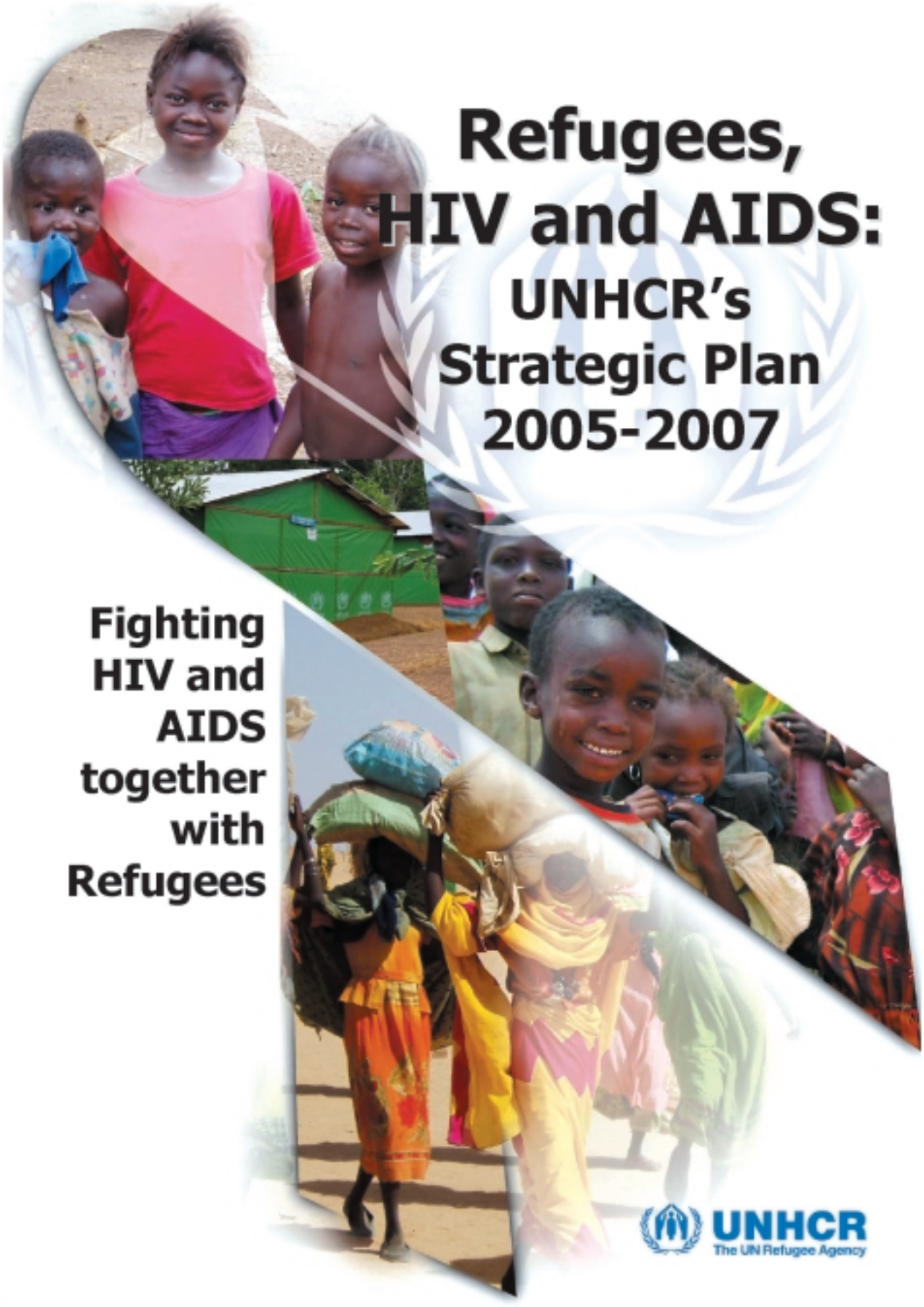


Refugees, HIV and AIDS:

UNHCR's Strategic Plan 2005-2007

Fighting HIV and AIDS together with Refugees

UNHCR
The UN Refugee Agency

I. TABLE OF CONTENTS Page

Figures:

Appendices:

II. EXECUTIVE SUMMARY

Refugees, HIV and AIDS: UNHCR's Strategic Plan for 2005-2007 is based on UNHCR's policies, lessons learned from the 2002-2004 Strategic Plan, technical guidance from the UNAIDS Secretariat and Cosponsors, and the IASC guidelines on HIV/AIDS in emergency settings. This current plan states UNHCR's objectives and key strategies from 2005 through 2007 to combat HIV and AIDS among refugees, returnees and other persons of concern as well as to ensure that the human rights of persons of concern to UNHCR who are living with HIV and AIDS are duly respected. The Strategic Plan elaborates UNHCR's objectives, key strategies and indicators to combat HIV among refugees, returnees and other persons of concern from 2005 through 2007. The plan is consistent with and complementary to other international HIV and AIDS objectives and strategies, including the Millennium Development Goals, the UN General Assembly Special Session on HIV/AIDS, the UN System Strategic Plan for HIV/AIDS and the UNAIDS Unified Budget and Workplan.

New epidemiologic data have shed light on the complex relationship between HIV, conflict and displacement. It is a misperception that the HIV prevalence among refugees is *always* higher than that among their surrounding local host country populations; evidence suggests that the opposite is more likely. The well-documented factors that increase the vulnerability to HIV among conflict-affected and forcibly displaced populations must be considered alongside other key factors, such as reduced mobility and accessibility of the population that may work to decrease HIV transmission. HIV prevalence levels among the refugees and host communities also influence HIV transmission, as do the levels of interaction between the two communities and their exposure to violence. Therefore, it is essential to combat the stereotypical and incorrect belief that 'refugees bring AIDS with them to local communities', which may lead to discriminatory practices. The context-specific circumstances in which refugees and other persons of concern to UNHCR live must be better understood and used to guide HIV programmes.

The ten objectives of the strategy are:

1) **Protection -** to ensure that refugees, asylum-seekers and other persons of concern who are affected by HIV and AIDS can live in dignity, free from discrimination, and that their human rights are respected, including their non-discriminatory enjoyment of the highest attainable standard of physical and mental health;
2) **Coordination and mainstreaming -** to ensure that HIV policies and interventions for refugees are coordinated, mainstreamed and integrated with those at the international, regional, sub-regional, country and organisational levels;
3) **Durable solutions -** to develop and incorporate HIV policies and interventions into UNHCR's programmes for durable solutions, including voluntary repatriation, local integration and resettlement, in order to mitigate the long-term effects of HIV;
4) **Advocacy -** to advocate for HIV-related protection, policy and programme integration, and sub-regional initiatives for refugees and other persons of concern in a consistent and sustained manner at all levels;
5) **Quality HIV programming -** to ensure appropriate, integrated HIV interventions for refugees, returnees and other persons of concern, in concert with national programmes in host countries and countries of return;
6) **Prevention -** to reduce HIV transmission and HIV morbidity through the implementation of culturally and linguistically appropriate health and community-based interventions;

7) **Support, care and treatment -** to reduce HIV morbidity and mortality; this includes access to antiretroviral therapy when available to surrounding host populations when appropriate;
8) **Assessment, surveillance, monitoring and evaluation -** to improve programme implementation and evaluation;
9) **Training and capacity building -** to improve HIV-related skills and capacities of UNHCR, its partners and refugees; and,
10) **Resource mobilization -** to increase funds and move beyond traditional donors to ensure the objectives stated in this Strategic Plan are achieved.

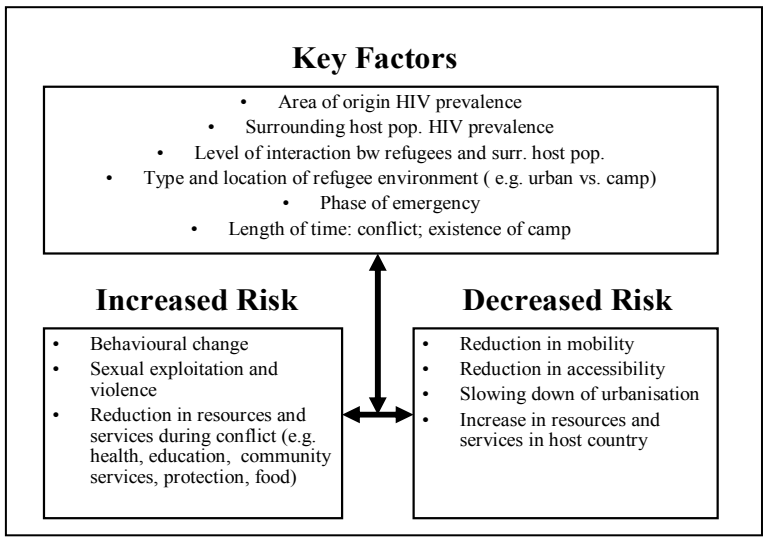
In addition to protection concerns and basic human rights principles, other fundamental approaches must be considered throughout this document and during all stages of programme implementation. These include the need to: 1) **integrate** refugees into HIV policies, funding proposals and programmes of countries of asylum; 2) address the needs of refugee **women and children** and mainstream gender and age; 3) adopt a **sub-regional approach** reflecting the cycle of displacement; and, 4) **advocate** for the elimination of HIV-related **discrimination** against refugees and other persons of concern to UNHCR.

