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**HIV/AIDS among Conflict-Affected and Displaced Populations:
Dispelling Myths and Taking Action**

SUMMARY

Conflict, displacement, food insecurity and poverty make affected populations more vulnerable to HIV transmission. However, the common assumption that this vulnerability *necessarily* translates into more HIV infections and consequently fuels the HIV/AIDS epidemic is not supported by data. Whether or not conflict and displacement affect HIV transmission depends upon numerous competing and interacting factors. This paper further explores and explains the epidemiology of HIV/AIDS in conflict.

There are some unique characteristics that must be specifically addressed when planning and implementing HIV/AIDS interventions among populations affected by conflict as compared with those in resource poor settings. These issues in the areas of protection, vulnerable groups, programming, coordination and integration are discussed throughout this article. Frameworks for assessment, monitoring and evaluation are provided to improve standardisation and comparability of HIV/AIDS interventions and their effectiveness among conflict-affected populations over time as well as among different conflict settings. Areas for future HIV/AIDS operational research in conflict are provided.

Recommendations in this paper are limited to those that are actionable and targeted primarily at the United Nations System and specifically at members of the IAAG. These include 1) Field testing and evaluating the newly developed guidelines for HIV/AIDS interventions in emergency settings as well as developing actions sheets for the other phases of emergencies in the guidelines; 2) Including conflicted-affected and displaced populations in national HIV/AIDS strategic plans, proposals and interventions; 3) Implementing pilot projects for comprehensive HIV/AIDS interventions among such populations; and 4) Holding of a multi-stakeholder 'HIV/AIDS and Conflict' meeting in 2004 to address these and other issues raised in this paper. The IAAG is requested to consider the actions proposed in the recommendations section, to amend as necessary, and then to agree and to adopt them as they see fit.

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INTRODUCTION

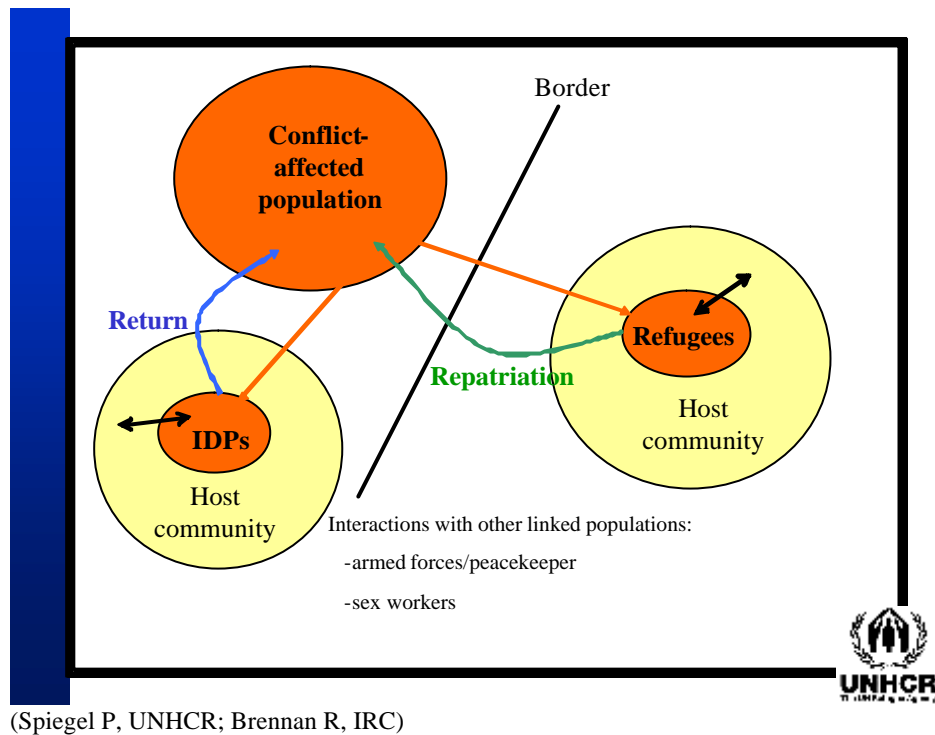
Conflict, displacement, food insecurity and poverty have the potential to make affected populations more vulnerable to human immunodeficiency virus (HIV) transmission. The United Nations (UN) General Assembly (UNGASS) passed the Declaration of Commitment on HIV/Acquired immunodeficiency syndrome (AIDS) in June 2001, stating that “populations destabilised by armed conflict...including refugees, internally displaced persons, and in particular women and children, are at increased risk of exposure to HIV infection”.¹ However, the common assumption that this vulnerability *necessarily* translates into more HIV infections and consequently fuels the HIV/AIDS epidemic is not supported by data. Whether or not conflict and displacement affect HIV transmission depends upon numerous competing and interacting factors.

