refugees and aids

What should the humanitarian community do?

AIDS is a long-term emergency and a crisis for the human race.
(Peter Piot, Executive Director, UNAIDS)

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Contents

Introduction

As humanitarian actors working in refugee[1] situations, we cannot close our eyes to the deadly threat of HIV/AIDS. We must assume greater proactive responsibility for enabling refugees to protect themselves from the spread of HIV infection and to lessen the impact on those infected and affected.

40 million

people are living with HIV/AIDS. This figure is over 50% higher than projected by the World Health Organization in 1991.

The question is not whether more people will die. **More people will die**. The question is how many generations will suffer as ours is doing today; and how many generations will be saddled with a spreading virus, catastrophic economic and social losses, and heart-breaking, pervasive loss of life.

(Kofi Annan, UN Secretary-General)

In order to be effective in preventing and managing HIV/AIDS, staff working in all sectors and areas, including security, protection, site planning, community services, education and health, must assume responsibility for HIV/AIDS-related activities in their respective programs. If we fail to take up the challenge, many will die, leaving dependents and adding to the burdens of refugees.

- Of those who are infected with HIV, almost 70% are found in sub-Saharan Africa. In Africa, more than 12 million children have already been orphaned by AIDS. This figure is expected to rise to 24 million by 2010.
- More than 20 million people have died of AIDS since the beginning of the epidemic.
- About one-third of those currently living with HIV/AIDS are aged 15-24. Most of them do not know they carry the virus.
- 5 million new HIV infections occurred in 2001.
- An estimated 6.1 million people in South and Southeast Asia were living with HIV in 2001.
- Eastern Europe is experiencing the fastest-growing AIDS epidemic in the world.

UNAIDS, AIDS Epidemic Update: December 2001, UNAIDS and WHO

This document was produced by the Women's Commission for Refugee Women and Children under the auspices of the Inter-agency Working Group on Reproductive Health in Refugee Situations to provide user-friendly guidance and mobilize humanitarian actors working in refugee settings to address HIV/AIDS.

The aim of the document is to stimulate policy makers, managers and implementers to strengthen their response to HIV/AIDS. It is not a comprehensive guide to HIV/AIDS programming in refugee settings. Readers are encouraged to utilize the key resource materials, among others, referenced at the end of this document.

modes of transmission of hiv|aids

HIV spreads in three ways: through **sex;** through **blood;** and from **an infected mother to her baby.**

HIV does not spread through coughing or sneezing, shaking hands, sharing a cup or plate, hugging, insect bites, spitting or through living or working with someone who has HIV infection or AIDS.

sex

Sex: The most common route of transmission of HIV is through sex. Preventing and controlling sexually transmitted infections (STIs)[2] is important in helping control the spread of HIV, as these infections substantially increase the risk of HIV transmission during sexual contact.

blood

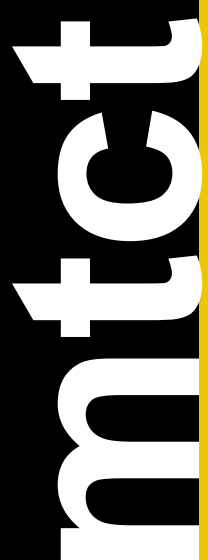
Blood: The virus can also be transmitted through blood and some other body fluids,[3] especially when infected blood enters the blood system directly, as in a transfusion or when drug users share injecting equipment. There is a small risk of transmission in healthcare settings. In refugee situations, it is essential that all blood for transfusion is tested first, and that universal precautions are strictly followed with all patients and all used equipment.

Universal precautions are a set of safety measures designed to prevent the transmission of HIV and other infections from patient to patient, healthcare worker to patient and patient to healthcare worker. The guiding principle for the control of infection by HIV and other infections which may be transmitted through blood, blood products and body fluids is that all should be assumed to be potentially infectious.[4]

Percentage of infants born to HIV-positive women becoming infected

- If not breastfed — 15 to 30%
- If breastfed up to six months — 25 to 35%
- If breastfed for 18 to 24 months — 30 to 40%

Adapted from De Cock, JAMA 2000



Mother-to-child transmission (MTCT): Transmission of HIV from an infected mother to her infant can occur during pregnancy, during labor or after delivery through breast milk. In the absence of preventive interventions, about one-third of babies born to HIV-infected women become infected with HIV in developing countries.