III. INTRODUCTION

Conflict, displacement, food insecurity and poverty have the potential to make refugees and other affected populations more vulnerable to Human Immunodeficiency Virus (HIV) transmission. The United Nations General Assembly Special Session (UNGASS) on HIV/ Acquired Immunodeficiency Disease Syndrome (AIDS) adopted its Declaration of Commitment in June 2001, which states, inter alia, that 'populations destabilized by armed conflict including refugees, internally displaced persons, and in particular, women and children, are at increased risk of exposure to HIV infection'.[1*] Mitigation, prevention, care and treatment of HIV among refugees and other persons of concern to the United Nations High Commissioner for Refugees (UNHCR) are essential components of UNHCR's protection mandate. In accordance with UNGASS[1] and the International Guidelines on HIV/AIDS and Human Rights,[2] UNHCR adopts a rights-based approach in HIV policies and programmes.

New epidemiologic data have shed light on the complex relationship between HIV, conflict and displacement. It is a misperception that the HIV prevalence among refugees is *always* higher than that among their surrounding local host country populations[A]; in fact, evidence suggests that the opposite is more likely. The well-documented factors that increase the vulnerability to HIV among conflict-affected and forcibly displaced populations must be considered alongside other key factors, such as reduced mobility and accessibility of the population that may work to decrease HIV transmission. HIV prevalence levels among the refugees and host communities also influence HIV transmission, as do the levels of interaction between the two communities and their exposure to violence (figure 1).[3] Therefore, it is essential to combat the stereotypical and incorrect belief that 'refugees bring AIDS with them to local communities', which may lead to discriminatory practices.[4] The context-specific circumstances in which refugees and other persons of concern to UNHCR live must be better understood and used to guide HIV programmes.

Figure 1: HIV risk factors for conflict and refugee camps[B]



[A] Throughout this document, surrounding local host populations will be referred to solely as host populations.
[B] Adapted from Spiegel PB. HIV/AIDS among conflict-affected and displaced populations: dispelling myths and taking action. *Disasters* 2004;28(3)**:**322-39.

This document focuses on refugees and other persons of concern to UNHCR, including, inter alia, asylum-seekers, returnees, and stateless persons. UNHCR's mandate has also been extended by the General Assembly in certain situations to include internally displaced persons (IDPs). UNHCR is currently assisting approximately 5.8 million internally displaced persons.[5] The objectives and strategies in this plan apply to all persons of concern to UNHCR, including those IDPs whom it assists.

UNHCR's 2005-2007 Strategic Plan on HIV, AIDS and Refugees is based on UNHCR's policies,[6-10] lessons learned from the successful implementation of the 2002-2004 Strategic Plan (appendix 2), field missions (appendix 3),[3,11,12] and technical and normative guidance from the United Nations Joint Programme for HIV/AIDS (UNAIDS) and the World Health Organization (WHO) and the guidelines for HIV/AIDS Interventions in Emergency Settings developed by the Inter-Agency Standing Committee (IASC) Task Force.[13] The Strategic Plan elaborates UNHCR's objectives, key strategies and indicators to combat HIV among refugees, returnees and other persons of concern from 2005 through 2007. The Plan is consistent with and complementary to other international HIV and AIDS objectives and strategies, including the Millennium Development Goals (MDGs), the United Nations System Strategic Plan for HIV/AIDS (UNSSP) and the UNAIDS Unified Budget and Workplan (UBW).

IV. 11 ESSENTIAL FACTORS

1. Refugees are a **unique** group often with special needs. Consequently, specific HIV policies and interventions need to be developed that may vary from those for other persons in resource-poor settings. For example:
   - Many refugees have suffered trauma and violence, including sexual violence, during conflict and flight. In addition, traditional community support structures are often destroyed during displacement. Thus, there are a variety of psycho-social issues in refugee populations which may not exist in more stable communities;
   - HIV prevention and education campaigns in countries of asylum are often inaccessible to refugees who frequently speak different languages and have different cultural backgrounds;
   - Durable solutions, such as repatriation, and the possible effects they may have on policies and interventions in the country of asylum must be considered (e.g. provision of antiretroviral therapy (ART) to refugees who will shortly be repatriating to an area of return where ART is not available); and,
   - Unique opportunities for prevention, support and care may exist in refugee situations that are uncommon in other situations (e.g. information-education-communication (IEC) materials during food distribution or supplementary feeding programmes, at transits centres during repatriation, and during registration).[14]

   However, in many ways, refugee communities are similar to other communities worldwide, including the existence of "core" groups that can spread HIV to the broader refugee community. Therefore, among the refugee population, specific HIV interventions should also be made available for commercial sex workers (CSWs), intravenous drug users (IDUs), and men having sex with men (MSM) in an accessible manner that does not expose them to discrimination.[12]

2. The linkage between the **protection of refugee and human rights** and effective HIV programmes is apparent as people will not seek HIV-related voluntary counselling and testing (VCT), treatment and care if lack of confidentiality, discrimination, risk of refoulement, restrictions on freedom of movement or other negative consequences exist. In addition, combating stigma or discrimination of any nature against refugees and others of concern is fundamental to UNHCR's protection mandate. UNHCR, its partners and host governments must therefore work together to ensure that refugees are not subject to any discriminatory practices based on real or perceived HIV status, and that both refugees and host communities have access to quality and confidential services.

3. HIV and AIDS constitute not just a health issue but a problem that affects the socio-cultural fabric, human rights and long-term economic well-being of refugees as well as the local population with which they interact. Thus, well-coordinated **multi-sectoral and multi-partner approaches** are critical to an effective HIV and AIDS programme. UNHCR's HIV and AIDS interventions are not implemented in a parallel fashion, but are integrated within and complementary to existing programmes (e.g. health, protection, community services, and education). It is essential to work in close partnership with refugees and their host communities, and with various national, sub-regional, regional and international actors (e.g. governments, United Nations agencies, international organizations, international

and local non-governmental organizations (NGOs), multilateral and bilateral institutions, religious institutions, and the private sector). UNHCR's HIV policies and interventions must fit within the larger United Nations and international HIV response; these include global strategies such as the "three-ones" and the "3 by 5". UNHCR's admission as the 10th cosponsor of UNAIDS in June 2004 assures an enabling environment for the achievement of greater synergies and coordination of action benefiting a wide range of populations.

4. Implementation of HIV and AIDS programmes in **emergency situations** is essential. Policies and interventions must begin at the onset of a crisis and continue throughout the displacement cycle (figure 2). UNHCR's HIV programmes in emergency settings will be guided by the strategies and priorities set forth in the IASC guidelines.[13] In UNHCR's care and maintenance programmes, national HIV policies and strategies will be the guidance for the programmes.

5. Refugees and their host communities generally interact closely and HIV programmes should be established that take into account this interaction. Thus, **integrated HIV programmes** that follow host government protocols, guidelines, and strategic plans should be implemented while parallel programmes should be avoided.
   - Under Article 23 of the 1951 Convention relating to the Status of Refugees, Contracting States shall accord to refugees lawfully staying in their territories access to the same "public relief and assistance" as their nationals, including medical care. Furthermore, international human rights law specifically addresses the right of everyone to the enjoyment of the highest attainable standard of physical and mental health under Article 12 of the International Covenant on Economic, Social and Cultural Rights, including access to medical service and medical attention in the event of sickness. Additionally, the right to health is recognized, inter alia, in article 5 (e) (iv) of the International Convention on the Elimination of All Forms of Racial Discrimination of 1965, in articles 11.1 (f) and 12 of the Convention on the Elimination of All Forms of Discrimination against Women of 1979 and in article 24 of the Convention on the Rights of the Child of 1989. Several regional human rights instruments also recognize the right to health, such as the European Social Charter of 1961 as revised (art. 11), the African Charter on Human and Peoples' Rights of 1981 (art. 16) and the Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights of 1988 (art. 10).
   - Host governments should ensure that refugees can exercise, without discrimination, the right to the highest attainable standard of physical and mental health. Therefore, refugees should have access on a non-discriminatory basis to the national health or HIV programmes which are available to the host population.
   - Donors should recognize the limited technical and financial resources of many asylum countries, which often cannot meet the needs of their own populations let alone contribute to refugee programmes. Donors should encourage host countries with refugee populations to include refugees and the hosting communities in their HIV proposals while providing additional and sufficient funds to allow these governments to meet this demand.

- UNHCR must play a central role in advocating for host countries and donors to include refugees and other persons of concern in HIV and AIDS proposals and programmes.

6. **Women and girls** are more susceptible to HIV due to gender discrimination and violence, biology, insufficient access to HIV prevention information and services, inability to negotiate safer sex, and lack of female-controlled HIV prevention methods. AIDS is affecting women most severely in places where heterosexual sex is a dominant mode of HIV transmission, as is the case in sub-Saharan Africa and the Caribbean. Adult women in sub-Saharan Africa are up to 1.3 times more likely to be infected with HIV than their male counterparts; this inequality is greatest among young women aged 15–24 years, who are approximately three times more likely to be infected than young men of the same age. Furthermore, women are more likely to take in orphans, provide home-based care, cultivate crops and seek other forms of income to sustain their families. The above factors may be more pronounced among refugee women and girls due to their vulnerability to sexual exploitation and violence throughout the displacement cycle (figure 2). Policies and programmes must be prioritized and tailored to their needs as well as to the elderly who also have an increased burden.

