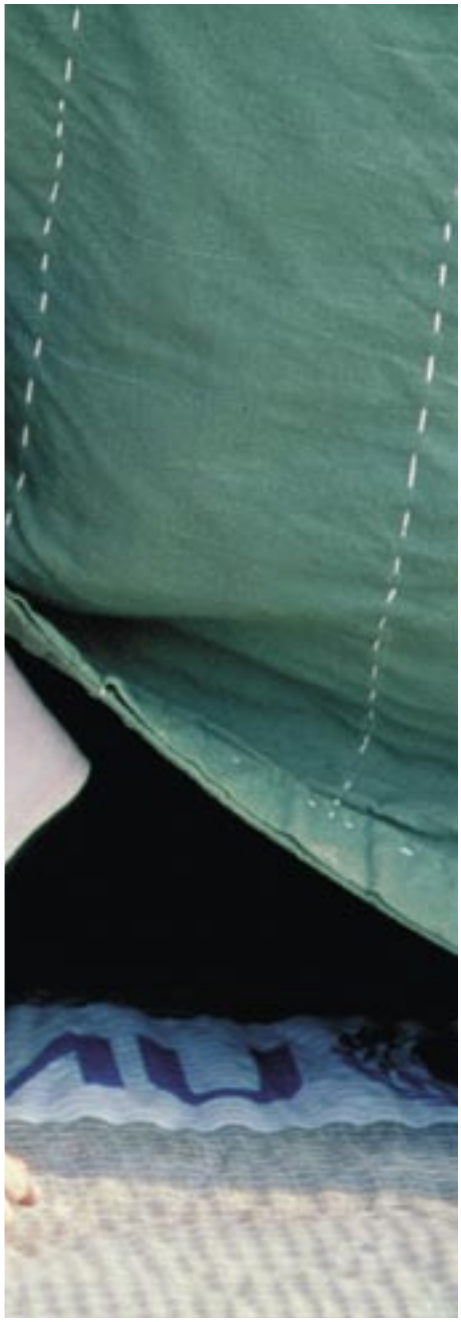
# Strategies to support the HIV-related needs of refugees and host populations

A joint publication of the Joint United Nations Programme on HIV/AIDS (UNAIDS) and the United Nations High Commissioner for Refugees (UNHCR)

UNAIDS BEST PRACTICE COLLECTION



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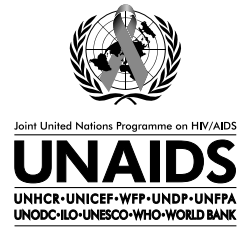


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This Best Practice was prepared by Paul Spiegel, Andrea Miller and Marian Schilperoord

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# Abbreviations and acronyms

| | |
|---|---|
| 4Rs | Repatriation, Reintegration, Rehabilitation and Reconstruction |
| AIDS | Acquired Immunodeficiency Syndrome |
| ART | Antiretroviral Therapy |
| DRC | Democratic Republic of Congo |
| Global Fund | Global Fund to Fight AIDS, Tuberculosis and Malaria |
| GLIA | Great Lakes Initiative on AIDS |
| HIV | Human Immunodeficiency Virus |
| IDPs | Internally Displaced Persons |
| MAP | World Bank Multi-Country HIV/AIDS Program for Africa |
| NSPs | National Strategic Plans |
| PMTCT | Prevention of Mother-to-Child Transmission |
| SRS | Self-Reliance Strategy |
| STI | Sexually Transmitted Infection |
| VCT | Voluntary Counselling and Testing |
| UNAIDS | Joint United Nations Programme on HIV/AIDS |
| UNHCR | United Nations High Commissioner for Refugees |

# Executive Summary

The ongoing plight of refugees and displaced people worldwide is one of today's great tragedies. In 2005, the global number of refugees and displaced people rose by 13% to 19.2 million people. Over four million of these refugees and other displaced people live in sub-Saharan Africa.

These groups are called "people of concern to" The Office of the United Nations High Commissioner for Refugees (UNHCR)—the UN agency which leads in providing global assistance to refugees and displaced people. The groups can include refugees, civilians who have returned home but still need help, persons displaced internally within their own countries, asylum seekers and stateless people. These groups are usually are torn from their lives and families, their community social structures destroyed, and their ability to cope is severely compromised. In their new "temporary" settings they struggle to survive at every level. Because the normal social safety nets are often absent, women and girls can be subject to sexual violence and rape, and generally drug and alcohol abuse are often rife. At the same time, health care services are often only minimal or non-existent. A variety of complex factors within refugee camps or displacement settlements makes the people living there enormously vulnerable to acquiring human immunodeficiency virus (HIV).

In today's conflict-affected world, this situation is made worse by the fact that the number of individuals of concern to UNHCR is constantly increasing. At the same time, in 2004, the total number of people worldwide living with HIV reached its highest level ever, approximately 39.4 million people.[1] Most of these cases were in sub-Saharan Africa; 25.4 million people were reported to be HIV-positive in the region. Providing health-care services to all of these groups is a daunting task—a task that becomes even more difficult in relation to providing HIV-related care and services.

Many countries are already overburdened by the impact of AIDS, and are often unable or unwilling to provide these populations with the HIV-related services they require. This places many refugees in a unique situation. They are no longer guaranteed the protection of their country of origin, they often do not have the assistance of the country of asylum, and they go without the HIV-related services which they need and to which they are entitled under international human rights instruments. This failure to provide HIV prevention and care to refugees not only undermines effective HIV prevention and care efforts, it also hinders effective HIV prevention and care for host country populations. Since refugee populations now remain on average in their host country for 17 years,[2] the implications for both refugee and host populations are very serious.

Addressing HIV-related needs in the context of refugee situations requires a change in the thinking of the authorities in many countries of asylum. It is impossible to determine the actual length of time that refugees will remain in the host country. However, it is critical that during this time both refugees and surrounding host populations receive all necessary HIV-related services, including those that require long-term funding and planning.

Failure to provide these interventions could be very harmful to both refugees and the surrounding host populations. In order to meet the HIV-related needs in the context of refugee situations, UNHCR and UNAIDS advocate for the implementation of the best practices described below. Both organizations believe that these practices will generate more effective, equitable

and sustainable frameworks to help countries better address both the needs of refugees and their own citizens, whether they are displaced themselves or hosting refugees in their communities.

## Best Practices for refugee-hosting countries

In this study, UNHCR and UNAIDS seek to inform and support key decision-makers on HIV-related issues facing refugees, other populations of concern to UNHCR, and the populations of host countries. The content of this document focuses on sub-Saharan Africa, but the concepts discussed are applicable to refugee situations outside this region. This report presents an overview of the following areas.

a) The various transitions of refugee life—often referred to as the "cycle of displacement"—which begin at the onset of a complex emergency and last until a durable solution is implemented. In this context, this Best Practice describes possible links between displacement and the vulnerability of refugees to HIV infection. It also describes the impact of HIV and various interventions for HIV prevention, treatment and care.

b) The rights of refugees, including but not limited to the host country's general responsibility to ensure that refugees have non-discriminatory access to existing HIV-related services, including the provision of antiretroviral therapy.

c) Best practices aimed at supporting and improving the provision of HIV-related services to both refugee and surrounding host country populations through refugee integration, subregional initiatives and combined funding streams.

### *Best Practice 1: Integrating refugee issues into national health and HIV programmes*

Integrating refugee issues into national health and HIV programmes can provide benefits to both refugees and host country populations. Through integration, funds that would have normally gone into creating new health and HIV services can be used to improve the local public health system. This improves services available to local populations and it has also been shown to improve the cost-effectiveness of providing services to refugees.[3] In addition, in some instances refugees may be housed in remote isolated areas where local public health services may be insufficient or nonexistent. The integration of refugee issues into national programmes can bring improved infrastructure and services that may allow local communities to gain access to health and HIV-related services that were previously not available. The introduction of these services becomes increasingly important as the host country takes to scale increased access to HIV prevention and treatment.

### *Best Practice 2: Implementing subregional initiatives*

Many clusters of countries across sub-Saharan Africa have joined together to address the impact of migration and displacement on HIV within the various subregions. With the help of donors and aid agencies, these countries have put aside political differences and have come together to develop subregional plans to address the HIV-related needs of refugee and surrounding populations. Creating these plans makes it possible to provide HIV-related services to mobile and displaced persons, including refugees and others who cross borders. These mobile populations often have not had any other access to HIV-related services until these subregional initiatives were created. The plans provide prevention information and commodities. They

also work to ensure continuity of treatment and care by providing standardized protocols that reach across borders. This makes it possible to introduce and provide antiretroviral therapy in a continuous fashion to these mobile populations. Finally, subregional plans help ensure that more comprehensive, integrated and better harmonized services are provided, and they can also serve to improve programme efficiency and lower costs in both HIV prevention and care terms.