The risk of MTCT is greatest when the level of virus in the mother's blood is high. This occurs in the weeks after a woman first becomes infected, and again, generally years later, when she develops AIDS-related symptoms.[6] The risk of MTCT is greater during vaginal delivery than during elective cesarean. However, cesarean births are not always the best option in refugee situations because of the risk of infection and other complications. Invasive procedures during delivery, such as artificial rupture of membranes or episiotomy, may increase the risk of MTCT.

stis and hiv

Sexually transmitted infections and HIV spread fastest where there is poverty, powerlessness and social instability characteristic of refugee and internally displaced populations. The disturbance of community and family life among displaced populations may disrupt social norms governing sexual behavior. Adolescents may start sexual relations at an earlier age, take sexual risks, such as having sexual intercourse without using a condom, and face exploitation in the absence of traditional socio-cultural constraints. During civil strife and flight, displaced persons, especially women and girls, are at increased risk of sexual violence, including rape. Women and children may be coerced into having sex to obtain their survival needs.

In refugee settings, populations from low HIV prevalence areas may now be living close to a population with high prevalence. Peace-keeping forces, military and police may also be susceptible to infection and facilitating the spread of HIV in refugee situations.[7]

protection and human rights

HIV/AIDS must be addressed within the framework of the international refugee protection regime, as laid out in the 1951 Refugee Convention and other international human rights instruments which provide for the respect of the rights of persons affected by HIV/AIDS.

In accordance with UNAIDS and WHO policies, UNHCR strictly **opposes mandatory HIV testing** of refugees because of the risk of indirect violation of human rights through discriminatory consequences for individuals who test positive for HIV. Mandatory testing does nothing to stop the spread of the virus.

Human Rights: All refugee relief operations must respect and protect human rights. The provision of HIV/AIDS education and services should be seen as part of meeting refugees' basic rights to life, health, education and information. Refugees also have a right to freedom from violence, including sexual and gender-based violence. Coercion and discrimination, including mandatory testing, are never justified (Refugees and AIDS – Technical Update. UNAIDS, Sept. 1997)

Consideration of how to protect and promote the rights of refugees can generate creative ideas to reduce vulnerability to HIV. For example, promoting refugees' right to dignity might include stimulating social activities that encourage respect and trust, raise morale and enable men and women to meet in socially acceptable ways.

Guiding principles for program responses

Human Rights

- Recognize that violations of human rights increase vulnerability to HIV and that responses to HIV/AIDS may breach human rights.
- Respect refugees' rights to informed consent by providing adequate information and counseling.
- Ensure accessible services, privacy, confidentiality and continuity of care.
- Recognize the importance of linking prevention with non-discriminatory care and support.
- Respect the right to live (and die) in dignity, and without undue pain.

Coordinated Multi-sectoral Approach

- Designate HIV/AIDS focal points.
- Design HIV/AIDS interventions in close consultation with the national HIV/AIDS control program.
- Integrate HIV/AIDS programming into existing activities.
- Coordinate, communicate and collaborate within and among sectors, with other organizations, including local nongovernmental organizations, and with refugees themselves.
- Recognize the uncertain and sometimes temporary nature of the refugee context; plan activities with short-term outcomes, as well as longer-term goals.
- Ensure that equitable HIV/AIDS services are provided to local and refugee populations.

Community Participation

- Include men, women, youth and people living with HIV in situation analysis, program planning, implementation and evaluation.
- Ensure activities that foster gender equity. Empower refugee women and girls at every level.

Quality of Care

- Understand that vulnerability to STIs and HIV is determined not only by individual behaviors but also by the societal context and by the coverage, quality and access to prevention, care and support services.[8]
- Identify and work with refugees previously trained in skills relevant to HIV prevention and care.
- Plan program activities based on the findings of the local situation analysis and published research, as well as routine monitoring and surveillance information.
- Identify groups and areas of high transmission within the refugee community to more effectively target specific HIV/AIDS activities.
- Monitor and evaluate program interventions and disseminate the lessons learned.

establishing hiv/aids interventions

Emergency Phase

Current humanitarian standards[9] include a Minimum Initial Services Package (MISP) of reproductive health activities to be provided in emergencies.[10 11] These activities are designed to reduce reproductive health morbidity and mortality. MISP can be implemented without a site-specific assessment. MISP activities to reduce the transmission of HIV include:

- identifying an individual and organization responsible for ensuring that the MISP is implemented;
- ensuring a safe blood supply;[12]
- implementing universal precautions;[13 14]
- guaranteeing the availability of free condoms;
- addressing the prevention and management of sexual violence;[15 16] and
- planning for comprehensive reproductive health services,[17] including a site-specific HIV/AIDS situation analysis.