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

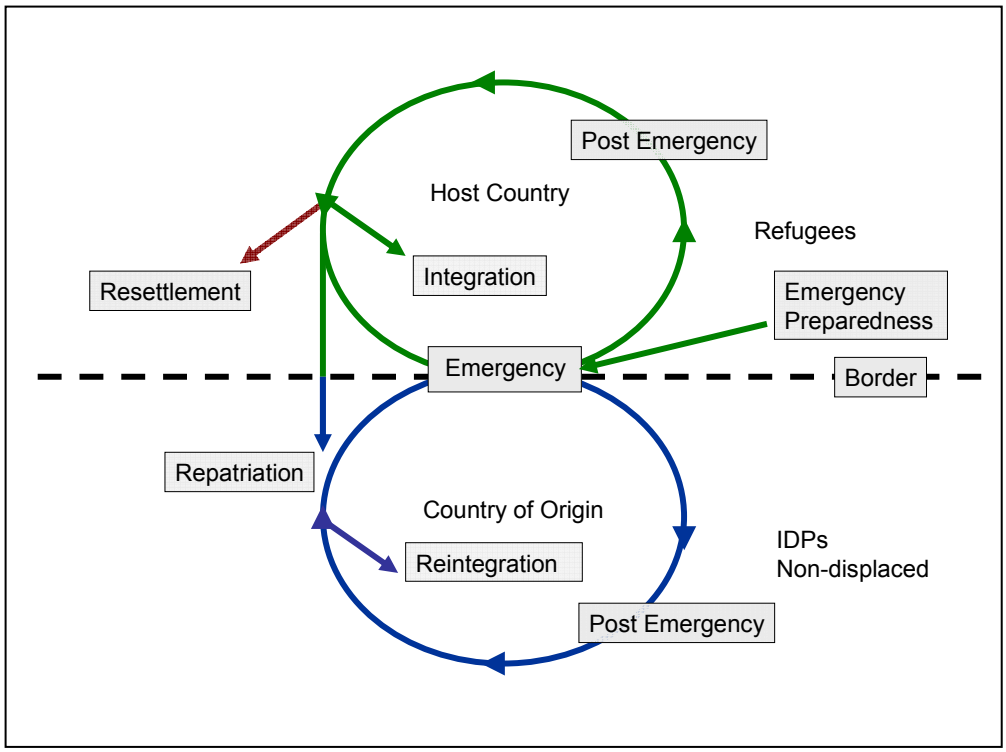
8. **Unaccompanied children, orphans and other children affected by HIV and AIDS** may experience economic hardship and psychosocial distress, suffer from increased malnutrition and illnesses, and may have a higher withdrawal rate from school than other children. These factors are enhanced among refugee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

9. Policies and HIV interventions for **urban refugees** can be more complicated because they are diverse groups who often live in widely dispersed areas, making them difficult to locate and access.[15, 16] Unlike refugees living in camps, the type, level and cost of services provided to urban refugees are not standardized and vary considerably. HIV-related support and services for those who are not yet self-reliant should be provided through support, where necessary, to national health and education services and not by the creation of parallel structures and special services for refugees.[15] Advocacy for urban refugees to access local services in a non-discriminatory manner is essential.

10. Refugees voluntarily **repatriating** to their country of origin may have lower, higher, or equal HIV prevalence to those living in the area of return. For those refugees who have been exposed to HIV programmes supported by NGOs and host governments, their knowledge of HIV may be higher and their behaviour less risky than the non-displaced persons and IDPs in their country of origin. Furthermore, many refugees have acquired important and valuable HIV-related skills that can be used in their country of origin (e.g. those involved in providing camp-based health care and education). HIV interventions for returnees are primarily the responsibility of the government of the country of origin, supported by UNAIDS and its Co-sponsors. However, UNHCR should play a key role in ensuring continuity between host country and country-of-origin HIV programmes, and initiating essential programmes in areas of return where no other agencies or programmes are operational. Overall, HIV policies and programmes need to be directed towards all persons in the area of return and not solely for returnees in order to avoid stigma and discrimination and to have a broader effect.

11. **Sub-regional initiatives** can develop policies and provide HIV interventions to marginalized populations that might not otherwise benefit from national programmes. Continuity of services for refugees and other mobile populations can be better ensured and improved by agreeing on diagnostic and treatment protocols, and bulk ordering of medications and supplies can aid countries in the sub-region. Such agreements will also aid in repatriation planning and implementation. Given the displacement cycle of refugees (figure 2), UNHCR encourages the international community to adopt a broader and more innovative approach to combating the HIV epidemic across international boundaries.[3] HIV policies and interventions for refugee and other mobile populations must go beyond the country level and should be sub-regional in nature.

Figure 2: Cycle of displacement



V. Objectives, Expected Accomplishments, Indicators of Achievement

1. **Protection Objective:** to ensure that refugees, asylum-seekers and other persons of concern who are affected by HIV and AIDS can live in dignity, free from discrimination, and that their human rights are respected, including their non-discriminatory enjoyment of the highest attainable standard of physical and mental health.

Expected Accomplishments	Indicators of Achievement[D]	05	06	07
i. Refugees and asylum seekers are not discriminated on the basis of HIV infection or subject to adverse measures based on HIV status	i. (a) Reduction in laws and practices that discriminate against HIV-positive refugees and asylum- seekers actively monitored, documented and followed up	●		
	(b) No. of laws and practices that have changed re: i (a) (cross ref obj 4)		●	●
	(c) No. of reports of and corresponding interventions on HIV protection-related issues using UNHCR's Annual Protection Reporting mechanism (cross ref obj 8)		●	●
ii. Provision of VCT and discontinuation of mandatory testing of asylum-seekers and refugees (with exception of testing for blood transfusions) since this does not prevent spread of the virus and is at variance with relevant human rights standards[17]	ii. (a) Same as i (a) re: mandatory testing			
	(b) Same as i (b) re: mandatory testing			
	(c) Same as i (c) re: mandatory testing			
iii. HIV stigma and discrimination towards refugees and by refugees reduced (cross ref obj 4)	iii. (a) Increase from 7 to 25 the no. of country operations that have implemented specific programmes to decrease HIV discrimination and stigma for refugees and surrounding communities		●	●
	(b) Increase by 25% positive changes in attitudes and behaviour re: stigma towards people living with HIV and AIDS (PLWH/As) recorded by behavioural surveillance surveys (BSS); (cross ref obj 8)		●	●
iv. Confidentiality and the right to privacy is respected of persons of concern who are living with HIV	iv. Same as i (c) re: mandatory testing			
v. Refugee women and girls empowered through basic rights awareness and lifeskills training to reduce their vulnerability to HIV and AIDS (cross ref obj 6)[18C]	v. (a) Same as iii (a) re: women and girls rights awareness		●	●
	(b) Positive changes in knowledge, attitudes and behaviour as recorded by BSS (cross ref obj 8)		●	●
vi. Protection of refugee children, including adolescents, with special attention to separated and unaccompanied children and orphans (cross ref obj 6)[18]	vi. (a) Baseline data on no. of children and sexual abuse collected (cross ref obj 8)	●		
	(b) Increased no. of reports of and interventions (cross ref obj 8)		●	●
	(c) Increased no. of trainings for HCR personnel and partners (cross ref obj 9)		●	●

[C] Attitudes and behaviour of men also need to be addressed.

[D] Indicators refer to achievements over 3 years. At the end of each year, all countries with major HIV programmes will report on the HIV indicators listed in this plan using UNHCR's HIV Information System.

2. **Coordination and Mainstreaming Objective:** To ensure that HIV policies and interventions for refugees are coordinated, mainstreamed and integrated with those at the international, regional, sub-regional, country and organizational levels.

Expected Accomplishments	Indicators of Achievement	05	06	07
I. Within UNHCR (appendix 4)				
i. Maintain existing and expand HIV focal points at headquarters and field level	i. Increase no. of focal points from 34 to 50	●	—	●
ii. UNHCR's HIV unit maintained and expanded	ii. (a) All 4 HIV Regional Coord. to continue work in four sub-regions of sub-Saharan Africa	●	—	●
	(b) 1-2 HIV Regional Coordinators in Asia and North Africa	●	—	●
	(c) 1 HIV Regional Coordinator in Eastern Europe		●	●
	(d) 2 Technical Officers working at HQ level	●	—	●
	(e) 1 UNAIDS Liaison/Technical Officer at UNHCR	●	—	●
iii. Mainstreaming and integration of HIV programmes and funds that have been provided by headquarters to selected country offices	iii. Increase from 5 to 20 the no. of country operations that mainstream HIV programmes and funds	●	—	●
iv. Improved coordination on HIV issues among country offices during repatriation programmes	iv. 100% of repatriation programmes have cross-border HIV component	●	—	●
II. Within International System				
i. Continued active participation in HIV-related international coordination and planning systems	i. (a) Participation in Inter-Agency Advisory Group on AIDS	●	●	
	(b) Participation in IASC task force on HIV in Emergency Settings	●	—	●
	(c) Participation in process of MDGs	●	—	●
ii. Increased participation within the UN system (particularly since becoming Cosponsor of UNAIDS)	ii. (a) Participation in UNSSP	●	—	●
	(b) Participation in evaluation of UNGASS	●	●	
	(c) Participation in development of UN and global HIV strategies	●	—	●
	(d) Participation in UNAIDS initiated theme groups and meetings	●	—	●
	(e) Participation in UBW	●	—	●
	(f) See 2. I. ii (e)			

