern part of the country has had war for the last 25 years
- The prolonged war resulted into
 - Displacement of people
 - Disruption of Social services
 - Distraction of Infrastructure

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HIV Situation in Uganda

- HIV is among the top 5 leading causes of morbidity and mortality in Uganda (12% of annual deaths are due to AIDS)
- Annual infection is estimated at >100,000
- About 900,000 Persons are living with HIV (Mid-North 205,010)
- Those in need of ART are between 150,000 - 200,000 (in Mid-North about 41,002, & 4,100 Children)

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HIV Situation in Uganda Cont.

- Over 1 million Ugandans have died since onset of the epidemic
- Over 2 million children in Uganda are orphans (50% of these due to AIDS)
- Mid-North HIV prevalence 8.3% (Uganda 6.4%) – UHSBS 2004/5
- Mid-north HIV prevalence according ANC sentinel surveillance is 12.8% (Uganda 6.5%)
- HIV prevalence among children estimated at 0.7% (90% acquired through MTCT)

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ART Provision

- ART is provided within the comprehensive HIV/AIDS Care package
- Implementation is within the National Health care system
- Currently about 80,000 (about 40% of those who need) are accessing ART (Mid-North 4,147 i.e. only 10% of those who need)

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Constraints in providing ART

- Human resource gap
 - Under staffing
 - High attrition rate
- Logistics supply chain management
- Poor monitoring and follow-up of patients
- These constraints are multiplied in conflict situations

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Constraints in providing ART in Conflict & post-conflict situation

- Population is displaced from existing infrastructure
- Existing infrastructure is destroyed
- Inaccessibility of health services
- Provision of comprehensive care services including ART difficult (Laboratory diagnostic, on-going counseling, monitoring of patients, loss to follow-up)

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Constraints ... Cont.

- Referral difficult due to poor roads, presence of land mines, and poor transport
- Pre-occupation with war situation affects adherence to ART
- Unwillingness of H/W to work in conflict situation and IDP camps
- Poor access to water and sanitation
- Lack of electricity
- Food insecurity

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Opportunities

The conflict and post-conflict situation has drawn attraction for support both locally and externally

- Re-organization of social services structure to include other partners to provide services UN agencies (WHO, UNICEF, UNFPA, WFP, UNHCR, URC), International and local NGOs
- Strengthening IDP camps through VHT concept to provide basic care services in the community (Patient support, Treatment literacy, Counseling, Health education & promotion in general)

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Opportunities ... Cont.

- Provision of support to strengthen functional health facilities to provide outreach services and support supervision
- Integration of services to include ART, PMTCT, TB, Reproductive health, HCT, HBC, palliative care
- Re-activation of lower health facilities with close proximity to IDP camps
- Availability of resources to recruit extra human resource

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Conclusion

Although there are many challenges in providing ART in a conflict and post conflict situation, this is possible given the available opportunities

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Acknowledgements

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Thank You For
Listening To
Me

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Lawrence Ojom, St. Joseph Hospital/AVSI, Uganda (slides 79-100)

Constraints and opportunities to provide ART for displaced population and in/post conflict situation:

NORTHERN UGANDA EXPERIENCE

Presented by
Dr. Lawrence Ojom
Medical Superintendent St. Joseph's Hospital Kitgum - Uganda


"HIV/AIDS, Conflict and Displacement"
August 12, 2006
TORONTO Marriott Downtown Eaton Centre

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Presentation Layout

- Background
- HIV/AIDS in Uganda - overview
- HIV/AIDS services sites coverage in Northern Uganda
- ART in Northern Uganda
- Constraints to provide ART
- Opportunities to provide ART
- Concluding Remarks

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Background

- Northern Uganda (Acholi Sub-region): Gulu, Kitgum and Pader districts
- Population: 1,151,700 people:
 - Gulu = 503,800
 - Kitgum = 320,000
 - Pader = 327,900
- 20% of the pop are children under 5 years

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Background Cont.

- The region has been affected by a 20-year conflict, with periods of intensive fighting (2002) alternated with periods of relative peace (currently).



- Consequences: displacement of over 90% (about 1,000,000 people) of the population in 107 Internally Displaced Person (IDP) camps; abduction of children, death, and weakening of the health and socio-economic services.