### *Best practice 3: Combining funding streams*

Integrating refugee issues into national policies and programmes can improve access to funding for both refugees and local populations living in host country territory. Typically, funding for refugee assistance, including health and HIV-related issues, comes from humanitarian funding streams in the form of humanitarian support. The relatively easy access and minimal restrictions related to humanitarian aid is extremely important and beneficial during times of crisis. However, the limited duration (approximately one year) of humanitarian funding frameworks can make long-term planning for HIV interventions difficult. Conversely, funding for HIV-related services as provided for in national AIDS plans comes from development funding streams. This funding can last for several years, but is often earmarked for specific programmes—possibly restricting the host country's ability to address unexpected and evolving needs, such as those related to displacement. When the HIV-related needs of refugees are addressed in the context of existing national and local health- and HIV-related plans of the host country, programmes for both local populations and refugees may benefit from access to the two different but complementary funding streams.

### *Conclusion*

Conflict and forced displacements continue to occur. When this happens it is more effective and efficient from a public health and programme perspective to deal with the HIV-related needs of the populations affected by the displacement (refugees, internally displaced people and host populations) in an integrated and holistic fashion, preferably under the umbrella of the national aid strategy. This approach ensures that the refugees receive the HIV-related assistance they need. It also ensures that local populations do not suffer from the displacement around them. Due to the displacement cycle of refugees, subregional planning processes are crucial to ensure coordination among countries, as well as the continuity of prevention and care for local populations, refugees and returnees. Integrating humanitarian and development funding for HIV-related services for refugees and surrounding populations benefits both populations because it provides improved more efficient service delivery and makes programmes more sustainable. In this document, UNHCR and UNAIDS highlight these benefits and discuss strategies that will improve the implementation of HIV-related services for both host country populations and refugees.

# Introduction

Providing health-care services to refugees and other "people of concern to" The Office of the United Nations High Commissioner for Refugees (UNHCR) is a daunting task—a task that becomes even more difficult in relation to providing HIV- and AIDS-related care and services.

Refugees and displaced people are torn from their lives and families, their community social structures destroyed, and their ability to cope is severely compromised. In their new "temporary" settings they struggle to survive at every level. Because the normal social safety nets are often absent, women and girls can be subject to sexual violence and rape, and drug and alcohol abuse are often rife. At the same time, health care services are often only minimal or non-existent. The plight of refugees makes them very vulnerable to acquiring human immuno-deficiency virus.

In today's conflict-affected world, this situation is made worse by the fact that the number of individuals of concern to UNHCR is constantly increasing. In 2005, the number rose by 13% to 19.2 million people. Over four million of these refugees and other displaced people live in sub-Saharan Africa. At the same time, in 2004, the total number of people worldwide living with HIV reached its highest level ever, approximately 39.4 million people.[1] Most of these cases were in sub-Saharan Africa; 25.4 million people were reported to be HIV-positive in the region.

The governments of countries which provide asylum, along with national and international humanitarian and aid agencies, struggle to provide help for all of these groups. But many of these countries are already overburdened by the impact of AIDS, and are often unable or unwilling to provide these populations with the HIV-related services they need. This undermines effective HIV prevention and care efforts for refugees and displaced people, and also weakens effective HIV prevention and care for host country populations. On average, refugee populations now remain in their host country for 17 years,[2] which has profound implications both for them and their host countries.

Providing HIV-related services to conflict-affected and displaced populations is a difficult yet critical undertaking. The 1951 Convention relating to the Status of Refugees and other human rights instruments stipulate that countries of asylum are responsible for ensuring equal and non-discriminatory access to existing health services for refugees. However, despite this, the HIV-related needs of refugees are seldom included in country responses to the AIDS epidemic, particularly National Strategic Plans and/or national AIDS-related proposals submitted to major donors.[5] This is detrimental to the HIV prevention and care needs and efforts of both refugees and host populations.

UNHCR and UNAIDS recommend including and integrating refugee health care into National Strategic Plans and other HIV-related host country policies and programmes. This best practice publication demonstrates the value of and need for this approach. It also reviews the circumstances that make a refugee's situation unique, examines how the host country's management of refugee situations affects host populations, and suggests what can be done to address the needs of refugees living with HIV.

In addition, this document promotes the idea that subregional initiatives are particularly effective in working with refugees, internally displaced persons and returnees. These displaced populations are especially vulnerable to HIV infection. This factor has forced several countries to look beyond their national programmes and borders to meet their needs. Subregional initiatives call for developing HIV policies and interventions that reach across borders to ensure that these marginalized groups have continuous access to comprehensive HIV interventions.

Finally, this study examines the current funding situation of HIV interventions for refugees; what is available and from whom, what is needed, and why including refugees in national HIV policies and programmes is beneficial to both the populations of countries of asylum and origin.[3]

## Overview

### a) Refugee protection principles

Under Article 23 of the 1951 Convention relating to the Status of Refugees, States parties shall accord to refugees lawfully staying in their territories access to the same "public relief and assistance" as their nationals, including medical care. 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. The right to health is also recognized in a number of other international and regional human rights instruments.[a]

According to the Committee on Economic, Social and Cultural Rights, the International Covenant on Economic, Social and Cultural Rights "proscribes any discrimination in access to health care and underlying determinants of health, as well as to means and entitlements for their procurement, on the grounds of race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth, physical or mental disability, health status (including HIV and AIDS), sexual orientation and civil, political, social or other status, which has the intention or effect of nullifying or impairing the equal enjoyment or exercise of the right to health".[b]

Governments should ensure that refugees, internally displaced persons and returnees can exercise, without discrimination, the right to the highest attainable standard of physical and mental health. Therefore, these groups should have access on a non-discriminatory basis to existing national health or HIV programmes or to equivalent health and HIV services provided through humanitarian assistance.

In addition to the right to health care, host country policies toward refugees need to be guided by the fundamental principles of other relevant human rights. These principles would include, inter alia, the right to be free from discrimination, the right to privacy, and the right to liberty and security of the person. On this basis, UNHCR and UNAIDS strongly oppose mandatory HIV testing or health policies that target refugees, arguing that these policies do not

[a] See, 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 (article 11), the African Charter on Human and Peoples' Rights of 1981 (article 16) and the Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights of 1988 (article 10).

[b] Committee on Economic, Social and Cultural Rights, General Comment No. 14 (2000), paragraph 18.

serve public health goals. UNHCR and UNAIDS take the position that that an individual's HIV status should not in any way impact their rights as a refugee, including their protection against refoulement. (Non-refoulement is the concept laid out in the UN Convention relating to the Status of Refugees which prohibits States from returning a refugee or asylum seeker to territories where there is a risk that his or her life or freedom would be threatened on account of race, religion, nationality, membership of a particular social group, or political opinion.)

International standards of HIV testing require the three "Cs" be applied in any HIV testing situation, that is, informed consent, confidentiality and counselling. Furthermore, measures are needed to ensure that referral and support services are available. UNHCR and UNAIDS support widespread access to HIV testing as a gateway to more effective prevention and treatment efforts. However, they stress also that people will only come forward for HIV testing if authorities provide protection from stigma and discrimination and offer access to care and treatment.

**b) The situation of refugees**

At the 2001 United Nations General Assembly Special Session on HIV/AIDS, governments recognized 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". In this forum and in many others, it has clearly been acknowledged that HIV is a critical factor to be considered in the context of forced displacement.

1. However, the relationship between vulnerability to HIV and conflict and displacement is complex and depends on various factors specific to a particular situation.[4–6] For example, there is a common misperception that refugees "bring HIV" with them. This is often not the case. Some refugees come from areas with lower HIV prevalence than that of the host communities; while others come from areas with higher prevalence. Furthermore, many complex and often competing factors specific to a particular context may raise or reduce the vulnerability of refugee and host populations to HIV[6] including the following:

   - HIV prevalence within the local population in the country of asylum;
   - HIV prevalence within the local population in country of origin;
   - the amount of interaction between local and displaced populations;
   - the amount of reduced mobility and isolation of the displaced population due to the conflict and displacement;
   - the degree to which the refugees, returnees, and internally displaced populations have had *less* access than local populations to HIV-prevention programmes involving HIV information, education and means of prevention (condoms, sexually transmitted infection services, confidential voluntary testing and counselling); and
   - the degree to which the refugees, returnees, and internally displaced populations have had *more* access than the local populations to HIV-prevention programmes, e.g. refugees who have benefited from national and international assistance such as that provided under the auspices of UNHCR.