2. Coordination and Mainstreaming Objective (cont)

Expected Accomplishments	Indicators of Achievement	05	06	07
III. Within Regional/Sub-regional System				
i. Enhanced participation in UN regional mechanisms	i. (a) Increased participation in UN Regional Inter-Agency Coordination Support Office (b) 100% participation in UNAIDS Inter-Country Teams	●		●
ii. Increased involvement in sub-regional initiatives (cross ref obj 4)	ii. (a) Continued active participation in the Great Lakes Initiative on AIDS (GLIA) (b) Active participation by UNHCR in Mano River Union AIDS Initiative (c) Active participation by UNHCR in Oubangui-Chiari Initiative on AIDS (d) Aid in creation of similar sub-regional AIDS initiatives in East Africa, North Africa, Asia, and Eastern Europe	●		●
IV. Within Country				
i. Capital level Improved collaboration with NACPs	i. 1. ≥ 1 visit/yr by representative of NACP to refugee operations with major HIV programmes[E] (cross ref obj 4)	●		●
Improved participation by UNHCR in UN Theme Groups on HIV and associated Technical Working Groups	i. 2. ≥75% participation by UNHCR in Theme Group and Technical Group meetings	●		●
Regular HIV coordination meetings using existing mechanisms (e.g. health coordination or community service coordination meetings)	i. 3. 100% of refugee operations with major HIV component conduct regular coordination meetings with an HIV component	●		●
ii. District 1) Improved coordination with district officials involved in HIV programmes to ensure integration; includes referral hospitals and nearby clinics for local surrounding populations (pop.).	ii. Increased no. of integrated HIV programmes for refugees and local surrounding population (cross ref obj 5)	●		●
iii. Within Refugee and Host Communities 1) Regular HIV multi-sectoral committee meetings that include representatives from government (gov.), NGOs, refugees (e.g. political and religious leaders, women, youth, health and community service workers, surrounding local communities and UN agencies)	iii. 100% of refugee operations with major HIV programmes conduct regular HIV coordination meetings	●		●

[E] For this Plan, defined as those operations where UNHCR and its partners are involved in the provision of HIV and AIDS interventions to ≥10,000 refugees.

3. **Durable Solutions Objective:** To develop and incorporate HIV policies and interventions into UNHCR's programmes for durable solutions** and to mitigate the long term effects of HIV.

Expected Accomplishments	Indicators of Achievement	05	06	07
Repatriation:				
i. specific HIV interventions implemented in three phases of HIV and repatriation programmes				
I. Pre-repatriation	i. I. (a) 100% of country operations undertaking major repatriation operations[F] document refugee workers with HIV-related skills (e.g. health and education) and provide names to NGOs and gov. to ensure skills utilised on return (b) Certificates and letters of recommendation provided to trained refugees to certify acquired skills and experience to facilitate their use upon return to country of origin (c) 100% of country operations undertaking major repatriation operations undertake active public information campaign in capitals and districts of return to reduce discrimination and misinformation (cross ref obj 1 and 4) (d) 100% of country operations undertaking major repatriation operations collect and share pop.-based (not individual) HIV-related information about refugees and pop. in area of return with gov. and organisations involved in HIV policy and programmes (cross ref obj 5) (e) 100% of country operations undertaking major repatriation operations include HIV programmes, with ART[G] where appropriate (cross ref obj 7)	●	●	●
II. During repatriation	i. II. (a) 100% of pregnant women diagnosed as HIV-positive where PMTCT is available in host country but not in country of origin offered treatment for mother and newborn before repatriating (analogous to tuberculosis treatment) (b) 100% of major repatriation operations provide HIV repatriation packages[H] (cross ref obj 6) (c) 100% of returnees who were working on HIV issues (e.g. nurses, community health workers) provided with sufficient IEC materials and condoms for early part of the post-repatriation period if they are not available in the area of return within the country of origin in major repatriation operations (cross ref obj 6)	●	●	●
III. Post- repatriation	i.III.100 % of countries of origin have multi-sectoral and multi-partner HIV plans for whole pop. in areas of return[I]	●	●	●
Resettlement:				
ii. Automatic waivers granted where HIV and AIDS constitutes a bar to resettlement or local integration (cross ref obj 1 and 4)	i. 100% of countries provide automatic waiver to refugees who test positive for HIV for resettlement or local integration	●	●	●
iii. HIV testing required by resettlement countries conducted according to international standards; including confidentiality, pre and post-test counselling, referral and support (cross ref obj 1 and 4)	ii. Reduction in no. of reports of unacceptable HIV-testing practices	●	●	●

** UNHCR's framework for durable solutions; development assistance for refugees (DAR), 4Rs framework (Repatriation, Reintegration, Rehabilitation and Reconstruction), and development through local integration (DLI).

[F] For this plan, defined as repatriation operations with ≥5,000 refugees/year.
[G] UNHCR will develop comprehensive ART policy in 2005.
[H] These include HIV IEC materials in local languages and condoms in a culturally appropriate manner. They can be provided and some HIV training can occur in transit camps in host country or country of origin and may be combined with landmine training, when appropriate.
[I] Many areas of return for repatriated refugees have underdeveloped or nonexistent HIV programmes. Essential services, such as those stated in the IASC guidelines should be implemented, followed by more comprehensive services.

4. **Advocacy Objective:** To advocate for HIV-related protection, policy and programme integration, and sub-regional initiatives for refugees and other persons of concern in a consistent and sustained manner at all levels.

Expected Accomplishments	Indicators of Achievement	05	06	07
i. Increased access to and integration with NACPs for refugees and other persons of concern to UNHCR (cross ref obj 2)	i. (a) Increase from 15 to 23 the no. of countries in sub-Saharan Africa with ≥10,000 refugees (total of 28 in 2005) who include refugees as a target group in their HIV national strategic plans		●	●
	(aa) Gather baseline data, undertake analysis and determine indicator:			
	I. Asia and N. Africa	●		
	II. E. Europe		●	
	(ab) Undertake activities to obtain indicator			
	(b) I. Asia and N. Africa		●	●
	II. E. Europe			●
	Increase from 12 to 20 the no. of countries in sub-Saharan Africa with ≥10,000 refugees (total of 28 in 2005) who submit HIV proposals to major donors which include provisions for refugees (cross ref obj 10)		●	●
	(ba) Gather baseline data, undertake analysis and determine indicator:			
	I. Asia and N. Africa	●		
	II. E. Europe		●	
	(bb) Undertake activities to obtain indicator			
	I. Asia and N. Africa		●	●
	II. E. Europe			●
	(c) Increase from 3 to 20 the no. of countries in sub-Saharan Africa with ≥10,000 refugees (total of 28 in 2005) who provide ART to refugees when host pop. have access to and are being provided ART (cross ref obj 2, 5, 7)		●	●
	(ca) Gather baseline data, undertake analysis and determine indicator:			
	I. Asia and N. Africa	●		
	II. E. Europe		●	
	(cb) Undertake activities to obtain indicator			
	I. Asia and N. Africa		●	●
	II. E. Europe			●
ii. For Protection, see obj 1 (i) and 1 (iii)				
iii. For Coordination and Mainstreaming, including subregional initiatives, see obj 2 (III) (ii) and 2 (IV) (1)				
iv. For Durable Solutions, see obj 3 (i) (I) and 3 (ii)				

5. Quality HIV Programming Objective: To ensure appropriate HIV interventions for refugees, returnees and other persons of concern, in an integrated manner.

Expected Accomplishments	Indicators of Achievement	05	06	07
i. Essential HIV interventions, as stated in IASC matrix (appendix 5) and guidelines,[13] are provided in all refugee situations from onset of an emergency [J] (cross ref obj 1, 3, 6 and 7)	i. 100% of refugee situations where UNHCR is coordinating health and community services have essential HIV interventions		●	●
ii. Provision of similar type of interventions to refugees as that available to local surrounding communities, after essential services have been provided [K] (cross ref obj 1, 3, 6 and 7)	ii. ≥75% of HIV interventions provided to provided to host pop. are provided to refugees, including ART		●	●
iii. Refugee participation at all stages of HIV and AIDS programmes promoted and refugees empowered to take responsibility themselves for HIV prevention (cross ref all objectives)	iii. See obj 2 (IV) (iii)			
iv. HIV programmes targeting refugees also made available to host community, if possible (cross ref all objectives)	See obj 2 (IV) (II) (III)			
v. HIV programmes provided to refugees should conform to host gov. protocols and guidelines as long as they meet internationally accepted standards (cross ref obj 3, 6 and 7)	iv. ≥90% of HIV protocols and guidelines for refugees are the same as those of host gov.		●	●

[J] All commonly accepted HIV prevention, support, care and treatment interventions provided to persons in low resource settings should be provided to refugees, according to phase of emergency and type of services being provided to local surrounding communities (these known interventions will not be listed in this document). Interventions stated in objective 5, 6 and 7 are emphasized because there have been problems noted in their implementation during 2002-04 or because of new global programmes that will affect refugees. They should be provided to refugees and surrounding populations in integrated manner according to stage of emergency. Where UNHCR is not involved in coordinating or implementing of such services, as is often the case with urban refugees compared with refugees in camps, UNHCR must actively advocate for accessible services for refugees in a non-discriminatory manner.