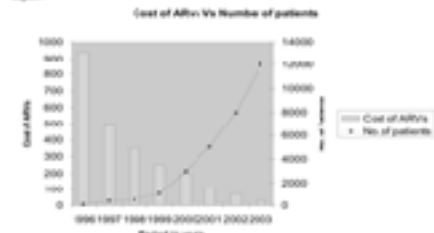
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HIV/AIDS in Uganda - Overview

- 1982 first two cases reported in Rakai district
- GOVERNMENT RESPONSE to HIV/AIDS in UGANDA:
 - Openness about the epidemic and political commitment and support
 - Multisectoral approach to HIV/AIDS prevention and control.
- HIV prevalence rate in Uganda varies from region to region (highest: 8.5% in Kampala; 8.2% North-central & lowest 2.3% in West Nile) & shows a decline from 18% in 1992 to about 6.4 to date.
- ART in Uganda started in 1992
- 56% of HIV- Ugandans who need ART receive treatment (UNAIDS Report 2006).

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Costs of ARVs-A major constraint despite tremendous price reductions



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HIV/AIDS Services Sites Coverage in Northern Uganda

Despite National and Global efforts to scale up HIV/AIDS services, there is still limited access in Northern Uganda (mainly in hospitals in urban areas):

HIV/AIDS sites	Gulu District	Kitgum District	Pader District	TOTAL
HIV Counselling & Testing	30%	39%	14%	27%
PMTCT	13%	21%	7%	14%
ART	14%	12%	7%	11%


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ART in Northern Uganda @ June 2006

13 sites (11%) out of 115 health facilities in N. Uganda are providing ART (6 urban Hospitals, 2 rural Hospital & 5 rural Health Centers) to 3,128 HIV-clients.

	N ART-CLIENTS	TARGET (end 2006)
Gulu District (5 sites)		
Lacor Hospital	1,250	1,500
Gulu Regional Hospital	600	800
Gulu Independent	40	100
TASO (ICRC Site)	507	1,000
Anaka Hospital	43	100
Kitgum District (4 sites)		
St. Joseph's Hospital Kitgum	450	670
Kitgum Hospital	100	200
H/Centers (Padibe, Nam Okora)	28	100
Pader District (4 sites)		
Katongo Hospital	80	200
H/Centers (Pajule, Pader TC, Patongo)	30	50
TOTAL (13/115)	3,128 (66%)	4,720

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in Northern Uganda June 2006 Cont.


- Total Population** 1,151,700
- Total Adults 15-59 (50% of Pop)** 575,850
- Adults HIV+ (Prevalance 8.2%)** 47,220
- Adults Eligible for ART (20%)** 9,444
- Adults on ART** 3,128
- ART Coverage National)** 33% (vs. 56%)

The above figures may increase if the current scaling of ART services to rural facilities is done and the set target achieved, to about 50% by end 2006.

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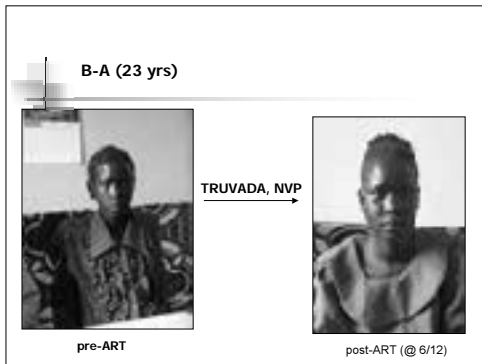
ART-Summary

- ART services are limited to few sites yet the demand is very high.
- ARVs available at low price (but still not affordable) or free of charge (from projects/programs).
- Paediatric ART available in 3 facilities (limited number of children, 250).
- Diagnostic facilities are very poor and in urban area (only 5 CD4 machines, 1 out of use, & NO PCR).
- Over 70% of ART-clients in Northern Uganda are located within the urban areas.
- Clients are started ARV based on clinical assessment (WHO Staging) especially in rural H/Facilities.
- Adherence support by local CBOs

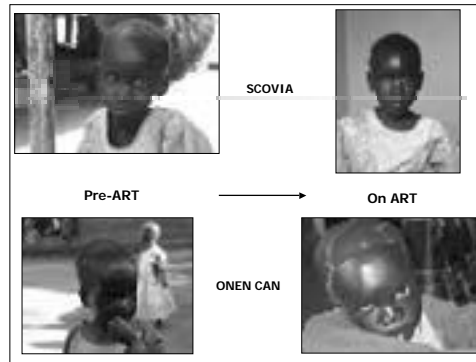


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CONSTRAINTS TO PROVIDE ART

1. Intermittent Insecurity → community access to basic services, coordination, supervision and follow up of clients in IDP camps.
2. Unfavorable Conditions in the IDP Camps → poor situation in the communities, increasing immorality, breakdown of family structure, overcrowding and night commuting especially of children and young adults.
3. Limited provision of effective and efficient HIV/AIDS Services → lack of skilled personnel, equipment and poor and inadequate infrastructure.
4. Inadequate Social Services → providing ARVs needs all other aspects of life to be taken into consideration.