Since the end of the cold war, armed conflicts, defined as open, armed clashes between two or more centrally organised parties, with continuity between the clashes, in disputes about power over government and territory,² have changed from being primarily interstate to intrastate. Of the 118 armed conflicts in over 80 states that occurred worldwide from 1990 to 1999, 10 (9%) can be defined as interstate conflicts while 100 (85%) were primarily or exclusively internal conflicts. The war in the Democratic Republic of Congo (DRC) was the only multi-state armed conflict in the 1990s. This increase in intrastate armed conflict brings new challenges to the international community as issues of sovereignty are involved and consequently access to affected populations may be reduced (e.g. Chechnya).

Hundreds of millions of persons are currently affected worldwide by armed conflict, both directly and indirectly. Conflict sends people fleeing to seek refuge either within their own country as internally displaced persons (IDPs) or across an international border to become refugees. By the end of 2002, there were approximately 40 million displaced persons globally; 15 million refugees^{3,4} and 25 million IDPs.⁵ Many other persons are affected by the devastating consequences of conflict while remaining in their homes, however, their numbers are not known.

Sub Saharan Africa (SSA) is disproportionately affected by the HIV/AIDS epidemic, poverty and armed conflict. In areas with high HIV prevalence and conflict, such as in SSA, HIV/AIDS may act as a double edged sword. The epidemiology of HIV/AIDS during conflict is complicated, but conflict has been shown to be associated with several factors that render affected populations more vulnerable to HIV transmission. In addition, HIV/AIDS may reduce the coping mechanisms and resilience of populations affected by conflicts. While persons affected by conflict do not necessarily have high HIV prevalence rates, they are inextricably linked to any successful effort to combat the catastrophic epidemic and must be included in all HIV/AIDS programming.⁶ Forced migrant populations have complex interactions with various communities and high risk groups with who they come into contact (figure 1).

Figure 1: Possible Forced Migration in Conflict Situations



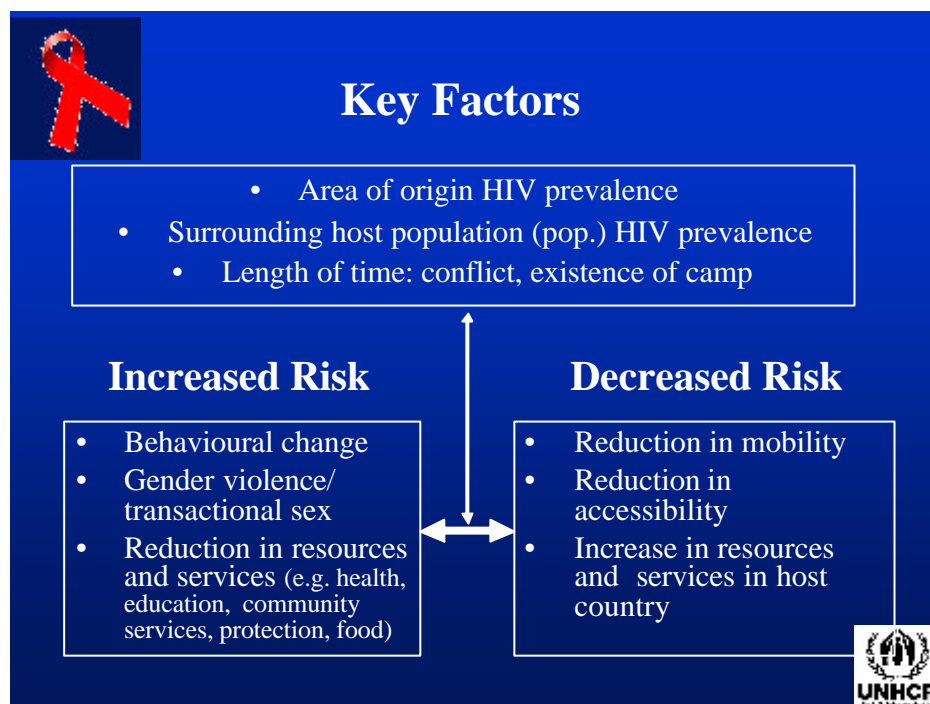
HIV/AIDS EPIDEMIOLOGY

The complex relationship between HIV/AIDS and conflict is still not well described. Many recent publications have asserted that conflict is directly associated with an increase in HIV/AIDS transmission.⁷⁻¹² One paper even claimed that women are six times more likely to contract HIV in a refugee camp than the general population outside of the camp.¹³ However, when one examines available data, the picture is not so simple or uniform. It must be clearly recognised at the outset that collecting data during and after conflict is difficult and fraught with biases.^{14,15} Therefore, analysis and interpretation of these data must be undertaken carefully and biases clearly stated.