[K] In circumstances where surrounding host community is not receiving these essential services, UNHCR should continue to provide such services to refugees while advocating for, and whenever possible, aiding governments in providing similar services to surrounding local host community. If HIV services provided to surrounding local community are far behind those provided to other populations in sub-region, UNHCR and its partners can provide more advanced services to refugees, while advocating for, and whenever possible, aiding governments in providing such services to surrounding host community.

6. Prevention Objective: To reduce HIV transmission and HIV morbidity.

Expected Accomplishments	Indicators of Achievement	05	06	07
i. Provision of essential HIV prevention programmes[J] in all situations where UNHCR works using the IASC matrix[13] and guidelines as framework	i. (a) 100% of refugee situations have sufficient and accessible culturally appropriate IEC materials in local languages (b) Increased no. of male and female condoms/ person /month[M] (c) 100% of refugee situations are following universal precautions (d) 100% of refugee situations have access to safe blood supply (e) Increased no. of innovative interventions that are unique to refugee circumstances (e.g. IEC during food distribution or census)[14] (f) Increased no. interventions for core groups (e.g. CSWs, MSM, IDUs) (g) Increased no. of harm-reduction programmes	●		●
ii. Implementation of VCT as soon as feasible and qualified and professional counselling ensured[L] (cross ref obj 1 and 7)[17]	ii. (a) Increase from 7 to 15 the no. of country operations where refugees have access to VCT (b) 100% of VCT have systems in place to ensure confidentiality (c) 100% of VCT programmes have established referral system for those found to be HIV positive (d) ≥75% of VCT programmes have post-test clubs (e) ≥75% of country operations with both VCT and tuberculosis (TB) and sexually transmitted infection (STI) programmes have established bilateral links	●		●
iii. Implementation of prevention of mother-to-child transmission (PMTCT) programmes as soon as feasible in conjunction with host gov. programmes	iii. Increase from 6 to 12 the no. of country operations where refugees have access to PMTCT	●		●
iv. Implementation of sexual violence education programmes in coordinated and comprehensive manner (cross ref obj 1)[18]	iv. (a) Increase from 1 to 7 the no. of country operations where refugees have access to PEP[N] (b) Same as obj 1 (iv)	●		●
v. Provision of prophylaxis of opportunistic infections (OIs) for PLWH/As	v. ≥50% of country operations with major HIV programmes provide trimethoprim-sulfamethoxazole prophylaxis for children and adults[19]	●		●

[L] VCT is the gateway to HIV prevention as well as support, care and treatment. Availability of ART is not a prerequisite for establishing VCT.

[M] Community-based condom education and distribution in a confidential manner with increased accessibility

[N] Post-exposure prophylaxis (PEP) for rape survivors has now been implemented in some refugee situations. The introduction of PEP in all refugee situations should be encouraged.

7. **Support, Care and Treatment Objective:** To reduce HIV morbidity and mortality.

Expected Accomplishments	Indicators of Achievement	05	06	07
i. Provision of essential HIV support, care and treatment programmes[J] in all situations where UNHCR works using the IASC matrix and guidelines as framework[13]	i. (a) ≥75% of UNHCR operations that support health clinics employ proper diagnosis and treatment of STIs using a syndromic approach (b) ≥ 60% of partners of STI patients notified and treated	●	—	●
ii. Establishment of multi-disciplinary teams to deliver home-based and palliative care programmes using a community-based approach in confidential manner (to all persons living with chronic illness and not just PLWH/As).	ii. Increase from 5 to 10 country operations with major HIV programmes that provide multi-disciplinary home-based care programmes	●	—	●
iii. Accessible and appropriate care for cases of sexual violence should be implemented in a confidential and caring manner	iii. (a) Increased percentage of refugee pop. that have access to confidential care and treatment (b) Incidence of reported cases of sexual violence (c) ≥90% of reported survivors of rape received appropriate care and treatment in a confidential manner (including PEP in country operations that provide PEP)	●	—	●
iv. Availability and accessibility of long term ART to refugees when it is accessible to the local host pop. (cross ref obj 2 and 4)	iv. Same as obj 5 (i)			
v. Early identification of refugee children made vulnerable by HIV and AIDS to provide necessary support, initiate family tracing and family reunification processes, and to work towards an appropriate durable solution	v. Increased no. of programmes with interventions for orphans and unaccompanied minors	●	—	●
vi. Capacity-strengthening of communities to better support, treat and care its members affected and infected by HIV and AIDS	vi. Same as obj 1 (iii), (v), (vi); 2 (iii); 3 (i); 5; 6; 7; and 9 (iii)			
vii. Provision of sufficient and appropriate macro and micro nutrients according to international standards	vii. Use indicators listed in UNHCR and WFP's programme strategies manual[14] according to context	●	—	●

8. **Assessment, Surveillance, Monitoring and Evaluation Objective:** To improve programme implementation and evaluation.

Expected Accomplishments	Indicators of Achievement	05	06	07
i. Implementation of standardized assessments[O]	i. ≥90% of HIV assessments are undertaken using UNHCR's framework for assessing HIV in all refugee situations (appendix 6)	●		●
ii. Develop and implement practical and informative HIV Information System (HIVIS)[P] (cross ref all obj)	ii. (a) Finalization of HIVIS	●		
	(b) Field test HIVIS	●	●	
	(c) Implementation of HIVIS in ≥15 country operations		●	●
iii. Dissemination of lessons learned from HIV programmes within UNHCR and to its partners together with regular feedback to those involved in providing HIV interventions (cross ref all obj)	iii. (a) Publish UNHCR-UNAIDS Best Practise document	●		
	(b) Publish UNHCR Field Experience document on PEP	●		
	(c) 100% mission reports are disseminated to involved countries and UNHCR's HIV focal points	●		●
iv. Continue programmatic research[Q] (cross ref all obj)	iv. (a) Implement HIV-food-nutrition research field studies with WFP[14]	●	●	
	(b) Effects of interactions among armed groups, conflict-affected pop. (displaced and non-displaced pop). and surrounding communities on intra-country and inter-country HIV transmission	●		●
	(c) Methods to improve integration of HIV programmes in displaced and non-displaced pop	●		●
	(d) Development of innovative prevention, care and support strategies that utilize the unique context of conflict settings (e.g., food distribution, reception centres, censuses)	●		●
	(e) Provision and compliance of ART including PEP to refugees following sexual violence or occupational exposure, PMTCT, and long term ART	●		●

[O] Standardization allows for comparison among different situations as well as trends over time during same situation

[P] HIVIS allows for standardized supervision, monitoring and evaluation of HIV interventions using input, process and outcome indicators. It consists of 3 components: 1) Surveys, including sentinel surveillance and modified BSS with displacement and post-displacement/interaction component. Whenever possible, surveys should be undertaken among refugee and local surrounding host population communities; 2) Health system and protection reporting; and 3) HIV programme onsite inspection tool [previous experience has shown that certain HIV-related activities cannot be consistently and reliably reported and need onsite inspection (e.g. coordination meetings, supply chain disruptions, universal precautions)]. The HIVIS is consistent and compatible with other established HIV monitoring and evaluation systems and their indicators.

[Q] Sentinel surveillance and BSS are not considered programmatic research but essential for programme intervention and evaluation.

9. **Training and Capacity Building Objective:** To improve HIV and related skills and capacities of UNHCR, its partners and refugees.

	Expected Accomplishments		Indicators of Achievement	05	06	07
i.	Training and capacity building re: HIV knowledge and skills within UNHCR increased	i.	(a) HIV component included in protection and resettlement training workshops and courses (b) HIV component included in general staff training (e.g. OMLP and workplace policy) (c) ≥1 HIV sub-regional workshop/yr (d) Same as obj 1 (v) (c)	●	●	●
ii.	Training and capacity building re: HIV knowledge and skills of international and national partners increased	ii.	(a) Increase no. and type of HIV training courses provided (e.g. clinical AIDS diagnosis, syndromic STI diagnosis and treatment, VCT) (b) ≥1 HIV sub-regional workshop/yr	●	●	●
iii.	Training and capacity building re: HIV knowledge and skills of refugees increased	iii.	Increased no. and type of HIV training workshops provided to specific groups	●	●	●
iv.	Integration in field trainings of persons providing services for refugees as well as local surrounding pop.	iv.	(a) Increased percentage of integrated HIV trainings and workshops at country and field level that included personnel working with refugees as well as local host pop. (b) Increased percentage of integrated HIV workshops at field level that included refugees as well as local host pop.	●	●	●
v.	Functioning HIV and workplace policy and programme developed for UNHCR staff and their families that includes ART (cross ref obj 6 and 7)	v.	(a) Development of UNHCR HIV workplace policy (b) Implementation of UNHCR HIV workplace policy (c) ≥90% of UNHCR staff and their families in all duty stations have access to post-exposure prophylaxis (PEP)	●	●	●

10. **Resource Mobilization Objective:** To increase funds and move beyond traditional donors to ensure the objectives stated in this Strategic Plan are achieved.