Therefore, it is essential that the context-specific circumstances in which refugees, displaced persons and their respective host populations live be better understood and used to guide HIV policies and programmes. Countries of asylum need also to recognize that in order to

successfully respond to the AIDS epidemic among their own populations, they should include the refugees living among or near those populations.[7] For their part, countries of origin must develop national HIV programmes and policies that address internally displaced people, as well as refugees who return home.

In host countries, refugees are often housed in remote and inaccessible areas where HIV programmes may be less developed. Therefore, improving HIV interventions in an integrated manner for both refugees and the surrounding host population will invariably improve services for both communities. In host countries, where there are urban refugees and internally displaced persons, particular efforts must be made to reach these people for whom there are often no records and who do not receive direct material support or services from host governments or humanitarian agencies.[8–10]

At the United Nations General Assembly Special Session on HIV/AIDS, governments called on "all United Nations agencies, regional and international organizations, as well as nongovernmental organizations 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".[11] Yet, refugee issues are seldom included in host countries' strategies (see Appendix 1), policies and programmes and their needs are generally not addressed in proposals submitted to or funded by major donors (see Appendices 2 and 3).[7] This undermines effective HIV prevention and care efforts for both refugees and host populations.

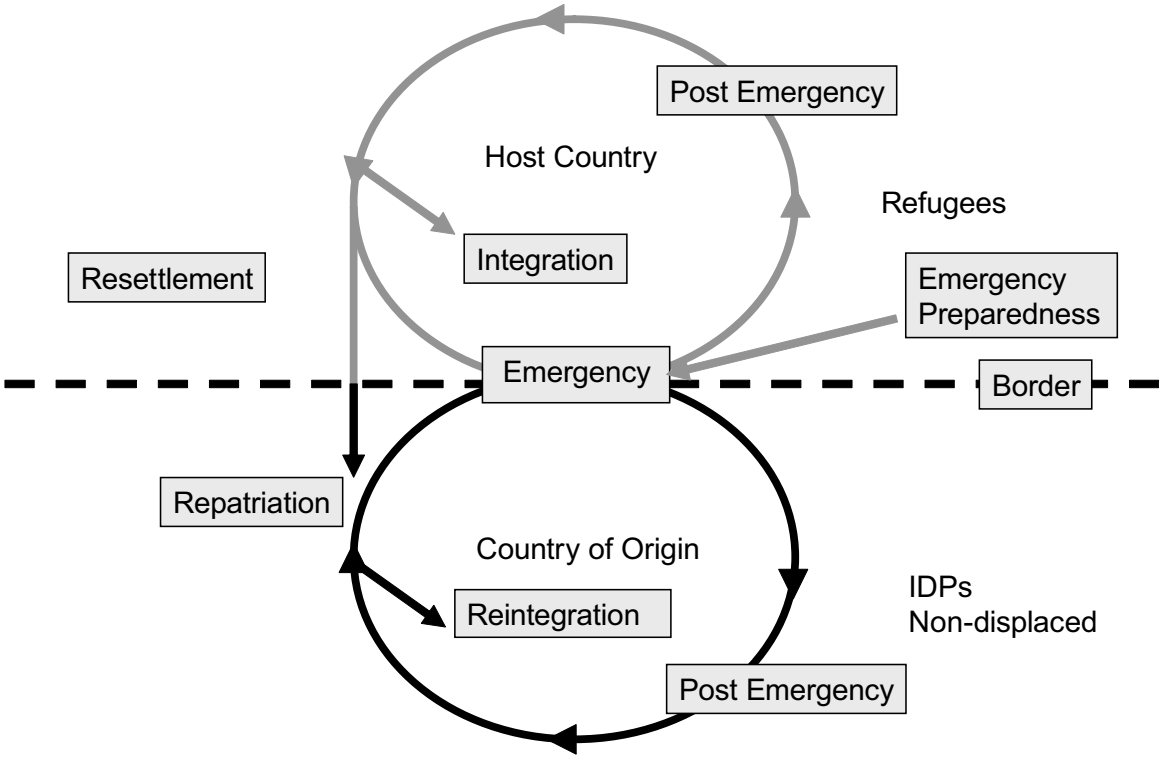
**c) Cycle of displacement and HIV service provision**

The displacement of refugees into countries of asylum has a huge impact, not only on their lives, but also the lives of the host communities. Refugees typically arrive in a host country, having fled persecution, conflict or some other emergency in their home country. This begins a period that is often fraught with instability and sometimes frequent movement, and which is commonly referred to as the *cycle of displacement* (see Figure 1).

The cycle has been simplified in this figure to include three main stages of transition, although additional movement may occur during this period, and subgroups among the population may be in different phases of transition. The first is typically referred to as the *emergency phase* and is associated with the onset of a complex emergency that often forces individuals to leave their home country and seek refuge in another country. The second phase or *post-emergency phase* is marked by greater stability, often allowing refugees to gain access to more comprehensive services in the country of asylum. In the *third and final stage*, refugees are able to return home, resettle in a third country or integrate into the population of their host country.

The refugee experience within the cycle of displacement is dependent upon many complex interacting factors, including the total number of refugees crossing the border, the available land and other resources in the host country, and the duration and intensity of the conflict and/or emergency in the country of origin. Within the cycle of displacement, there are several key challenges and opportunities linked to meeting the HIV-related needs of both refugees and the surrounding host populations.

**Figure 1: Refugee cycle of displacement**




**i. Emergency phase**

The first phase or emergency phase may be marked by extreme hardships, including deprivation of housing, food, and security, not to mention health services and information. Such hardships may increase vulnerability to HIV infection among refugees and/or host populations because these situations often involve increases in sexual violence against women and children, commercial and transactional sex and sexual partners, sexually transmitted infections, and exposure to unsafe blood and medical injection practices, combined with reduced access to condoms and HIV health services and information.

*Recommended HIV interventions*

The Inter-agency Standing Committee guidelines on HIV/AIDS interventions in emergency settings[12] recommend a minimum set of interventions that authorities should undertake. These include but are not limited to the following: (i) establishing coordination mechanisms; (ii) providing access to basic health care for the most vulnerable people; (iii) providing a safe blood supply; (iv) adhering to universal precautions; (v) providing basic HIV education materials; (vi) providing condoms; (vii) offering syndromic sexually transmitted infection treatment; (viii) providing appropriate care for intravenous drug users; (ix) managing the consequences of sexual violence; and (x) ensuring safe maternal deliveries. These services also provide the foundation for more comprehensive HIV interventions (e.g. confidential voluntary counselling and testing and prevention of mother-to-child transmission), which should occur during periods of greater stability.

### ii. Post emergency or stabilization phase

The second phase, or post-emergency phase, is associated with greater stability. Mortality rates decrease and basic needs (e.g. food, water, shelter) should already be met. During this period infectious diseases can be contained and additional more comprehensive interventions related to preventing HIV transmission, as well as providing HIV support, care and treatment are possible.

*Recommended HIV interventions*

HIV prevention interventions should be expanded to include comprehensive programmes to prevent sexual violence; provision of post-exposure prophylaxis; more targeted information-education-communication materials for high risk groups, including injecting drug users, sex workers and men who have sex with men; voluntary counselling and testing; reproductive health services for young people; and services for preventing mother-to-child transmission of HIV. Furthermore, palliative and home-based support and care should be provided for people living with AIDS. Other care and treatment interventions include prophylaxis and treatment of opportunistic infections and antiretroviral therapy.

### iii. Durable solutions: repatriation, local Integration and resettlement

In the final stage of the cycle, refugees prepare to: (i) repatriate to their home country; (ii) locally integrate into their host country population; or (iii) resettle in a third country. During this period, policies and practices can leave HIV-affected refugees feeling vulnerable and isolated. These include refugees being forced to undergo mandatory HIV testing, discrimination against refugees living with HIV, disclosure of their HIV status to authorities, threats to family unity, and threats to remove their continued access to HIV interventions, including antiretroviral therapy.

Refugee groups who return to their country of origin may have lower, higher or the same HIV prevalence as their host populations or their compatriots who remained in the country of origin. Each situation is unique and must be examined according to the context. Refugees who have been exposed to the HIV programmes of national and international nongovernmental organizations and host governments may have a greater degree of HIV knowledge and take fewer risks in relation to HIV exposure than non-displaced people or internally displaced persons in their home country. Furthermore, many refugees receive training and develop important HIV skills that can be used in their country of origin.[13] HIV-related services are primarily the responsibility of the country of origin. In order to avoid stigma and discrimination and have a broader effect, overall HIV policies and programmes need to be directed to everyone in the area of return in an integrated manner and not be solely for returnees, internally displaced persons or other groups.