Factors that increase conflict affected and forced migrant populations vulnerability are well documented.^{7,16-18} These include breakdown in social structures, lack of income and basic needs, sexual violence and abuse, and lack of health infrastructure and education. However, factors that may decrease HIV transmission in such situations are rarely considered. These include reduced mobility and accessibility (e.g. destroyed infrastructure reducing travel to high prevalence urban areas, displacement to remote locations and surviving in the “bush”) and in the case of many refugee camps, improved protection, health, education, and social services. Finally, all of this is dependent upon the HIV prevalence among the affected community pre-conflict, the HIV prevalence among the surrounding community for those who have been displaced, exposure to violence during conflict and flight, and the level of interaction between the two communities. Complicating these factors are the duration of the conflict and the length of time the displaced population has resided in a particular camp (figure 2). The former may keep persons isolated and inaccessible for years while the latter, depending upon the camps location, may have the same

result. Furthermore, long term post emergency refugee camps generally have better preventive and curative health services than the surrounding local populations.¹⁹

Figure 2: HIV Risk Factors for Conflict and Displaced Persons Camps



(Spiegel P, UNHCR, 2003)

An analysis of available data has made it possible to describe several different scenarios in which the relationship between HIV/AIDS and conflict presents different epidemiological patterns:

i. Prolonged Conflict Retarding the Progression of HIV

Population-based HIV behavioural and biological surveillance surveys from the Centers for Disease Control and Prevention have shown lower than expected HIV prevalence rates in Sierra Leone (0.9% in accessible areas covering 79% of the population and Southern Sudan (2.3% HIV prevalence among pregnant women in antenatal clinics in both Yei and Rumbek)^{20,21} These HIV prevalence rates are lower than all of the surrounding countries, respectively, many of which have not been in conflict. Prior to these studies, both Sierra Leone and Southern Sudan had been in a protracted conflict situations for many years. Part of their populations were often isolated for long periods of time as accessibility and mobility were severely limited. Low HIV prevalence rates relative to surrounding countries have also been reported in Angola, another country that endured decades of civil war.²²

Although sexual violence was reportedly high throughout all three wars, especially in Sierra Leone, the relatively low prevalence of the virus among the pre-war populations and possibly the paramilitaries may not have been sufficient to accelerate the HIV infection among the entire population. Although sexual violence increases HIV transmission because of increased lacerations, the pre-requisite that the assailant(s) must be HIV positive remains. Furthermore, the number of persons raped who then become

HIV positive must be compared to the total number of persons in the country to estimate how these horrific acts will affect the HIV incidence and prevalence in a country.