	Expected Accomplishments		Indicators of Achievement	05	06	07
i.	Continuation of headquarters' HIV project (VAR) to allow for provision of additional HIV funds to various country offices as programme expands	i.	Yearly increase in headquarters' VAR project	●	—	●
ii.	Continuation of advocacy efforts with major donors to have refugees included in country proposals where applicable, and to facilitate sub-regional approaches[18]	ii.	(a) Increased no. of funded host country and sub-regional proposals that include refugees (b) Same as obj 2 (III) (ii) (d) (c) Same as obj 4 (i) (b)	●	—	●
iii.	Promotion of bilateral funding by donors to UNHCR's partners with coordination, monitoring and evaluation by UNHCR	iii.	Percentage increase in funded HIV host country and sub-regional proposals for refugees provided to UNHCR's partners compared to previous years.	●	—	●

[18] Major donors include but are not limited to: 1) governments who provide funds bilaterally to host countries and those with repatriation or durable solutions programmes; 2) World Bank which has funded GLIA and refugees and returnees in Democratic Republic of Congo's Multi-country AIDS programme; 3) Global Fund to Fight AIDS, Tuberculosis and Malaria; 4) U.S. President's Emergency Plan for AIDS Relief; 5) African Development Bank who has funded the Mano River Union Initiative on AIDS and the Oubangui-Chiari Initiative on AIDS; and 6) Private organizations and corporations.

Appendix 1: Acronyms

4Rs	Repatriation, Reintegration, Rehabilitation and Reconstruction
AIDS	Acquired Immunodeficiency Disease Syndrome
ART	Antiretroviral therapy
BSS	Behavioural Surveillance Surveys
CSW	Commercial Sex Worker
DAR	Development Assistance for Refugees
DLI	Development through Local Integration
HIV	Human Immunodeficiency Virus
HIVIS	HIV Information System
IASC	Inter-Agency Standing Committee
IDPs	Internally Displaced Persons
IDUs	Intravenous Drug Users
IEC	Information-Education-Communication
MDG	Millennium Development Goals
MSM	Men having Sex with Men
NACP	National AIDS Control Programme
NGO	Non-governmental Organization
OHCHR	Office of the High Commissioner for Human Rights
OI	Opportunistic Infection
PEP	Post-Exposure Prophylaxis
PLWH/As	People living with HIV and AIDS
PMTCT	Prevention of Mother-to-Child Transmission
STI	Sexually Transmitted Infection
TB	Tuberculosis
UBW	Unified Budget Workplan
UN	United Nations
UNAIDS	United Nations Joint Programme for HIV/AIDS
UNGASS	United Nations General Assembly Special Session
UNHCR	United Nations High Commissioner for Refugees
UNSSP	United Nations System Strategic Plan
VCT	Voluntary Counselling and Testing

HIV/AIDS AND REFUGEES

UNHCR's Strategic Plan

2002 - 2004

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

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

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

A. INTRODUCTION

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

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

B. UNHCR's OBJECTIVES

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

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

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

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

- Undertake standardised situational and theoretical cost analyses to be used as planning tools in the field (documents developed and available upon request).
- Assess existing or new HIV/AIDS programmes and design effective projects based upon results.[f]

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

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

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

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

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

- Promote basic HIV/AIDS programmes in all refugee situations based upon various components within the following three broad areas:

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

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

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

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

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

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

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

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

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

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

C. IMPORTANT FACTORS FOR CONSIDERATION

1. The linkage between the protection of human rights and effective HIV/AIDS programmes is apparent as people will not seek HIV-related counselling, testing, treatment and care if lack of confidentiality, discrimination, refoulement, restrictions to freedom of movement, or other negative consequences exist. For these reasons, an essential component of a comprehensive response is the facilitation and creation of a legal and ethical environment which is protective of human rights.
2. HIV/AIDS is not just a health issue but a problem that affects the socio-cultural fabric, human rights and long-term economic well-being of refugees. Thus, it is fundamental to develop multi-sectoral and multi-partner approaches. It is essential to work in close partnership with various national, regional and international actors, including the refugees themselves, to establish effective programmes.
3. Implementation of HIV/AIDS programmes in emergency situations is essential. However, donors and partners must recognise that HIV/AIDS is primarily a development issue that requires long-term commitment to improve the health and well-being of individuals and their communities.
4. Women, in particular adolescent girls, as well as young people are vulnerable groups at high risk of infection and special attention must be focused upon them when designing programmes. Other high-risk groups that facilitate the infection to the broader community, such as commercial sex workers and intravenous drug users, also need to be targeted. Programmes targeting AIDS orphans are also necessary.
5. In strengthening existing or creating new HIV/AIDS programmes for refugees, it is crucial to recognise the limited technical and financial resources of most asylum countries, which generally cannot meet the needs of their own population let alone contribute to refugee programmes.
6. The introduction of Prevention of Mother to Child Transmission (PMTCT) and Anti-retroviral (ARV) treatment programmes pose significant challenges, and consideration must be given to the related technical and financial factors before implementation of such programmes.

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

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

D. MAIN STRATEGIES (2002-2004)

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

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

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

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

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

- Regional Bureaux and DOS will identify and establish HIV/AIDS focal points in various countries. In addition, regional technical consultants will be identified in each of the three broad HIV/AIDS categories (outlined in section B.1, 3rd bullet) and put at the disposal of the pilot sites, as well as other countries with existing HIV/AIDS programmes (see Organisational Structure chart -Appendix 2). Both HIV/AIDS focal points and consultants may be employed by UNHCR or its partners.
- The HIV/AIDS ExCom Advisory Group (see Appendix 3) will serve as an advocacy and support group, while the Inter-Agency Working Group on Reproductive Health (some 25 NGOs and UN agencies), as well as other partners, will provide access to technical support at the regional and country level.
- The Inter-Agency HIV/AIDS working group in Emergency Settings, chaired by WHO, will provide technical assistance to UNHCR and its partners. An expert group on HIV/AIDS and Refugees will be created to help UNHCR in planning for its HIV/AIDS programmes and to provide technical advice.
- UNHCR will establish close links with UN Theme Groups and NACPs to encourage them to include refugees in their mandates. UNHCR will follow the policies of NACPs in their respective countries. Where available, UNHCR will use NACPs' technical resources and, where needed, will assist in their technical capacity building efforts.
- UNHCR will further enter into partnership, when feasible and as needed, with UNAIDS and its co-sponsors (UNFPA, UNICEF, World Bank, UNESCO, UNDP, ILO, UNDCP and WHO), bi-lateral donors at central, regional and local levels, regional bodies (e.g. African Union, ECOWAS), and UNHCR's partners.[h]
- Major emphasis will be placed on building the capacity of local partners and refugees. Successful implementation of HIV/AIDS programmes will help to strengthen other existing programmes and enable the creation of new programmes.[i]

4. Continue to support current HIV/AIDS programmes.

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

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

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

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

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

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

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

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

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

6. Limited scope of UNHCR activities in returnee situations.

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

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

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

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

7. Access additional financial resources.

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

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

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

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

  iii. Seek access to the UN Secretary-General's Global Fund for HIV/AIDS, Tuberculosis and Malaria with partners, governments and private organisations.