These and other development-related initiatives need support from governments and aid agencies. In its “4Rs” or “Repatriation, Reintegration, Rehabilitation and Reconstruction” programme, UNHCR calls for introducing additional resources to support national development in order to safeguard the country’s future stability and avoid the recurrence of large refugee situations. Developing adequate HIV programmes must be an essential part of any plan for sustainable reintegration. Aid agencies and donor agencies need to encourage and support including HIV services in implementing the 4Rs. Refugees leaving countries of asylum that provided antiretroviral therapy need to have assurance that their treatment will be continued throughout and after repatriation. If such essential drugs and treatment are denied or not available, refugees who might otherwise return home may wish to remain in their host country.

In cases in which refugees do not repatriate and are willing and able to integrate locally, UNHCR promotes durable solutions, such as programmes called Development through Local Integration and Development Assistance for Refugees, to assist in this process. These programmes focus on areas that host refugees and specifically address the burden placed on asylum countries. They provide targeted assistance that allows refugees to become more productive and better able to integrate into the host community. This assistance may also lower the incidence of risk-taking behaviours which often hasten the spread of HIV.

Refugees who are not able to return safely home or remain in their country of asylum may seek resettlement in a third country. Although certain resettlement countries require pre-departure health screening, including HIV testing, a refugee should not be denied a resettlement opportunity on the basis of his or her HIV status. A refugee should never be refouled due to their HIV status. In cases in which pre-departure testing is done, the international standards mentioned above with regard to voluntary counselling and testing should be met, including pre- and post-test professional counselling, as well as ensuring the confidentiality of results.

*Recommended HIV interventions*

HIV prevention activities in refugee camps should be ongoing. However, efforts should be made to intensify existing programmes prior to the refugees return to their countries of origin. In particular, HIV repatriation packages that include information-education-communication materials in the appropriate local languages and condoms should be distributed, and appropriate HIV training provided. Many areas of return for repatriated refugees have underdeveloped or non-existent HIV programmes. Therefore, public information campaigns and more comprehensive education programmes need to be implemented in these areas before and during repatriation in order to reduce instances of general discrimination against returnees, as well as any HIV-related discrimination and misinformation.

In cases in which refugees are unable to repatriate but have the opportunity to integrate locally or resettle in a third country, HIV-status should not be a barrier. Countries that require HIV testing for local integration or resettlement should provide automatic waivers to refugees who test positive for HIV.

# BEST PRACTICE Integrating refugee issues into host country HIV policies and programmes

## Introduction

Between 1993 and 2003, the average duration of refugee situations has significantly increased, from nine years to 17 years.[2] During this period, refugees are dependent on the host country government and surrounding population, and where necessary, humanitarian agencies for essential needs including health care. Frequently, there are simply not enough resources to meet these needs.

In response to the lack of resources and continued need for improved coordination within the international community, UNAIDS, in cooperation with the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund) and World Bank initiated discussions to develop a set of key principles known as the "Three Ones".[14] These are: (i) **One** agreed HIV Action Framework that provides the basis for coordinating the work of all partners; (ii) **One** National AIDS Coordinating Authority, with a broad based multi-sector mandate; and (iii) **One** agreed country level Monitoring and Evaluation System. It is essential that refugees be included as stakeholders within the "Three Ones" planning process. Including assistance for refugees in host country policies and programmes serves as a vital link for bringing forth additional resources in the response to AIDS, and is also a critical component for effectively responding to the epidemic.

Nevertheless, the success rate of integrating refugee considerations into National Strategic Plans is uneven at best. In 2004, 28 countries in Africa hosted more than 10 000 refugees. UNHCR reviewed 25 (89%) National Strategic Plans and found that 17 (68%) included refugee issues, while eight (32%) did not. Of those that submitted plans, 11 (44%) described specific activities for refugees, and 14 (56%) did not (see Appendix 1).

A total of 25 of the 28 countries (89%) submitted proposals that contained an HIV component to the Global Fund. Of those which submitted proposals, 13 (52%) included refugee issues, while the remaining 12 (48%) did not. Eight (32%) mentioned specific activities for refugees, while 17 (68%) did not (see Appendix 2).

The World Bank's Multi-Country HIV/AIDS Program for Africa (MAP) has also funded HIV projects in 19 (67%) of the 28 refugee-hosting African countries. Within that group, 14 (74%) included refugee issues; five (26%) did not. Only nine (47%) of those included specific activities for refugees, while the other 10 (53%) did not (see Appendix 3).

## Integrating refugee issues into HIV programmes and policies benefits the host population, as well as refugees

The integration of refugee issues into National Strategic Plans and other national HIV and AIDS policies and programmes can be very beneficial to surrounding host country populations. Refugee populations often bring additional resources in the form of humanitarian assistance to the remote, often underserved areas in which they are housed. This can

help surrounding local population in several ways. For example, in Guinea funding for refugee health care was used to improve the health local system.[2] This allowed aid agencies to avoid the expense of creating a duplicate system, while also lowering the cost of providing care to the refugee population. In areas where no local system exists, surrounding local communities are often able to use health services provided by aid agencies in the refugee camps. This allows them to gain access to basic health care and essential HIV interventions, and also provides the infrastructure to support the provision of antiretroviral therapy. Integrating refugee issues into national programmes helps achieve the following benefits: it

i. Helps gain access to additional resources

   In some cases, by integrating refugee issues into national programmes, host countries have been able to gain access to additional resources for their own population. For instance, in 2001, the Government of the Republic of Zambia launched a multi-year, US$ 25 million project called the Zambia Initiative. It had the expressed purpose of "reducing poverty, linking relief and development assistance, and contributing to peace and stability in refugee-hosting areas of Zambia."[15] The programme, supported mainly through bilateral funding, provided development assistance that benefited both refugees and the surrounding local communities in the western province of Zambia. Several interventions were chosen to receive funding, including some involving HIV and AIDS. In the most recent round of funding for this Initiative, the Swedish government provided money for HIV intervention programmes including an HIV drop-in centre.[16]

ii. Avoids creation of parallel services and systems, while reducing costs of health services for local populations and refugees

   Creating parallel HIV services for refugees is not only expensive and duplicative, but it can also be detrimental to the existing systems. Humanitarian agencies are often able to pay higher salaries than the national health system. This can result in draining away competent national staff from public health services dedicated to providing HIV and other related services to the local community. Furthermore, creating duplicate and often better systems can lead to inequalities that can create tension between refugees and the surrounding host community.[17]

   Introducing resources to enhance existing capacity have been shown to be much less expensive than developing completely new and often duplicate structures.[3] In Guinea, where UNHCR paid the Government for refugees to use the local health system on a fee-for-service basis, the overall yearly per person cost was much lower than those receiving services in camps—approximately US$ 4 compared with US$ 20.[3]

iii. Improves local health-care services

   Integrating refugee considerations into the national health system can provide valuable resources for improving local medical services. Again, in Guinea, the Government provided refugees with access to Guinean health services on a fee-for-service basis. The resources from the refugee programmes provided the funding needed to create new health centres, as well as needed improvements to existing centres in areas where refugees settled. These improvements benefited not only the refugee populations, but also the Guineans living in the area, who had better access to improved health care.

iv. Removes barriers to providing services, including antiretroviral therapy

In remote and extremely isolated areas, the number of refugees can sometimes be greater than the host community populations. In such areas, the services and infrastructure developed for refugees may be all that is available to the host community, or may provide additional services not found there. Clearly, the creation of integrated health services can provide additional benefits to the host population and may be particularly relevant to antiretroviral therapy as it becomes available.

Several countries hosting refugees have already made formal appeals to the World Health Organization for assistance in scaling up provision of antiretroviral therapy. It is essential for the health of both refugees and surrounding host populations that refugee assistance be included in these and all other antiretroviral therapy project proposals. The infrastructure developed for refugee camps, such as improved transport, increased human capacity, and training can help facilitate the introduction of antiretroviral therapy to refugees and surrounding host populations, particularly in resource poor settings.

Furthermore, aside from its therapeutic effects, introducing antiretroviral therapy should reduce the rate of HIV transmission among and between refugees and local populations by lowering viral loads, which has been associated with a reduced risk of contracting the virus. Provision of antiretroviral therapy has also been shown to increase incentives for people to use confidential voluntary counselling and testing services.[18] This increase in testing can bring people who otherwise might not go into health-care settings where targeted prevention messages and interventions can be given to those who test either positive or negative. As more people learn their status and gain added knowledge of the disease, the stigmatisation and discrimination that often accompanies HIV may be reduced.

v. Reduces discrimination and stigma

Integrating refugee issues into host country programmes can help reduce the misperception that "HIV is not in our community, but their community". In many instances, refugees have greater access to HIV prevention and care information though humanitarian assistance than the surrounding host population.