ii. Conflict Increasing the Progression of HIV

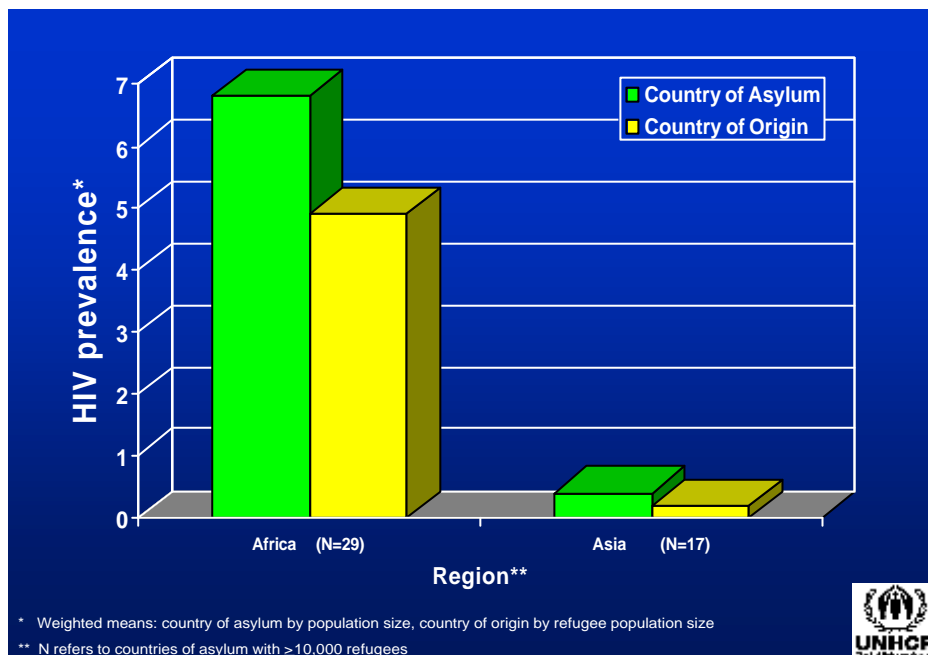
Increases in HIV infection among the general population in Eastern DRC (HIV prevalence between 15-24%), primarily due to massive sexual violence by paramilitary groups as well as foreign militaries (e.g. Rwanda, Uganda) and a breakdown of health services, have been reported.^{23,24} However, given the current instability in Eastern DRC, the quality of the data in these studies can be challenged.

In another scenario, there is concern that if the instability in the Ivory Coast continues and a large refugee crisis ensues, the HIV infection rates may increase in the surrounding host countries due to the influx. Ivory Coast had known stability and relative prosperity in West Africa for decades. Unfortunately, it also has a higher HIV prevalence than the countries surrounding it (e.g. Ghana, Mali, Burkina Faso; the prevalence of HIV in Liberia is not know).²⁵

iii. HIV in Refugee Camp Situations

On average, refugees come from countries in conflict and move to more stable host countries with higher HIV prevalence rates (figure 3). However, this is contextual, and each situation must be analysed independently and conclusions drawn accordingly.

Figure 3: HIV Prevalence by Asylum Country and Country of Origin by Region



(Spiegel P, Nankoe A, UNHCR, 2003)

Over the last two years, UNHCR and its partners conducted HIV sentinel surveillance among pregnant women in more than 20 camps housing some 800,000 refugees in Kenya, Rwanda, Sudan and Tanzania. Refugee populations in three of the four countries examined had significantly lower HIV prevalence rates than the surrounding host communities. In the fourth, the refugees and host community had comparable rates.

Figure 4: HIV Prevalence among Refugees, Surrounding Communities in Kenya and their Country of Origin

VULNERABLE GROUPS

i. **Women**

In conflict and displacement, women are at increased risk of sexual violence and abuse. Food insecurity, hunger, and unequal distribution of material goods put women and girls at risk of exploitation and abuse, including coercion into transactional sex for survival. Displacement may cause families and communities to split apart, destroying community structures and support systems that traditionally serve to protect women and children. This breakdown of communities may also lead men and women to engage in risky sexual behaviours. Women and children form the majority of displaced populations worldwide, as male family members are more likely to be involved in the conflict itself. Displaced women often find themselves as new heads of household, now responsible for providing for their families in addition to caring for their children. Targeted HIV/AIDS interventions that protect, train and educate women are essential.

ii. **Children**

In areas with high HIV prevalence and conflict, the vulnerability of children increases and the number of orphans due to the death of one or both parents may rise. Early efforts to identify vulnerable children, to initiate family tracing and implement community-based programmes that provide care and support for orphans and other vulnerable children need to be encouraged. Educational opportunities may be limited in conflict situations and thus basic HIV prevention messages targeting children must be a priority intervention. As with women, displaced children, particularly orphans and children made vulnerable by HIV/AIDS, are at increased risk for many types of abuse and exploitation, and may be coerced into transactional sex for survival. Additionally, the abusive use of children as soldiers and the extreme actions they are led to commit put this group at increased risk of contracting HIV.

iii. **Armed Personnel**

Armed personnel may be a significant vector of transmission of sexually transmitted infections (STIs), including HIV, among conflict-affected and displaced populations.^{9,18,26} HIV prevalence rates among some countries' militaries have been documented to be 2-5 times greater than their respective civilian populations.^{11,16} Furthermore, many of the intra-state conflicts have undisciplined, irregular armies and militias. Finally, there is a risk that UN peacekeepers coming from high prevalence HIV countries may also transmit HIV to conflict-affected and displaced populations because of their access to civilians, money and power. Conversely, those from low prevalence HIV countries may be at increased risk of contracting the virus. HIV/AIDS prevention must be an important training component among militaries, demilitarisation efforts, and UN peace keepers.