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

APPENDICES NOT INCLUDED

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

Appendix 3: Mission Reports

1. Spiegel P. HIV/AIDS in Refugee Camps: Kenya and Tanzania. Geneva: United Nations High Commissioner for Refugees, June 2002.
2. Spiegel P. HIV/AIDS in Uganda Refugee Settlements. Geneva: United Nations High Commissioner for Refugees, October 2002.
3. Bruns L, Spiegel P. Assessment of HIV/AIDS Programmes among Refugees in South Africa, Namibia and Zambia. Pretoria: United Nations High Commissioner for Refugees, March 2003.
4. Spiegel P, Jong de E. HIV/AIDS and Refugees/Returnees. Luanda: United Nations High Commissioner for Refugees, April 2003.
5. Schilperoord M, Musse A. Assessment of HIV/AIDS Programmes among Refugees in Kenya, Tanzania and Uganda. Geneva: United Nations High Commissioner for Refugees, May 2003.
6. Musse A. HIV/AIDS Programmes among Refugees in Ethiopia. Addis Ababa: United Nations High Commissioner for Refugees, June 2003.
7. Njogu P. Assessment of HIV/AIDS programmes in Uganda. Addis Ababa: United Nations High Commissioner for Refugees, July 2003.
8. Kalala JP. HIV/AIDS assessment and training in Mozambique by PPASA. Pretoria: United Nations High Commissioner for Refugees, October 2003.
9. Njogu P. HIV/AIDS Mission Report: Refugee Settlements in Uganda. Addis Ababa: United Nations High Commissioner for Refugees, November 2003.
10. Yiweza DD, Spiegel B, Celibacy. Etat des lieux des programmes VIH/SIDA en faveur des réfugiés en République démocratique du Congo et en République du Congo. Novembre 2003.
11. Njogu P. HIV/AIDS Assessment Mission in Refugee Camps in El-Showak, Sudan. Addis Ababa: United Nations High Commissioner for Refugees, February 2004.
12. Bruns L. Monitoring Mission: HIV/AIDS Programmes in Refugee Camps in Zambia. Pretoria: United Nations High Commissioner for Refugees, February 2004.
13. Yiweza DD. Etat des lieux des programmes VIH/SIDA en faveur des réfugiés au Rwanda et au Burundi. Kinshasha : HCR, février 2004.
14. Bruns L, Bonelli F. HIV/AIDS Programmes in Returnee Areas in Angola: Monitoring and Support Mission. Pretoria: United Nations High Commissioner for Refugees, April 2004.
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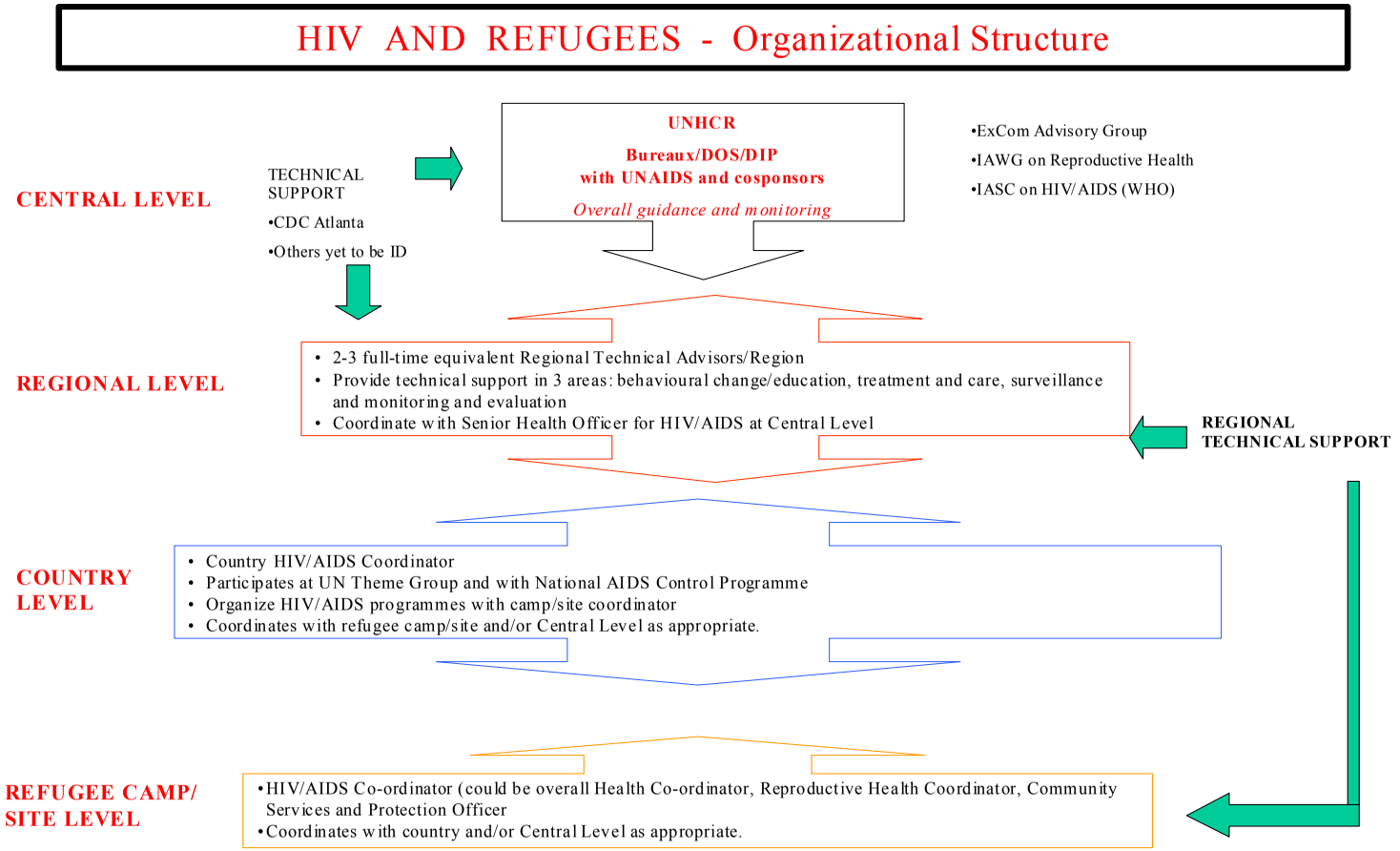
Appendix 4: HIV and Refugees - Organizational Structure



Appendix 5: HIV/AIDS Interventions in Emergency Settings Matrix

Sectoral Response	Emergency preparedness	Minimum response (to be conducted even in the midst of emergency)	Comprehensive response (Stabilized phase)
1. Coordination	• Determine coordination structures • Identify and list partners • Establish network of resource persons • Raise funds • Prepare contingency plans • Include HIV/AIDS in humanitarian action plans and train accordingly relief workers	1.1 Establish coordination mechanism	• Continue fundraising • Strengthen networks • Enhance information sharing • Build human capacity • Link emergency to development HIV action • Work with authorities • Assist government and non-state entities to promote and protect human rights[4]
2. Assessment and monitoring	• Conduct capacity and situation analysis • Develop indicators and tools • Involve local institutions and beneficiaries	2.1 Assess baseline data 2.2 Set up and manage a shared database 2.3 Monitor activities	• Maintain database • Monitor and evaluate all programmes • Assess data on prevalence, knowledge attitudes and practice, and impact of HIV/AIDS • Draw lessons from evaluations
3. Protection	• Review existing protection laws and policies • Promote human rights and best practices • Ensure that humanitarian activities minimize the risk of sexual violence, and exploitation, and HIV-related discrimination • Train uniformed forces and humanitarian workers on HIV/AIDS and sexual violence	3.1 Prevent and respond to sexual violence and exploitation 3.2 Protect orphans and separated children 3.3 Ensure access to condoms for peacekeepers, military and humanitarian staff	• Involve authorities to reduce HIV-related discrimination • Expand prevention and response to sexual violence and exploitation • Strengthen protection for orphans, separated children and young people • Institutionalize training for uniformed forces on HIV/AIDS, sexual violence and exploitation, and non-discrimination • Put in place HIV-related services for demobilized personnel • Strengthen IDP/refugee response
4. Water and sanitation	• Train staff on HIV/AIDS, sexual violence, gender, and non-discrimination	4.1 Include HIV considerations in water/sanitation planning	• Establish water/sanitation management committees • Organize awareness campaigns on hygiene and sanitation, targeting people affected by HIV
5. Food security and nutrition	• Contingency planning/preposition supplies • Train staff on special needs of HIV/AIDS affected populations • Include information about nutritional care and support of PLWHA in community nutrition education programmes • Support food security of HIV/AIDS-affected households	5.1 Target food aid to affected and at-risk households and communities 5.2 Plan nutrition and food needs for population with high HIV prevalence 5.3 Promote appropriate care and feeding practices for PLWHA 5.4 Support and protect food security of HIV/AIDS affected & at risk households and communities 5.5 Distribute food aid to affected households and communities	• Develop strategy to protect long-term food security of HIV affected people • Develop strategies and target vulnerable groups for agricultural extension programmes • Collaborate with community and home based care programmes in providing nutritional support • Assist the government in fulfilling its obligation to respect the human right to food
6. Shelter and site planning	• Ensure safety of potential sites • Train staff on HIV/AIDS, gender and non-discrimination	6.1 Establish safely designed sites	• Plan orderly movement of displaced

Sectoral Response	Emergency preparedness	Minimum response (to be conducted even in the midst of emergency)	Comprehensive response (Stabilized phase)
7. Health	• Map current services and practices • Plan and stock medical and RH supplies • Adapt/develop protocols • Train health personnel • Plan quality assurance mechanisms • Train staff on the issue of SGBV and the link with HIV/AIDS • Determine prevalence of injecting drug use • Develop instruction leaflets on cleaning injecting materials • Map and support prevention and care initiatives • Train staff and peer educators • Train health staff on RH issues linked with emergencies and the use of RH kits • Assess current practices in the application of universal precautions	7.1 Ensure access to basic health care for the most vulnerable 7.2 Ensure a safe blood supply 7.3 Provide condoms 7.4 Institute syndromic STI treatment 7.5 Ensure IDU appropriate care 7.6 Management of the consequences of SV 7.7 Ensure safe deliveries 7.8 Universal precautions	• Forecast longer-term needs; secure regular supplies; ensure appropriate training of the staff • Palliative care and home based care • Treatment of opportunistic infections and TB control programmes • Provision of ARV treatment • Safe blood transfusion services • Ensure regular supplies, include condoms with other RH activities • Reassess condoms based on demand • Management of STI, including condoms • Comprehensive sexual violence programmes • Control drug trafficking in camp settings • Use peer educators to provide counselling and education on risk reduction strategies • Voluntary counselling and testing • Reproductive health services for young people • Prevention of mother to child transmission • Enable/monitor/reinforce universal precautions in health care
8. Education	• Determine emergency education options for boys and girls • Train teachers on HIV/AIDS and sexual violence and exploitation	8.1 Ensure children's access to education	• Educate girls and boys (formal and non-formal) • Provide life skills-based HIV/AIDS education • Monitor and respond to sexual violence and exploitation in educational settings
9. Behaviour communication change and information education communication	• Prepare culturally appropriate messages in local languages • Prepare a basic BCC/IEC strategy • Involve key beneficiaries • Conduct awareness campaigns • Store key documents outside potential emergency areas		• Scale up BCC/IEC • Monitor and evaluate activities
10. HIV/AIDS in the workplace	• Review personnel policies regarding the management of PLWHA who work in humanitarian operations • Develop policies when there are none, aimed at minimizing the potential for discrimination • Stock materials for post-exposure prophylaxis (PEP)	10.1 Prevent discrimination by HIV status in staff management 10.2 Provide post-exposure prophylaxis (PEP) available for humanitarian staff	• Build capacity of supporting groups for PLWHA and their families • Establish workplace policies to eliminate discrimination against PLWHA • Post-exposure prophylaxis for all humanitarian workers available on regular basis

Appendix 6: Standardized Situational Framework to Analyse HIV Programmes

1) **Background**
   a) Refugee situation
   b) HIV situation in country or origin and host country (use UNAIDS/WHO country epidemiological fact sheets (http://www.who.int/GlobalAtlas/PDFFactory/HIV/index.asp); use sentinel sites nearest to areas where refugees left in country of origin and live in host country; should add map (see figure below)
   c) HIV situation in refugee context

2) **Funding**
   a) Does host country have access to MAP, GFATM, PEPFAR or other sources of funds?
   b) Do refugees benefit from them and how can they?