Post-emergency Phase

In the post-emergency phase, relevant organizations and a range of refugee representatives will need to plan additional STI and HIV prevention and care strategies.[18]

The selection of interventions will depend on the type of setting (i.e., camp, non-camp or resettled area), and the degree of stability and security. Priorities will also be determined by the findings of the situation analysis, including the prevalence of HIV in the country of origin, host and refugee populations if known, the level and pattern of risk factors and the social services available. Interventions need to address the interacting factors that result in vulnerability to HIV: the coverage and quality of prevention, care and support services, individual behaviors and the social and cultural context.

Interacting Factors That Result in Vulnerability to HIV

Adapted from Tarantola et.al

prevention of sexual transmission

- Providing services
- Changing individual behavior
- Addressing societal context

Strategies that relate to provision of services:

Condom distribution

The correct and consistent use of condoms will substantially reduce the risk of STIs, including HIV.

- Condoms (male and female) should be available in health centers and also in bars, the market area, food distribution centers and other areas where men, women and youth are likely to gather.
- Simple illustrated instruction leaflets should be available where condoms are distributed and condoms should be available wherever there are posters or leaflets regarding safe sex and HIV/AIDS.
- Base estimates for condom requirements should be on an average of 12 male condoms per sexually active male per month and 6 female condoms per sexually active female per month.[19]

STI prevention and management

STIs increase one's risk of becoming infected and of passing on HIV for both men and women. Therefore, it is essential to establish and integrate STI services and condom distribution into general health services as soon as possible. Define a management protocol for STIs consistent with national protocols that includes:

- early and effective case finding, case management, partner notification and treatment;
- preventive voluntary counseling and testing if available;
- qualified staff trained in STI protocols;
- user-friendly confidential services with special consideration to meet the needs of women and adolescents;
- a consistent supply of the appropriate medicines and condoms;
- a functioning health information system to examine trends, as well as gender and age distribution of disease;
- program monitoring for the quality of STI case management;
- STI screening in antenatal programs; and
- all staff, including volunteer workers, trained in STI prevention and taught to utilize information materials, such as brochures, and to distribute condoms.

Voluntary Counseling and Testing (VCT) for HIV

VCT can be a useful tool in promoting behavior change among refugees who test positive or negative for HIV, and it can act as an entry point to health care and other support mechanisms for those who test positive. Good counseling combined with testing assists people to make informed decisions and cope better with their health condition. Establish VCT for HIV in a refugee setting only if:

- VCT is available in the host country or country of origin to ensure that interventions are in line with national programs;
- informed consent, pre- and post-test counseling, and confidentiality can be assured (see box);
- a confirmatory testing strategy is in place, as outlined in UNAIDS Policy on HIV Testing and Counseling;[20]
- counseling, services and support are available for those found to be HIV-positive; and
- sufficient resources are available to train counselors and supply test kits.

Consent and Counseling

Informed consent requires an understanding of the implications of a positive test result and the voluntary decision to be tested. Pre-test counseling should include the individual's personal history and possible exposure to HIV, as well as his/her understanding of the modes of HIV transmission. During post-test counseling, when the test result is positive, the person should be advised as gently as possible with emotional support and a discussion about available care and social services. If the HIV test is negative, then the person must be advised about the "window period" of three to six months when a negative result may be false. This counseling session is an important opportunity to discuss methods of HIV transmission and prevention.

Strategies that relate to changing individual behaviors:

- Promote the development and dissemination of information, education and communication (IEC) materials for behavior change: posters, pamphlets, drama, puppet shows, song, radio, videos, newsletters, etc.

  Messages might relate to safer sex practices (abstinence, use of condoms, fidelity, non-penetrative sex); encouragement to seek treatment for STIs; and encouragement of respect and protection for women. The target audiences should include: peace-keeping forces, police, local military personnel, sex workers, their clients and youth. IEC materials are most effective if designed, produced and disseminated with the participation of their intended audience. Always pre-test IEC materials before production and distribution.

- Support peer education. Married and single women and men, teachers, youth and sex workers, among others, may be trained as peer educators.

- Facilitate education, awareness raising and advocacy by people living with HIV/AIDS.

- Ensure prevention counseling of STI patients by health workers.