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CONSTRAINTS TO PROVIDE ART Cont.

5. Inadequacy of funds → sustainability of ART programs (FUTURE?)
6. Poor coordination between different programmes.
7. Procurement and logistics management → un-interrupted supply of ARVs and consistency in the ART drug regimens.
8. OVCs

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OPPORTUNITIES TO PROVIDE ART

1. Promoting a holistic approach to HIV/AIDS care
improves survival options for PLWHAs; holistic approach broadens access to HIV/AIDS care and support services, improves survival and livelihood empowerment options to PLWHAs and OVCs. PMTCT mother said, 'now you have enabled me deliver a child free of HIV/AIDS, what about me and my husband and how do we keep and support this child?'
2. Using Post Test Clubs and Community Support groups
eases delivery of services; By the PLWHAs joining Post Test Clubs, Drama Groups and Community care Support Groups, sustainability of delivering HIV/AIDS care and support service to the grassroots is fostered. The support of ARVs, medication, home based care, food and non-food support offered by St. Joseph's hospital Kitgum in collaboration with local community groups has so far improved stigma aspect and adherence.

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OPPORTUNITIES TO PROVIDE ART Cont.

3. Promoting links with other HIV/AIDS services (PMTCT & HCT/VCT)
this encourages PLWHAs to seek for treatment and care and support services above all enhances positive behavioral change among target clients
4. Strengthening capacity of local partners to deliver HIV/AIDS care services
involving local partners and the community increase access options, acceptability and ownership of HIV/AIDS prevention, care and support services, which improve their profile and capacity in the management of HIV/AIDS. For example Meeting Point Kitgum has increased their area of operation in Kitgum and Pader districts and can now reach more clients and communities. Peer groups among women and youth have been formed and increased HIV/AIDS information dissemination channels created.

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OPPORTUNITIES TO PROVIDE ART Cont.

5. Improving and creating linkages and referral networks with the service providers
ignorance of the availability of services within the community coupled with poor linkage and referral system retards ART delivery. Well designed coordination strategies improve follow up of PLWHAs and OVC and prompt decision regarding care are taken.
6. Strengthening Poverty Eradication Strategies
poverty coupled with limited employment and income generation opportunities, directly contribute negatively to the efforts put to curb the spread of HIV/AIDS within the communities. It is important that HIV/AIDS activities especially ART activities integrate livelihood and employment or income generation strategies to eliminate poverty. This is very important here as the conflict is getting settled and the communities plan to resume activities in the villages.

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Concluding Remarks

- **Scaling up and expansion of HIV/AIDS services:**
 - Provision of IEC
 - New HCT/VCT and PMTCT sites in IDP camps
 - Improvement of collection and utilisation of accurate data at all levels
 - Follow up of babies born to HIV positive mothers
 - New paediatric ART sites
 - Training of personnel and community based groups to handle comprehensive aspects of HIV/AIDS
 - Improvement of the infrastructures, equipment, space and other related logistic supplies

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Concluding Remarks Cont

- **Improving Quality of HIV Programming:**
 - Government and Donors must ensure appropriate and intergrated HIV/AIDS interventions for the IDPs inline with national programmes
- **Durable Solutions:**
 - Insecurity problem must be solved and the IDP return home and live in peace and dignity.
 - Coordination among implementing agencies must be strengthened so that there is continuation of HIV/AIDS services
- **Improving support, care and treatment:**
 - As other communities, IDPs must have an HIV/AIDS comprehensive package (CTX prophylaxis, OIs treatment, socio-economical support)

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Concluding Remarks Cont

- **Resource Mobilisation**
 - Additional and large resources are required for ART programmes among the IDPs due to the fact that the community is in extreme poverty and all resources generated locally are lacking
- **Training and capacity building**
 - This must not be limited only to the technical or professionals but IDP Community based Groups for Local integration
 - Training should address assessment, servellance, monitoring and avaluation because there is commonly lack of data

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THANKS!!!



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 **UNHCR**
The UN Refugee Agency