3) **Policy**
   a) Existing National AIDS Control Policy, Guidelines and Manuals.
   b) Displaced persons specifically targeted as a vulnerable population under National AIDS Control Programme Policy.

4) **Protection**
   a) No mandatory HIV testing of displaced persons under any circumstances.
   b) No denial of access to asylum procedure, refoulement or denial of right to return on basis of HIV status.
   c) When required by resettlement countries, HIV testing conducted in accordance with established standards (i.e. accompanied by pre- and post test counselling and appropriate referral for follow up support and services).
   d) No laws or regulations prohibiting refugee access to public sector HIV/AIDS programmes in countries of asylum.
   e) Specific programmes in place to combat stigma and discrimination against people living with HIV/AIDS.
   f) Programmes in place to prevent and respond to sexual violence.*

5) **Urban vs. Camp/Site refugees:**
   a) Describe below activities separately for urban compared to camp/site refugees.

6) **Coordination and Supervision**
   a) Regular meetings among implementing partners in field and in capital.
   b) HIV/AIDS programmes specifically included in planning, implementation, monitoring and evaluation stages of programme cycle.
   c) Regular attendance at meetings of UN Theme Group on HIV/AIDS and associated Technical Working Groups at capital level.
   d) HIV/AIDS Coordinating Committee at camp/site level (including key members/groups of community as well as representatives from host surrounding communities)

7) **Prevention**
   a) Safe blood supply.
   b) Universal precautions.
   c) Condom promotion and distribution.
   d) Behavioural change and communication
      i) Development of educational/ awareness materials in appropriate languages
      ii) Programmes for in-school and out-of-school youth
      iii) Peer education
      iv) Youth centres
      v) Sports/ drama groups
      vi) Programmes aimed at reducing teen pregnancy and combating sexual violence.
   e) Integration with local surrounding host communities
   f) Uniformed services
   g) Voluntary counselling and testing.*
   h) Prevention of mother-to-child transmission.
   i) Prophylaxis of opportunistic infections.
   j) Post-exposure prophylaxis.

* Activity has both prevention as well as care and treatment components

8) Care, Support and Treatment

a) Sexually transmitted infections.*
b) Opportunistic infections, including tuberculosis.
c) Tuberculosis
d) Food and Nutrition.*
e) Home-based care.
f) People living with HIV/AIDS.
g) Orphans and child-headed households.
h) Anti-retroviral therapy

9) Surveillance, Monitoring and Evaluation

a) Behavioural surveillance surveys.
b) AIDS clinical case and mortality reporting.
c) Blood donors.
d) Syphilis among antenatal clinic attendees.
e) Sexually transmitted infections (by syndrome).
f) Condom distribution.
g) Opportunistic infections, including incidence of pulmonary tuberculosis.
h) HIV sentinel surveillance among pregnant women and high risk groups such as those attending sexually transmitted infection clinics.
i) Voluntary counselling and testing.
j) Prevention of mother-to-child transmission.
k) Sexual violence.
l) Post-exposure prophylaxis.

10) Data

a) For each camp/site, at a minimum fill in the data requested below (one column is filled in as an example):

	Country
	Name of Camp/Site
Total population	7,331
Mortality Rates (MR)	
Crude MR (deaths/10,000/day)[1]	0.28
<5 yrs MR (deaths/10,000/day)[2]	0.94
Universal precautions	
sufficient[3] needles / syringes	Yes
sufficient[3] gloves	Yes
blood transfusion screened for HIV	Yes
STI data	
No of condoms distributed[4]	0.3
sufficient[3] condoms	Yes
sufficient[3] STI drugs	Yes
STI syndromic approach	Yes
incidence male urethral discharge (new cases/1000 males/month)	73.00
incidence genital ulcer disease (new cases/1000 persons/month)	1.00
% syphilis pregnant women 1st visit ANC	SNP
VCT	
Access to VCT	No
PMTCT	
Access to PMTCT	No
# persons pre test counseling	NA
% PMTCT uptake # 1[5]	NA
% PMTCT uptake # 2[6]	NA
% HIV prevalence of PMTCT clients	NA
Sentinel surveillance among pregnant women	SNP
Latest HIV or RH BSS/KAPB	May 2004

[1] baseline in sub-Saharan Africa for non-emergency is 0.5 deaths/10,000/day

[2] baseline for sub-Saharan Africa is 1.0 deaths/10,000/day

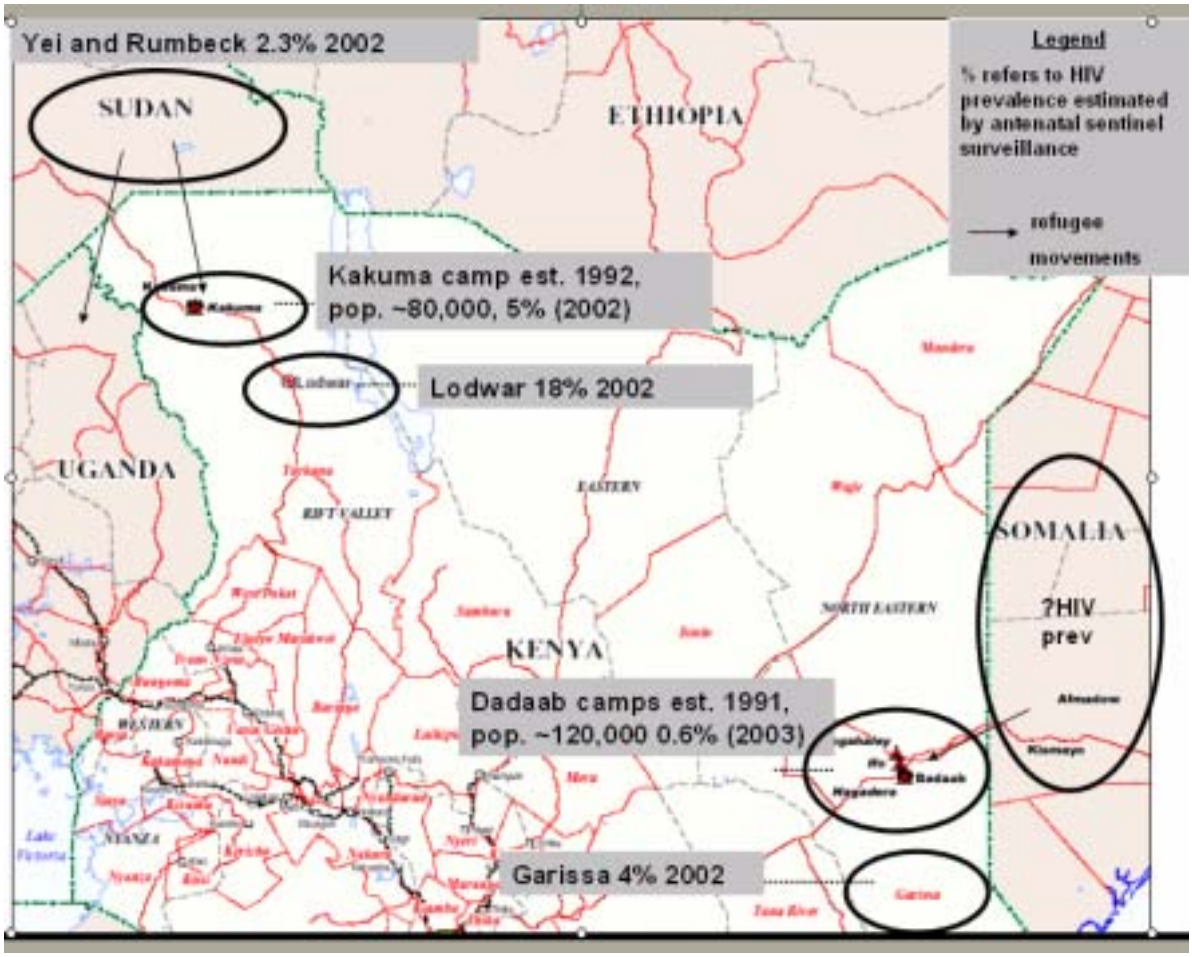
[3] sufficient supply defined as no stock out of >1 week at anytime during the past year

[4] goal for emergency phase is 0.5 condoms/person/month and for non-emergency phase is 1.0 condoms/person/month

[5] # women who counseled on MTCT an offered voluntary test /# women who had 1st ANC visit =%

[6] # women who counseled on MTCT, offered voluntary test during 1st ANC visit and accepted test /# women who had 1st ANC visit, were counseled on MTCT and offered voluntary test =%

SNP=service not provided; NR = not reported; RI = reported incorrectly; NA = not applicable


Yei and Rumbeck 2.3% 2002
SUDAN
ETHIOPIA
Legend
% refers to HIV prevalence estimated by antenatal sentinel surveillance
refugee movements
Kakuma camp est. 1992, pop. ~80,000, 5% (2002)
Lodwar 18% 2002
UGANDA
KENYA
SOMALIA
?HIV prev
Dadaab camps est. 1991, pop. ~120,000 0.6% (2003)
Garissa 4% 2002

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