iv. **Humanitarian Workers**

Humanitarian staff working in conflict situations often find themselves in isolated, unstable and unfamiliar surroundings. They may face increased occupational exposure to HIV in the health care setting as well as increased exposure to sexual violence. Furthermore, they may undertake high risk sexual behaviour which they might normally avoid. Humanitarian workers should receive training in and follow some form of code of conduct²⁷⁻²⁹ as well as the humanitarian charter.³⁰ As with UN peacekeepers and other military forces, adequate education and training must be provided to this group before their missions and counselling and condom accessibility should be available throughout their time in the field. Universal precautions and disposal of medical waste in a safe manner should be followed scrupulously.

PROTECTION

The linkage between the protection of human rights and effective HIV/AIDS programmes is apparent. People will not seek HIV-related counselling, testing, treatment and care when lack of confidentiality, discrimination, denial of access to the asylum procedure, threat of refoulement, restrictions to freedom of movement, or other negative consequences (real or perceived) exist. For these reasons, an essential component of any HIV/AIDS strategy is the facilitation and creation of a legal and ethical environment which protects human rights. Situations of conflict and displaced persons are more prone to human rights abuses, including sexual violence. Therefore, specific protection policies and programmes dealing with HIV/AIDS must be implemented in conflict-affected settings where human rights are frequently violated.

Key protection issues include the following:

1. No denial of access to asylum procedure, refoulement or denial of right to return on basis of HIV status.
2. No mandatory HIV testing of displaced persons under any circumstances.
3. When required by resettlement countries, HIV testing conducted in accordance with established standards (i.e. accompanied by pre- and post test counseling and appropriate referral for follow up support and services).
4. Effective procedures in place to maintain confidentiality of individual HIV status.
5. Informed consent obtained prior to further disclosure of HIV status, when necessary, for protection of assistance-related reasons.
6. Policies, laws and programmes in place to combat stigma and discrimination against persons living with HIV/AIDS.
7. No laws or regulations prohibiting displaced persons access to public sector HIV/AIDS programmes.

THE UNIQUE SITUATION OF REFUGEES

The UNGASS declaration called upon “all United Nations agencies, regional and international organisations, as well as non-governmental organisations (NGOs) involved with the provision and delivery of international assistance to countries and regions affected by conflicts...to incorporate as a matter of emergency HIV/AIDS prevention, care and awareness elements into their plans and programmes”.¹

Countries of asylum are ultimately responsible for the protection and well-being of people living on their soil, including refugees. However, refugees have consistently excluded from many host countries’ HIV/AIDS National Strategic Plans (NSPs) and their needs have not been addressed in proposals submitted to major donors.⁶ Refugees and local populations interact on a daily basis (figure 1). Their consistent exclusion is not only discriminatory but also undermines effective HIV/AIDS prevention and care efforts. Furthermore, refugees are often hosted in remote and inaccessible areas, far from cities where HIV/AIDS programmes are most developed. Improving HIV/AIDS interventions for refugees in an integrated manner with the surrounding host population will invariably improve services for both communities.

Of the 29 countries in Africa that host more than 10,000 refugees, UNHCR has been able to review 22 (76%) NSPs. While 14 (64%) mention refugees, 8 (36%) fail to do so. Of those that do mention refugees, 10 (71%) NSPs mention specific activities for refugees, while 4 (29%) NSPs fail to do so. The GFATM and the Multi-Country HIV/AIDS (MAP) Programmes of the World Bank have funded HIV/AIDS projects in 25 (86%) of these 29 refugee-hosting African states.

Only a minority of proposals include refugees; in the 23 countries with approved GFATM proposals containing an HIV component only 5 (22%) included activities for refugees while 8 (55%) of the 15 approved World Bank MAP projects included refugee-specific components.