For example, in July and August of 2004, a mobile photo exhibit of people living with HIV, called Positive Lives—sponsored by UNHCR and the UN Population Fund—was shown at three refugee camps in Kenya. The exhibit was supplemented by activities to encourage community discussion on related discrimination and stigma, along with peer education activities, condom promotion and distribution, street theatre and sports activities. This initiative offered refugees important opportunities to have their questions answered and receive information on HIV prevention and care. It also led to subsequent changes in beliefs and reduced discrimination and stigma among the participants.

**Case Study 1: An integrated approach to HIV awareness in Tanzania**

In Kibondo refugee camp in Tanzania, Stop AIDS, a local organization formed by refugees, linked up with the Tanzanian Service Health and Development for People Living with HIV/AIDS—a group within the local host population—to provide HIV awareness and education to both refugees and the surrounding community. The groups' efforts included providing education prevention activities and programmes to secondary schools, as well as to youth and adolescent groups as part of out-of-school activities. The two groups also worked together to organize joint concert sessions and mass campaigns in schools and public places, where members spoke publicly and helped to educate audiences on issues involved in living with HIV.

In the future, several of the Stop AIDS members studying at Tumaini University in Iringa, are planning to expand their activities to the University. In addition, the Tanganyika Christian Refugee Service, a nongovernmental organization supporting Stop AIDS groups in refugee camps, will launch a programme called Men Against AIDS in Tanzania. This programme will be integrated into the work already being done by the refugee camps' Stop AIDS members.

**Case Study 2: Benefits of integrating HIV programmes in Uganda**

In 1998, the Government of Uganda, the Directorate of Refugees and UNHCR began discussions on implementing the Self-Reliance Strategy (SRS). The Strategy was developed to offset the burden placed on host country governments during protracted refugee situations. Its overall goal is "to improve the standard of living of the people in Moyo, Arua, and Adjumani districts, including the refugees". The Strategy works to accomplish this by improving food self-sufficiency, increasing access to social services such as health and education, and boosting local government capacity to plan and deliver essential services.

In Uganda, at the beginning of 2005 there were over 220 000 refugees living and sharing health services with an estimated 135 000 people from surrounding communities. UNHCR designed its HIV services to work in conjunction with Uganda's National Strategic Plan. In Kyangwali and Palorinya settlements, the programmes developed were aimed at expanding and strengthening voluntary counselling and testing services and prevention of mother-to-child transmission for refugees and host nationals. The voluntary counselling and testing sites are supported jointly by the government and UNHCR, with services being provided to both host country and refugee populations. Currently there are eight static sites providing confidential voluntary counselling and testing throughout the settlements. To date, over 600 refugees and nationals have used voluntary counselling and testing services. From this group, a core post-test club of 25 members (13 refugees and 12 nationals) was established and trained to sensitize both refugee and surrounding host populations on HIV prevention and care through the use of music, dance and drama. Similar post-test clubs were established and equipped in Arua, Adjumani, Moyo and Mbarara districts to provide similar services there.

There are currently two functional prevention of mother-to-child transmission sites available for both host country nationals and refugees. The drugs administered at the onset of labour to HIV-positive women are provided by the government as part of its national policy. The cost to train counsellors is shared by the Government of Uganda and UNHCR. Site selection for sentinel surveillance and relevant staff training were also carried out jointly by the Government of Uganda and UNHCR. HIV and syphilis tests and the necessary equipment were provided by the national programme. The specimens collected are tested by the Government of Uganda and used in its national reporting process. Prevalence found for first quarter specimens (600 samples) was 1% to 2.35%. Furthermore, both the government and UNHCR have developed additional HIV services for both refugees and host country nationals. The Government of Uganda has promoted projects to sensitize refugee and surrounding host populations, provide HIV test kits, and train laboratory staff. UNHCR has given support for providing HIV test kits and has provided refrigerators for storing specimens. In addition to HIV programmes, other related health services have been provided by the Government of Uganda and UNHCR to both refugees and host country nationals, including the treatment of opportunistic infections and sexually transmitted infections. These have been shown to have a significant impact on the health outcomes of individuals with HIV. Finally, the World Food Programme has provided nutritional assistance to both host country nationals and refugees living with HIV.

# BEST PRACTICE: Implementing subregional initiatives

## Introduction

The World Bank's rationale for supporting subregional HIV projects states that "the spread of infectious diseases is tied to the movement of people. HIV travels across borders … some of the highest-risk behaviours take place in transport corridors, border stops, migrant labour camps, refugee settlements, and the like".[19] Introducing and funding subregional initiatives shows that governments and funding agencies recognize there is a need for broader, more innovative interventions that "cross borders".

Countries are often reluctant to invest their limited resources in remote, often isolated border areas, despite the need for such services. However, the possibility of HIV transmission by people who live in these areas and who often cross borders has forced many countries to re-examine their national response plans. In doing so, they have recognized the need to go beyond their existing efforts and join together with neighbouring countries to develop subregional initiatives that address the needs of more marginalized populations that might not otherwise benefit from national programmes.

Over the past several years, several subregional initiatives have been developed, in part, to aid displaced people as well as others who move across borders. These include the Great Lakes Initiative on AIDS (GLIA; see Case Study 3), the Oubangui-Chari River AIDS Initiative in Central Africa, and the Mano River Union AIDS Initiative in West Africa. Participating countries were able to draw on these subregional partnerships for additional funding to implement these cross-border initiatives. In March 2005, GLIA received final approval for a US$ 20 million grant from the World Bank,[20] the Oubangui-Chari River project received a grant for over US$ 8 million from the African Development Bank with some additional funding provided by UNAIDS, and the Mano River Union AIDS Initiative received US$ 7 million from the African Development Bank.

## Subregional initiatives add value to national programmes

i. They provide access to HIV prevention and care programmes for refugees and mobile populations

   Developing subregional AIDS initiatives makes for easier HIV-related intervention implementation with the various populations that may cross borders (e.g. transport workers, migrant workers and refugees). The daily lives of these people, many of whom are marginalized, often leaves them without access to essential HIV and other health-related services. They tend to live in remote border regions which facilitates their movement, but makes providing and continuing such services difficult. Introducing subregional initiatives addresses many of the HIV service delivery obstacles that they face. Subregional programmes may work across borders. Therefore, if these individuals move to another country, comparable HIV services would still be available. In addition, programme sites are often chosen based on migration patterns. This helps to ensure that services are available in areas that need them most.

ii. They improve HIV interventions targeted at local populations

Subregional initiatives improve access to HIV services for local populations. The HIV interventions provided by subregional programmes are designed to complement and, at times, supplement existing services in participating countries. These initiatives focus on the needs of people who may frequently travel across borders, but surrounding local populations can also benefit from the increase in services. The programmes created improve access to care and provide valuable HIV-prevention activities within the area. The introduction of information-education-communication materials and training leads to changes in behaviour, potentially lowering the risk of infection for all populations living in the subregion.

Furthermore, the framework of subregional initiatives can improve service delivery within existing national programmes. Programmes such as GLIA include goals to improve coordination and collaboration throughout the subregion. They achieve this by strengthening and developing partnerships, as well as by creating increased information sharing among member countries. Such strategies provide the basis for lasting improvements that will benefit all groups housed in the area.

iii. They ensure continuity of care and treatment

Subregional initiatives can provide consensus on standardized diagnosis and treatment protocols and algorithms which ensure continuity of care for refugee and mobile populations as they move within the subregion. Introducing these plans can make the continuation of antiretroviral therapy and other interventions possible. In the past, individuals taking antiretrovirals may not have been able to continue treatment if they moved to another country that did not provide the same type of antiretroviral drug. This consideration is especially problematic for refugees who may need to move several times over many years before returning to their home country, locally integrating into a host community or resettling in a third country.

iv. They improve efficiency and lower costs

Subregional initiatives can lower costs and improve health-care efficiency in participating countries. These initiatives mean that protocols can be improved and integrated, and that medications and supplies can be ordered in bulk, which reduces the overall price paid by the countries in the subregion. In addition, the ability to move drugs within the subregion according to need can help diminish waste (e.g. having to dispose of medications which have passed their expiry dates) thus further reducing costs.

v. They can create opportunities to gain additional funding

Introducing subregional initiatives can provide participating governments with new opportunities to gain access to additional HIV funds. Donors recognize that country-based programmes alone cannot effectively respond to the AIDS epidemic, and have begun funding subregional initiatives that address the unique needs of displaced populations such as refugees. Each of the 12 countries participating in the GLIA, Oubangui-Chari River and Mano River Union AIDS initiatives has received country-specific funding to provide HIV-related services from at least one of the three major donor programmes—the Global Fund, the World Bank and the United States President's

Emergency Plan for AIDS Relief. Furthermore, 11 of the 12 countries have received funding from at least two of these donors, and another four have received funding from all three.

vi. They help to increase dialogue between countries on HIV-related issues

Subregional initiatives offer a unique opportunity for communication, dialogue and exchange of experience at the political and technical levels. The information provided by participating countries on what "works" and does not "work" can be extremely valuable. Member countries can learn from their partners' experiences and can avoid using their limited resources on unsuccessful initiatives. Instead, they can choose to focus on programmes with proven records of success. Their ability to implement proven strategies can also improve their capacity to attract additional resources to implement HIV-related programmes. Finally, subregional initiatives demonstrate that the combined force of these partnerships is far greater than the individual efforts of each member. By working together, the group is able to demonstrate greater will than if each member works separately.

have received funding from at least two of these donors, with an additional four receiving funding from all three.