Strategies that relate to the societal context:

- Ensure broad community sensitization about HIV/AIDS for prevention awareness and to reduce the stigma that inhibits people from seeking services.
- Protect against sexual and gender-based violence. (See page 21.)
- Provide opportunities for social activities for adults and youth, such as community leisure centers, choirs, sports activities, dancing, theater, youth groups and support groups for men and women.
- Train facilitators to conduct a series of community discussions using participatory learning and action exercises for community behavior and attitude changes.[21]
- If feasible, support income generating activities, particularly for women and men who want to leave sex work.

Protect against sexual violence

- Camp layout should be designed in consultation with refugees, including women, with due consideration of security issues.
- Ensure proper registration of all refugees, with special attention to female and child heads of households.
- Ensure female refugees' access to camp services and essential goods, such as food, fuel and water.
- In collaboration with relevant local representatives, establish a committee to address the prevention of sexual violence.

prevention of transmission

- In health care settings
- Through injecting drug use
- From mother to child

Prevention of transmission in health care settings:

Blood Transfusion Safety[22]

- Screen all donated blood for HIV, syphilis, hepatitis B and C viruses.
- Identify donors who are at low risk of HIV infection.

Universal Precautions

- Universal precautions consist of: safe handling and disposal of sharps, safe decontamination of instruments, hand washing after all procedures, use of protective barriers to prevent direct contact with blood and body fluids, safe disposal of contaminated waste.
- Ensure adequate supplies and training of health workers in universal infection control precautions, including the safe handling of needles, sharps and medical waste.

Post-exposure Prophylaxis for Occupational Exposure to HIV

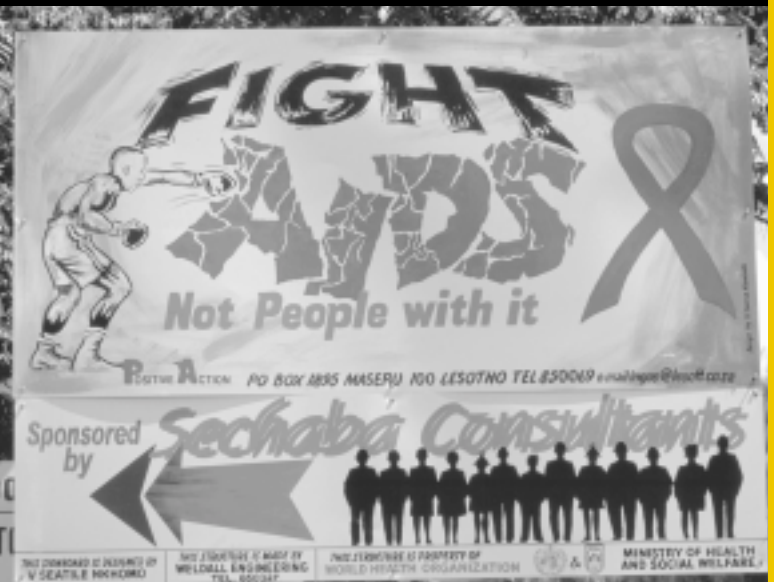
- Develop a protocol and provide training to staff to address occupational exposure to HIV, including information on post-exposure prophylaxis (PEP). Post-exposure prophylaxis means prevention after exposure, for example after a needle stick injury. A combination of antiretroviral drugs is used. The United States Public Health Service has established guidelines for the management of occupational exposures to HIV.[23] The UN and Medecins Sans Frontieres also have guidelines on PEP.

Post-exposure Prophylaxis for Non-occupational Exposure to HIV

- Explore the availability and use of PEP for preventing transmission of HIV after rape. Although the research on the efficacy of PEP after rape is inconclusive, it is used in some settings.[24] [25]

- If the service is available, develop a list of provider names and addresses for referrals.

Prevention of transmission through injecting drug use:



- Prevent people from starting to inject.
- Provide support and treatment services to people who want to stop injecting.
- Protect the health of those who inject and their sexual partners, their families and the community.
- Provide counseling, condoms, needle-syringe programs, drug substitute programs, bleach and instructions for cleaning needles if a sterile needle exchange program is not possible.