The situation for refugees not living in camps (e.g. urban refugees) as well as for IDPs is unknown but is likely to be worse than for refugees living in camps. Urban refugees are often undocumented, do not receive direct material support from UNHCR, and rely upon existing host government services that may discriminate against refugees.^{39,40} IDPs are often excluded from their government's HIV/AIDS programmes and do not have a specialised agency, such as UNHCR for the refugees, to advocate and provide programmes to cover their needs.⁴¹

PROGRAMMES

In the recent past, HIV/AIDS interventions were generally not included in humanitarian organisations' immediate response to conflict and emergency settings. It was considered to be more of a developmental and health issue and not to be an immediate life threatening disease as malaria or cholera. However, thinking has evolved and it is now generally accepted that HIV/AIDS interventions must be multisectoral and begin immediately at the onset of a conflict or emergency and be continued throughout every stage. The Inter-Agency Standing Committee (IASC) reference group for HIV/AIDS in emergency settings recently completed guidelines that provide a step-wise approach for implementing HIV/AIDS interventions.³¹ A matrix was developed that describes a sectoral response¹ for (1) emergency preparedness; (2) minimum response; (3) and comprehensive response (annex 1). Action sheets that provide guidance for key responses are provided for the minimum response in the guidelines. A multisectoral response with emphasis on coordination has been adopted. The Sphere project, which includes a humanitarian charter and minimum standards for disaster response revised their manual in 2004. It now includes HIV/AIDS as a cross cutting issue.³⁰

A *standardised* and *hierarchal* approach to the assessment and planning of HIV/AIDS programmes is needed to ensure that well-structured, multisectoral and integrated HIV/AIDS interventions are implemented in an appropriate manner. The IASC matrix listed above is one approach³¹ (annex 1). UNHCR has developed a framework for assessment of and planning for HIV/AIDS in conflict and displaced person situations (annex 2). Like the IASC matrix, it ensures the most important HIV/AIDS interventions are assessed and allows for the evaluation of programmes over time as well as for comparison across different programmes. This framework has been used by UNHCR to undertake HIV/AIDS assessment and planning missions throughout Africa.

As stated in the IASC guidelines, minimum essential HIV/AIDS interventions must be provided before comprehensive activities are initiated. This focused, *hierarchal* approach is essential given the security and resource constraints in, and the remoteness of, most conflict and displaced persons situations. Essential services (e.g. safe blood supply, universal precautions, treatment for STIs, condom distribution, information-education-communication (IEC) materials) must be made available before more complicated and resource intensive interventions, such as prevention of mother-to-child transmission (PMTCT) or long term antiretroviral therapy (ART), are provided.

¹ Coordination, assessment and monitoring, protection, water and sanitation, food security and nutrition, shelter and site planning, health, education, behavioural communication change and information-education-communication, and HIV/AIDS in the workplace.

However, comprehensive programmes that link HIV/AIDS prevention with care and treatment programmes are essential to combat the epidemic,³² and conflict affected and displaced populations should not be excluded from these approaches once the minimum HIV/AIDS activities have been implemented. Interventions ranging from voluntary counselling and testing (VCT), PMTCT, behavioural and sentinel surveillance, population-based surveys, and even ART have been implemented among such populations in the past few years.^{20,21,33-35}

The issue of ART is more complex in humanitarian settings than in typical resource poor settings due to migration and the consequent difficulties with access and follow-up. Pilot projects are necessary to examine modalities of drug distribution and other logistical factors, laboratory, compliance, surveillance, side effects, and resistance. A community-based infrastructure adapted to the specific situation should be employed.

HIV/AIDS programming for refugees presents some unique challenges. UNHCR's HIV/AIDS and Refugees Strategic Plan for 2002-04 requires "...UNHCR to work with governments through their National AIDS Control Programmes"³⁶. Together with its implementing partners, UNHCR follows the existing national protocols and guidelines of the host country. However, at times such protocols and guidelines do not exist, are outdated or are not being implemented in the remote areas in which refugees and IDPS are situated. Different languages and cultures require a modification of IEC materials and other interventions to suit the varied populations that are mixed together in conflict settings. The interaction between displaced persons and the surrounding population requires strong coordination and cooperation among the host government, international and local organisations and the communities themselves. Ultimately, the repatriation of refugees pose a particular problem, as they often return to countries that have fewer resources than the host country. Therefore, in the near future refugees may be receiving ART in host countries but may not have the ability to continue when they return to their country of origin. On the other hand, one never knows how long refugees will remain in host countries and they should have the same opportunity to benefit from ART as the surrounding host population. UNHCR is currently developing an ART policy for refugees.