**Case Study 3: Benefits of the Great Lakes Initiative on AIDS (GLIA)**

***Background***

In the Great Lakes region, HIV prevalence ranges from 4.1% to 8.8% for adults between 15 and 49 years old. Over six million people are estimated to be living with HIV across the subregion. Ministers of Health from the six participating countries (Burundi, Democratic Republic of Congo (DRC), Kenya, Rwanda, Tanzania, and Uganda) acknowledged that in order to address this growing epidemic, a broader, more regionally-focused response needs to be taken

In 1999, these member countries joined together and, with initial support from UNAIDS, launched the Great Lakes Initiative on AIDS (GLIA). These countries had developed national AIDS programmes, but they realized that they could not effectively halt the spread of the virus without addressing the key role that migration and displacement played in the transmission of HIV across the subregion. Soon after the creation of GLIA, a secretariat was formed, workshops were held, and pilot testing of cross-border HIV interventions in the transport sector began. In 2004, the GLIA Members states signed a Convention to make the Initiative an independent legal organization. This Convention has been ratified by each member state.

***Programme components***

The World Bank-funded MAP Project of GLIA has four main components. It provides: (i) HIV support to refugees, affected areas surrounding the refugee communities, internally displaced people, and returnees; (ii) support to HIV-related networks; (iii) support to Regional health-sector collaboration; and (iv) GLIA/MAP management, capacity strengthening, monitoring and evaluation, and reporting. The first component was specifically developed to meet the HIV-related service needs of refugees, internally displaced persons, members of the surrounding area communities and returnees. Sites and catchments areas that would receive funding for programmes were identified by the GLIA Member States and UNHCR.

It was determined that there would be one to two sites per country; each site consisting of refugees/internally displaced persons and surrounding host communities. Programmes for individuals in refugee-affected areas would be provided by National AIDS Commissions and would be addressed within the countries' national HIV/AIDS framework. UNHCR would be responsible for refugees; internally displaced persons would be decided upon on a case-by-case basis, while programmes for returnees were determined to be the shared responsibility of UNHCR and the National AIDS Commissions.

For component one of the Project, a memorandum of understanding and a contract has been developed by UNHCR and GLIA. These documents addressed the key issues of receipt and distribution of GLIA funding, submission and approval of UNHCR's annual work plan and budget, procedures for implementing subprojects, as well as hiring a programme administrator, a UNHCR Administrative Officer experienced in refugee and returnee issues, and a consultant to develop protocols and tools for monitoring and evaluation including biological and behavioural surveys.

***Outcomes and benefits***

In March 2005, as part of its second round Multi-Country HIV/AIDS Program, the World Bank approved a US$ 20 million grant to finance GLIA over the next four years. In addition to monetary benefits, GLIA forged strong partnerships across the region, despite some difficult relations between some of the six countries. GLIA partners include the six GLIA governments, UN organizations, bilateral and multilateral donors, nongovernmental organizations, faith-based organizations and the private sector. A standardized behavioural surveillance survey for displaced and surrounding host communities with components to address displacement and post-displacement/interaction has been developed and field tested in Rwanda and Kenya. There are now plans to undertake these surveys and to set up antenatal sentinel surveillance sites among refugee and surrounding host communities in all four countries during the first and fourth years. Field missions by representatives of the National AIDS Commissions, UNHCR and UNAIDS to the refugee sites and surrounding host communities have been undertaken in five countries, as well as a returnee site in Democratic Republic of the Congo. Joint HIV programme planning has been undertaken and plans of action completed for the first year of implementation in all six countries.

Other important outcomes of this partnership include the development of an Operations Manual in both French and English language editions, the creation of a monitoring and evaluation system, improved information exchange on health-related programmes for refugees, internally displaced persons and returnees, and the development of systems to review sexually transmitted infections, antiretroviral therapy, tuberculosis and other opportunistic infection treatment in order to harmonize protocols among the participating GLIA countries. Issues relating to opportunistic infections are particularly important within this region, since four of the six countries in the subregion (Democratic Republic of the Congo, Kenya, Tanzania and Uganda) have some of highest tuberculosis rates in sub-Saharan Africa.

# BEST PRACTICE: Combining humanitarian and development funding

## Introduction

From 2001 to 2004, global funding for HIV and AIDS increased nearly threefold, from nearly US$ 2.1 billion to US$ 6.1 billion, with an estimated US$ 10 billion to be available in 2007.[21] Although contributions have substantially increased, this figure is less than half of the US$ 20 billion estimated to be needed in 2007 for prevention and care in low and middle income countries.[1]

Contributions from major donors such as the United Kingdom's Department for International Development (DFID), Global Fund, the United States President's Emergency Plan for AIDS Relief, and the World Bank are on the rise, but are clearly not sufficient. Furthermore, problems with coordination, harmonization and alignment of funds and technical support have severely hampered programme implementation.

This problem led to the formation of The Global Task Team on Improving AIDS Coordination among Multilateral Institutions and International Donors which produced a report recommending major changes to the donor and United Nations communities.[22] The lack of resources, difficulties of harmonization and alignment by donors, and lack of coordination and sufficient technical expertise by UN agencies have often had a disproportionate impact on the marginalized refugee populations.

The value of including refugee issues in host country HIV policies and programmes has already been demonstrated in sub-Saharan Africa. In countries such as Guinea, Uganda and Zambia, additional funding was made available to the host governments, and refugee issues were included in local health care and other development programmes (see "Helps gain access to additional resources", page 18). Access to these additional resources has proved extremely beneficial to both refugees and the surrounding host communities.

**Case Study 4: Gaining access to additional funds by including refugees in Zambian Government programmes**

By creating partnerships, and with the support of the donor community and UNHCR, the Government of the Republic of Zambia was able to gain access to additional funding and provide improved services for both refugees and the surrounding community. The Zambian Government recognized that refugees were increasingly integrating into local communities, and took action. With assistance from UNHCR, it invited major donor governments to visit refugee hosting areas. This meeting led to the creation of Zambia Initiative and brought in millions of dollars in additional aid, some of which is specifically designated for HIV interventions.

Including interventions for refugees in national host HIV programmes would be a tremendous shift in terms of funding strategies for HIV-related programmes for refugee populations. HIV treatment and care requires both short-term and long-term interventions. The current funding system for refugee programmes falls under humanitarian or emergency grants, making it difficult to provide long-term interventions. However, these grants tend to have greater flexibility and fewer restrictions, which can be extremely beneficial to governments that need

funding. In contrast, funding for National Strategic Plans generally comes from development contributions, typically in the form of multilateral and bilateral assistance. These contributions are usually multi-year grants tied to more specific outcomes and with less flexibility. It is important to recognize that both sources of funding are important which is discussed below.

Refugee and national programmes typically function along humanitarian and development lines, respectively. But these lines have occasionally been blurred. In recent years, refugees have been included in some host country development initiatives, such as National Strategic Plans and subregional initiatives. In addition, programmes such as MAP have developed a more comprehensive approach, providing funding for an entire range of services, from institutional support to HIV prevention, care, mitigation and treatment. Furthermore, recent humanitarian crises aggravated by the presence of HIV have led to increased inquiry on whether humanitarian aid should be provided during non-refugee situations in order to address immediate threats related to HIV.[23]

Specifically, during the 2002-2003 crisis in southern Africa, aid agencies were forced to re-examine the impact of HIV on the crisis and the humanitarian community's ability to address it. The impact of HIV and its potential consequences for the region led to the suggestion that HIV should be considered "a long-term crisis",[24] reflecting the need for both short-term humanitarian and long-term development responses to the disease. During the 2002-2003 crisis, health systems failed to provide access to services to a large percentage of the population.[24] This was a failure in development, but it created an increased need for humanitarian aid during the crisis, which was not adequately met.

## Different streams of funding can act synergistically

i. Humanitarian aid can complement development aid in providing HIV interventions

In cases in which refugee issues are included or integrated into national programmes, it may be possible to use the two different funding streams to increase resources and provide more effective programmes for both refugees and the surrounding populations. For example, if refugees are using government health clinics, and UNHCR and its partners recognize the need to improve treatment and contract tracing of people with sexually transmitted infections through training and surveillance, both refugees and local populations would benefit.