The global community must adopt a broader and more innovative approach to fighting the HIV/AIDS epidemic across international boundaries. Recent conflicts in Ivory Coast, Liberia, and DRC, for example, saw armed military groups, refugees and economic migrants moving across many borders in West and Central Africa. Country by country plans will not work. Subregional approaches must be undertaken in conflict and displaced situations to effectively combat the epidemic. Some sub regional initiatives, such as the Great Lakes Initiative on AIDS (GLIA),³⁷ the Oubangi-Chiari HIV/AIDS Initiative, and the Mano River Union Initiative on HIV/AIDS³⁸ exist but need more international support and government cooperation. The current repatriation of Angolan refugees from numerous countries including Namibia, Zambia and DRC to Angola has shown the importance of subregional programming.^{22,39}

COORDINATION AND INTEGRATION

Coordination and integration are key components for all HIV/AIDS strategies, policies and programmes. They are essential for HIV/AIDS in conflict and displaced settings given their multisectoral and cross border nature. In these settings, numerous disparate groups must come together to improve their communication and coordination and to integrate their activities. Some examples of these varied actors include:

1. NGOs, including relief and development agencies.
2. UN agencies and international organisations.
3. Governments and political leaders.
4. Donors.
5. Health professionals, lawyers, anthropologists, teachers, and religious leaders.
6. Armed groups in conflict.
7. Refugees, IDPS and local surrounding populations.

Coordination and integration must occur at all levels. The following are some *examples*:

- i. International level**
UN System Strategic Plan for HIV/AIDS, IASC reference group for HIV/AIDS Interventions in Emergency Settings, and the IAAG as well as donor and recipient countries.
- ii. Regional/Sub-regional level**
UNAIDS Inter-Country Teams, Southern Africa's Regional Inter-Agency Coordination Support Office (RIACSO), and various subregional initiatives listed above.
- iii. Country level**
UN Theme Group on HIV/AIDS and associated technical working groups at capital level, and National AIDS Control Programmes.
- iv. Field level**
Multisectoral HIV/AIDS committees that include a wide range of persons in the community including service providers, political and religious leaders, women's groups, students, youth, teachers, and all conflict-affected communities.

The development of coordinated integrated HIV/AIDS strategies would be given an enormous boost if donor governments would loosen current restrictions on funding so money can be used more flexibly to provide HIV/AIDS programs to both displaced persons and local communities as well as relief and development organisations. This is currently being done in Uganda, where a self-reliance strategy has enabled numerous HIV/AIDS activities for refugees and local populations including VCT.

ASSESSMENT, MONITORING, EVALUATION AND OPERATIONAL RESEARCH

Despite the difficulties of undertaking assessments, monitoring and evaluation (M&E) as well as operational research in conflict and displaced persons settings, it is imperative to do so. Recent work by UNHCR, Save the Children, the International Rescue Committee and the Centers for Disease Control and Prevention, among other organisations, show that it is possible to carry out HIV sentinel surveillance surveys, HIV population-based surveys and HIV behavioural surveillance surveys in conflict and displaced persons settings.^{20,21,24,34} Although outside technical expertise may be required for many organisations to undertake such activities, behavioural and serological surveillance have allowed organisations to prioritise and target their programmes, provide a baseline and trends to evaluate their effectiveness, and act as an advocacy tool. Finally, such data have allowed us to better understand the complex interactions between conflict, displacement and the transmission of HIV that will ultimately allow us to better combat the epidemic.

Recently, UNHCR, WFP and UNICEF have undertaken a joint HIV/AIDS, food and nutrition operational research project in Zambia and Uganda to explore options for effective use of food aid to improve HIV/AIDS prevention, care and treatment in refugee camp settings. Results will

be ready in the first quarter of 2004. There are numerous other areas of research that need to be examined, some of which include:

- How interactions between armed groups, conflict affected populations (displaced and non-displaced populations) and surrounding communities affect HIV transmission (intra-country and inter-country).
- Methods to improve integration of HIV/AIDS programmes among displaced and non-displaced populations.
- Policies and programmes to reduce HIV/AIDS stigma and discrimination towards displaced populations from local communities/governments.
- Development of innovative preventive, care and support strategies that utilise the unique context of conflict and disaster-affected populations (e.g. food distribution, reception centres, censuses).
- Provision and compliance of ART to conflict affected populations including post-exposure prophylaxis to refugees following sexual violence or occupational exposure, PMTCT, long term ART.

RECOMMENDATIONS FOR ACTION

Recommendations provided in this section are limited to those that are actionable and targeted primarily at the United Nations System and specifically at IAAG members. The IAAG is requested to consider these actions, to amend as necessary, and then to agree and to adopt them as they see fit.

1. The IASC guidelines for HIV/AIDS interventions in emergency settings should be field tested and evaluated. Action sheets for emergency preparedness and comprehensive response of the guidelines should be constructed.
ACTION: IASC and IASC Reference Group.
2. Conflict-affected and displaced populations should be covered by national HIV/AIDS strategic plans, proposals and interventions.
ACTION: UN Country Teams supported by the UNAIDS Country Coordinator should work with national governments, UNHCR and other UN agencies, and donors to ensure inclusion.
3. Pilot projects for comprehensive HIV/AIDS interventions should be implemented for affected populations in conflict situations.
ACTION: IAAG members, particularly UNHCR, UNICEF, and the International Organisation for Migration, should work with national governments and NGO partners.
4. A multi-stakeholder meeting including UN system agencies, international organizations, NGOs, governments, donor agencies and representatives of affected populations should be organised in 2004 to discuss key issues related to HIV/AIDS interventions in conflict situations. Key issues include standardising approaches to and creating tools for HIV/AIDS assessment, planning, interventions and M&E; exploring flexible and coordinated funding approaches; advocacy issues; and operational research.
ACTION: UNHCR and the UNAIDS Secretariat.

Annex 1: Matrix for HIV/AIDS Interventions in Emergency Settings

Sectoral Response	Emergency preparedness	Minimum response (to be conducted even in the midst of emergency)	Comprehensive response (Stabilized phase)
1. Coordination	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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 rights⁴
2. Assessment and monitoring	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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

Sectoral Response	Emergency preparedness	Minimum response (to be conducted even in the midst of emergency)	Comprehensive response (Stabilized phase)
4. Water and sanitation	<ul style="list-style-type: none"> • Train staff on HIV/AIDS, sexual violence, gender, and non-discrimination 	4.1 Include HIV considerations in water/sanitation planning	<ul style="list-style-type: none"> • Establish water/sanitation management committees • Organize awareness campaigns on hygiene and sanitation, targeting people affected by HIV
5. Food security and nutrition	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • Ensure safety of potential sites • Train staff on HIV/AIDS, gender and non-discrimination 	6.1 Establish safely designed sites	<ul style="list-style-type: none"> • Plan orderly movement of displaced
7. Health	<ul style="list-style-type: none"> • 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 	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	<ul style="list-style-type: none"> • 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

Sectoral Response	Emergency preparedness	Minimum response (to be conducted even in the midst of emergency)	Comprehensive response (Stabilized phase)
7. Health cont	<ul style="list-style-type: none"> • Train health staff on RH issues linked with emergencies and the use of RH kits • Assess current practices in the application of universal precautions 	<p>7.5 Ensure IDU appropriate care</p> <p>7.6 Management of the consequences of SV</p> <p>7.7 Ensure safe deliveries</p> <p>7.8 Universal precautions</p>	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • Educate girls and boys (formal and non-formal) • Provide lifeskills-based HIV/AIDS education • Monitor and respond to sexual violence and exploitation in educational settings • Scale up BCC/IEC • Monitor and evaluate activities
9. Behaviour communication change and information education communication	<ul style="list-style-type: none"> • 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 		
10. HIV/AIDS in the workplace	<ul style="list-style-type: none"> • Review personnel policies regarding the management of PLWHA who work in humanitarian operations • Develop policies when there are none, aimed at minimising the potential for discrimination • Stock materials for post-exposure prophylaxis (PEP) 	<p>10.1 Prevent discrimination by HIV status in staff management</p> <p>10.2 Provide post-exposure prophylaxis (PEP) available for humanitarian staff</p>	<ul style="list-style-type: none"> • 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

ANNEX 1: HIV/AIDS and Conflict/Displaced Persons Assessment and Planning Tool Framework

1) 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.

2) 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 counseling 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.*

3) 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.

4) Prevention

- a. Safe blood supply.
- b. Universal precautions.
- c. Condom promotion and distribution.
- d. Behavioural change and communication (including development of educational/ awareness materials in appropriate languages; programmes for in-school and out-of-school youth; peer education; youth centres; sports/ drama groups; programmes aimed at reducing teen pregnancy and combating sexual violence).
- e. Voluntary counseling and testing.*
- f. Prevention of mother-to-child transmission.
- g. Prophylaxis of opportunistic infections.
- h. Post-exposure prophylaxis.

5) Care, Support and Treatment

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

6) 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 counseling and testing.
- j. Prevention of mother-to-child transmission.
- k. Sexual violence.
- l. Post-exposure prophylaxis .

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

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