High HIV prevalence in populations can have a severe impact on already fragile situations in which people have limited coping mechanisms. As discussed above, the incidence of AIDS in the southern African region in 2002-2003 increased the seriousness of what was originally viewed as a food crisis. During this period, the Regional Inter-Agency Coordination and Support Office was formed to address the humanitarian response to the food security crisis within the six Southern Africa countries.[25] As the impact of AIDS on the crisis became known, the Office sought to broaden its scope of work and to address people's increased vulnerability caused by the epidemic. During this period, coping mechanisms collapsed and local populations were often unable to manage. This called for a broader-based humanitarian response, in close partnership with nongovernmental organizations, in order to address the unforeseen consequences of HIV on the region.

ii. Use development aid to fund HIV programmes for refugee and surrounding populations

Providing HIV-related services to refugees should not be considered strictly a humanitarian issue. In many cases emergency interventions are needed, but the programmes must also respond to the longer-term consequences of the disease. This can only occur if both refugee and surrounding populations are included in development grants for national and subregional programmes.

Including refugee issues in programmes funded by development grants can benefit both refugees and the surrounding local community. In cases such as GLIA, the programme provided essential additional funding to address vulnerability to HIV among refugee populations and country nationals (see pages 11 and 24). Specifically, behavioural surveillance surveys were incorporated into the planning process in order to monitor and evaluate the activities for these populations. If these proved to be successful, then GLIA countries and donors would be able to replicate them.[21] Programmes such as GLIA allow countries to gain access to the funding necessary to provide the long-term interventions essential to the global effort to effectively respond to AIDS. The international community should facilitate access for countries, creating and using new funding streams that include refugees and mobile populations.

The Global Fund and the World Bank have already made tremendous progress towards making the funding process more accessible for eligible recipients. Both organizations have worked to create more flexible, yet accountable systems for making additional resources available. In particular, the Global Fund has developed a system in which grant proposals are developed by a Country Coordinating Mechanism made up of representatives from both the public and private sector.

This emphasis on partnership throughout the grant cycle has helped many countries increase their local capacity. These partnerships have stimulated new discussion and improved collaboration among all sectors involved. Furthermore, they have also given nongovernmental organizations, faith-based organizations and communities with people living with HIV unprecedented opportunities to actively participate in health policy and spending decisions.[26] If the Global Task Team recommendations are fully implemented by the donor and UN communities, refugees and other displaced populations should benefit.

The Task Team report stresses national ownership of HIV-related plans and priorities. Therefore, country UN HIV/AIDS Theme Groups need to make a concerted effort to advocate that refugee issues be integrated into host country plans and priorities.

**Case Study 5: World Bank's Multi-Country HIV-AIDS Program (MAP) for the Democratic Republic of the Congo**

***Background***

In 2003, as the Democratic Republic of the Congo (DRC) was in discussions with the World Bank regarding its MAP, UNHCR introduced the possibility of including refugee issues in the Democratic Republic of the Congo proposal. Staff from the World Bank and the National AIDS Control Programme met with UNHCR representatives in Kinshasa to discuss the proposal. After several meetings and a mission to a Congolese refugee camp in Bas Congo, it was decided that UNHCR would become a partner in this process, and refugee issues would be included in the Republic's MAP proposal. The Democratic Republic of the Congo's decision to work with UNHCR was influenced by the role the UN agency had played in developing the GLIA MAP proposal, and by its presence in remote areas where the Government provides limited services. Current estimates indicate that between 10% and 20% of the total number of patients using the refugee health facilities are members of the host community.

***Implementation***

In response to the agreement with DRC, UNHCR prepared an action plan of HIV interventions and outcomes that was presented to the National AIDS Control Programme. The plan was accepted by the World Bank. The plan provides HIV interventions for refugee populations and surrounding internally displaced persons who live near the refugees, as well as returnees from Angola and Congo-Brazzaville. Specific programmes targeting prevention, care and treatment include behaviour change and communication interventions, condom distribution and education, universal precautions and blood safety, voluntary counselling and testing, prevention of mother-to-child transmission services, treatment of sexually transmitted infections, treatment of opportunistic infections, and the possible introduction of antiretroviral therapy.

DRC's MAP programme was approved by the World Bank in 2004. UNHCR started implementing additional HIV activities in selected refugee, internally displaced person and returnee settings in 2005. UNHCR and the National AIDS Control Programme will conduct joint assessment missions to refugee sites proposed to be included in the plan. The Government of the Democratic Republic of the Congo has agreed to use the UNHCR-GLIA contract and memorandum of understanding agreement as a model for the Republic's MAP proposal.

## Conclusion

The AIDS pandemic has had a devastating global impact; sub-Saharan Africa has been disproportionately affected by the disease. Countries in this region have few resources and are often unable to provide HIV services to their nationals, let alone to the refugees they are hosting. Nevertheless, when governments have been able to meet their obligations to address the health-care needs of refugees, local populations have also benefited, particularly in relation to HIV.

However, experience has shown that even though it is extremely important, the concept of integrating refugee issues into local initiatives is still not carried out on a wide scale. This means that broader and more innovative subregional policies and initiatives need to be adopted. Host countries, humanitarian and development agencies and donors need to continue to seek new ways to address the cross-border realities of the AIDS epidemic. Developing subregional initiatives such as GLIA has proved crucial. These initiatives cross national boundaries to develop transnational policies and interventions for providing HIV-related services, and have provided the six countries involved with the means to meet the unique requirements of the displaced and mobile populations which interact with their citizens. Other subregional initiatives need to be developed and fully implemented.

However, these subregional HIV policies and plans covering the needs of refugees, internally displaced persons and returnees can only be implemented if additional funding is made available. In order to address the long-term consequences of HIV, this funding needs to go beyond traditional humanitarian sources and needs to include development funding. However, global resources still fall far short of what recent funding estimates recommend as necessary to adequately address the epidemic.

If refugees and other displaced persons are to be assured of even the minimum basic HIV services, greater and more creative efforts will have to be made to gain access to all available resources from both humanitarian and development funding streams. If refugees and other displaced persons are to benefit from the recommendations by the Global Task Team on Improving AIDS Coordination among Multilateral Institutions and International Donors, all participants, especially the UN system, need to actively advocate on behalf of refugees and other displaced populations.

This document has described best practice strategies which can support the HIV-related needs of refugees and host populations, including frameworks through which governments, donors, and humanitarian and development agencies may better address the needs of these populations. UNHCR and UNAIDS hope that those involved in planning and providing HIV-related services in all conflict-affected and refugee-hosting countries will consider implementing the strategies recommended as they continue with their vital work to effectively respond to the AIDS epidemic. These efforts will help to ensure that all populations, whether local or foreign, however marginalized or stigmatized, receive essential and comprehensive HIV-related prevention, care and treatment services.

# Appendix 1: Refugee inclusion in National Strategic Plan activities

## National Strategic Plans on HIV/AIDS

| Country | Plan exists 1=yes; 2=no; 3=unknown | Plan mentions refs 1=yes; 2=no | specific activities 1=yes; 2=no | Period covered |
|---|---|---|---|---|
| Algeria | 1 | 2 | 2 | 2002-2006 |
| Angola | 1 | 1 | 2 | 2003-2008 |
| Burundi | 1 | 1 | 1 | 2002-2006 |
| Cameroon | 1 | 2 | 2 | 2000-2005 |
| Central African Republic | 1 | 1 | 1 | 2002-2004 |
| Chad | 2 | 2 | 2 | New plan to be finalized |
| Congo-B | 1 | 1 | 1 | 2003-2007 |
| Cote d'Ivoire | 1 | 1 | 2 | 2002-2004 |
| Democratic Republic of Congo | 1 | 2 | 2 | New plan to be finalized |
| Djibouti | 1 | 2 | 2 | 2003-2007 |
| Egypt | 2 | 2 | 2 | |
| Ethiopia | 1 | 1 | 1 | 2001-2005 |
| Gabon | 1 | 1 | 1 | 2001-2005 |
| Ghana | 1 | 2 | 2 | 2001-2005 |
| Guinea | 1 | 1 | 1 | 2003-2007 |
| Kenya | 1 | 2 | 2 | 2000-2005 |
| Liberia | 1 | 1 | 1 | 2004-2007 |
| Libyan Arab Jamahiriya | 2 | 2 | 2 | |
| Namibia | 1 | 1 | 1 | 2004-2009 |
| Rwanda | 1 | 1 | 1 | 2002-2006 |
| Senegal | 1 | 1 | 2 | 2002-2006 |
| Sierra Leone | 1 | 1 | 2 | 2002-2006 |
| South Africa | 1 | 2 | 2 | 2000-2005 |
| Sudan | 1 | 1 | 2 | 2003-2007 |
| Togo | 1 | 2 | 2 | 2001-2005 |
| Uganda | 1 | 1 | 1 | 200/1-2005/6 |
| United Republic of Tanzania | 1 | 1 | 1 | 2003-2007 |
| Zambia | 1 | 1 | 1 | 2002-2005 |
| | | | | |
| | **Have plan** | **Refugees mentioned** | **Refugee activities stated** | |
| Answer | 28 | 24 | 25 | |
| YES | 25 (86%) | 17 (68%) | 11 (44%) | |
| NO | 3 (14%) | 8 (32%) | 13 (56%) | |

# Appendix 2: Refugee inclusion in approved HIV proposals from the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund)

### Approved HIV proposal from Global Fund

| Country | Approved 1=yes; 2= no | Round | Plan incl. ref to refugees 1=yes; 2=no; 3=N/A | specific activities 1=yes; 2=no; 3=N/A |
|---|---|---|---|---|
| Algeria | 1 | Round 3 | 2 | 2 |
| Angola | 1 | Round 4 | 1 | 1 |
| Burundi* | 1 | Round 1 | 1 | 2 |
| Cameroon** | 1 | Round 3 and Round 4 | 2 | 2 |
| Central African Republic | 1 | Round 2 and Round 4 | 2 | 2 |
| Chad | 1 | Round 3 | 1 | 1 |
| Congo-B | 2 | | 2 | 2 |
| Cote d'Ivoire | 1 | Round 2 and Round 3 (activities for refugees in Round 3) | 1 | 1 |
| Democratic Republic of Congo | 1 | Round 3 | 1 | 2 |
| Djibouti | 1 | Round 4 | 1 | 2 |
| Egypt | 2 | | 2 | 2 |
| Ethiopia | 1 | Round 2 and Round 4 | 2 | 2 |
| Gabon | 1 | Round 3 | 2 | 2 |
| Ghana* | 1 | Round 1 | 2 | 2 |
| Guinea | 1 | Round 2 | 1 | 2 |
| Kenya* | 1 | Round 1 and Round 2 (Round 1 scanned manually) | 2 | 2 |
| Liberia | 1 | Round 2 | 2 | 2 |
| Libyan Arab Jamahiriya | 2 | | 2 | 2 |
| Namibia | 1 | Round 2 | 1 | 1 |
| Rwanda* | 1 | Round 1 and Round 3 (Round 1 scanned manually) | 2 | 2 |
| Senegal* | 1 | Round 1 | 2 | 2 |
| Sierra Leone | 1 | Round 4 | 1 | 1 |
| South Africa | 1 | Rounds 1, 2 and 3 | 2 | 2 |
| Sudan* | 1 | Round 3 and Round 4 (activities for refugees in Round 3) | 1 | 1 |

| | | | | |
|---|---|---|---|---|
| Togo | 1 | Round 2, Round 4 | 2 | 2 |
| Uganda | 1 | Rounds 1 and 3 (activities for refugees in Round 1) | 1 | 1 |
| United Republic of Tanzania* | 1 | Round 1 (Scanned manually), Round 2 (Zanzibar), Round 3, and Round 4 (refugees included in Round 4) | 1 | 2 |
| Zambia* | 1 | Round 1 Funding for 4 different groups, Round 4 – ART funding (activities for refugees in all three Round 1 proposals) | 1 | 1 |
| | | | | |
| Answer | 28 | | 25 | 25 |
| YES | 25 (89%) | | 13 (52%) | 8 (32%) |
| NO | 3 (11%) | | 12 (48%) | 17(68%) |

* Document was reviewed manually

** Full proposal not available on website, summary proposal reviewed.

# Appendix 3: Refugee inclusion in World Bank Multi-Country AIDS Programs for Africa

### World Bank - Multi-Country AIDS Program for Africa (MAP)*

| Country | Approved 1=yes; 2= no | Plan mentions refugees 1=yes; 2=no | Specific activities 1=yes; 2=no |
|---|---|---|---|
| Algeria | 2 | 2 | 2 |
| Angola | 1 | 1 | 2 |
| Burundi | 1 | 1 | 1 |
| Cameroon | 1 | 2 | 2 |
| Central African Republic | 1 | 2 | 2 |
| Chad | 2 | 2 | 2 |
| Congo-B | 1 | 1 | 1 |
| Cote d'Ivoire | 1 | 1 | 2 |
| Democratic Republic of Congo | 1 | 1 | 1 |
| Djibouti | 1 | 1 | 1 |
| Egypt | 2 | 2 | 2 |
| Ethiopia | 1 | 1 | 1 |
| Gabon | 2 | 2 | 2 |
| Ghana | 1 | 2 | 2 |
| Guinea | 1 | 1 | 1 |
| Kenya | 1 | 1 | 2 |
| Liberia | 2 | 2 | 2 |
| Libyan Arab Jamahiriya | 2 | 2 | 2 |
| Namibia | 2 | 2 | 2 |
| Rwanda | 1 | 1 | 1 |
| Senegal | 1 | 1 | 1 |
| Sierra Leone | 1 | 1 | 1 |
| South Africa | 2 | 2 | 2 |
| Sudan | 2 | 2 | 2 |
| Togo** | 1 | 1 | 2 |
| Uganda | 1 | 2 | 2 |
| United Republic of Tanzania | 1 | 2 | 2 |
| Zambia | 1 | 1 | 2 |
| | | | |
| Answer | 28 | 19 | 19 |
| YES | 19 (68%) | 14 (74%) | 9 (47%) |
| NO | 9 (32%) | 5 (26%) | 10 (53%) |

* Findings based on MAP Project Appraisal Documents (PAD)

** Project Information Document (PID) reviewed

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The Joint United Nations Programme on HIV/AIDS (UNAIDS) brings together ten UN agencies in a common effort to fight the epidemic: the Office of the United Nations High Commissioner for Refugees (UNHCR), the United Nations Children's Fund (UNICEF), the World Food Programme (WFP), the United Nations Development Programme (UNDP), the United Nations Population Fund (UNFPA), the United Nations Office on Drugs and Crime (UNODC), the International Labour Organization (ILO), the United Nations Educational, Scientific and Cultural Organization (UNESCO), the World Health Organization (WHO), and the World Bank.

UNAIDS, as a cosponsored programme, unites the responses to the epidemic of its ten cosponsoring organizations and supplements these efforts with special initiatives. Its purpose is to lead and assist an expansion of the international response to HIV/AIDS on all fronts. UNAIDS works with a broad range of partners – governmental and nongovernmental, business, scientific and lay – to share knowledge, skills and best practices across boundaries.

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UNAIDS • BEST • PRACTICE • COLLECTION

The UNAIDS Best Practice Collection

- is a series of information materials from UNAIDS that promote learning, share experience and empower people and partners (people living with HIV, affected communities, civil society, governments, the private sector and international organizations) engaged in an expanded response to the HIV/AIDS epidemic and its impact;
- provides a voice to those working to combat the epidemic and mitigate its effects;
- provides information about what has worked in specific settings, for the benefit of others facing similar challenges;
- fills a gap in key policy and programmatic areas by providing technical and strategic guidance as well as state-of-the-art knowledge on prevention, care and impact- alleviation in multiple settings;
- aims at stimulating new initiatives in the interest of scaling up the country-level response to the HIV/AIDS epidemic; and
- is a UNAIDS interagency effort in partnership with other organizations and parties.

Find out more about the Best Practice Collection and other UNAIDS publications from www.unaids.org. Readers are encouraged to send their comments and suggestions to the UNAIDS Secretariat in care of the Best Practice Manager, UNAIDS, 20 avenue Appia, 1211 Geneva 27, Switzerland.

**Strategies to support the HIV-related needs of refugees and host populations**

UNHCR and UNAIDS seek to inform and support key decision-makers on HIV-related issues facing refugees, other populations of concern to UNHCR, and the populations of host countries. Though the content of this study focuses on sub-Saharan Africa, the concepts discussed are applicable to refugee situations outside this region. The study presents an overview on the various transitions of refugee life, often referred to as the “cycle of displacement”, the rights of refugees, including but not limited to the host country’s general responsibility to ensure that refugees have non-discriminatory access to existing HIV-related services and Best Practices aimed at supporting and improving the provision of HIV-related services to both refugee and surrounding host country populations through refugee integration, subregional initiatives and combined funding streams.

Where conflict and forced displacement occur, it is more effective and efficient from the point of view of public health and programme effectiveness to deal with the HIV-related needs of the populations affected by the displacement (refugees, internally displaced and host populations) in an integrated and holistic fashion, preferably under the umbrella of the national aid strategy. This approach serves not only to ensure that the refugees receive the HIV-related assistance they need but also that local populations do not suffer from the displacement around them.

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