Prevention of mother-to-child transmission:

UNAIDS recommends three integrated strategies to prevent mother-to-child transmission of HIV:[26]

1. Preventing HIV infection in young people and women of childbearing age

This can be achieved through community education about HIV, especially addressing men, screening and treatment of STIs, increasing access to VCT, promoting condoms, and providing access to safe blood. New HIV infections during pregnancy or the breastfeeding period are associated with particularly high rates of transmission from a mother to her infant. Advise men that unprotected sex with others while their partner is pregnant or breastfeeding carries a high risk of acquiring HIV infection, which can be transmitted to their partner and so to their infant.

2. Preventing unwanted pregnancy among women/couples with HIV infection

Strengthen men's and women's reproductive health services. Encourage planning for pregnancies. Train health workers to counsel HIV-positive women or women with HIV-related signs and symptoms about their risk of MTCT. However, HIV should never be used as a reason to pressure women into having or not having children. New mothers who do not breastfeed or stop breastfeeding early are at greater risk of becoming pregnant. Family planning services are particularly important for HIV-infected women who choose to avoid breastfeeding for the prevention of MTCT.

3. Preventing transmission of HIV from an infected mother to her infant

Ways to reduce the risk of transmission from the mother to the child include:

- Using antiretroviral drugs to reduce HIV viral load during pregnancy and delivery and/or post-partum.
- Providing elective cesarian section before the onset of labor where feasible and safe.
- Avoiding unnecessary invasive procedures (artificial rupture of membranes, episiotomy).
- Avoiding breastfeeding when replacement feeding is acceptable, affordable, sustainable and safe.

Current recommendations of the inter-agency task team on infant feeding and HIV-infected mothers:[27]

- When replacement feeding is acceptable, feasible, affordable, sustainable and safe, avoidance of all breastfeeding by HIV-infected mothers is recommended.
- If any of these conditions is not met, exclusive breastfeeding is recommended during the first months of life.
- All HIV-infected mothers should receive counseling, which includes provision of general information about the risks and benefits of various infant feeding options, and specific guidance in selecting the option most likely to be suitable for their situation. Whatever a mother decides, she should be supported in her choice.
- To minimize HIV transmission risk, breastfeeding should be discontinued as soon as feasible, taking into account local circumstances, the individual woman's situation and the risks of replacement feeding (including infections other than HIV and malnutrition).
- HIV-infected women who breastfeed should be assisted to ensure that they breastfeed exclusively and use a good breastfeeding technique to prevent breast conditions, such as mastitis, breast abscess and nipple fissure, which should be treated promptly if they occur.

However, making these interventions available to women in resource-limited settings in a safe and sustainable manner is complex. In refugee settings, where facilities are generally inadequate, supplies of milk or formula cannot be guaranteed, and women may need to travel with their babies, it will almost always be safer for the baby to be breastfed, even if the mother is known to be infected with HIV. Therefore, in these settings, exclusive breastfeeding (nothing but breast milk, not even water) is likely to be the safest option for the baby. The woman should be supported in her choice of infant feeding method. Early cessation of breastfeeding should only be considered when adequate replacement food can be provided sustainably and safely fed to the infant. If the baby is not breastfed, a cup and spoon should be used rather than a bottle.

In refugee settings where resources are scarce and women may have difficulty accessing cesarean section for complicated deliveries, it is not likely to be feasible or safe to offer elective cesarean section to HIV-positive pregnant women.

care for people living with hiv/aids

Enabling people to live positively with HIV

- Reduce stigma and discrimination.
- Establish support groups for people living with HIV and their families.
- Encourage beneficial disclosure, e.g., spouse, clinician, care giver.
- Establish workplace policies addressing discrimination.

Comprehensive care for people infected with or affected by HIV

Establish a continuum of care, including:

- Clinic and hospital care: Develop clinical guidelines based on national guidelines for case management of HIV-related illnesses for the treatment of symptoms and opportunistic infections, including prophylaxis where feasible and appropriate. Include access to antiretroviral treatment if appropriate and feasible. Ensure nutritional needs and tuberculosis control are addressed.
- Draw up an essential drug list for care of HIV-related illnesses and ensure the procurement and supply of these drugs.[28] Train health workers in the use of clinical guidelines and essential drug list.
- Home-based care: Recruit and train volunteers to provide home-based care. Secure supplemental food rations as needed. Assure a link between home-based care and clinical services.
- Palliative care: Assist people with advanced HIV infection/AIDS-related illnesses to be as comfortable as possible. Support hygiene, address fever, itching, diarrhea, cough and, especially, symptomatic relief of pain.
- Encourage and support the development and training of self-help and other community-based groups to meet the medical, social and emotional needs of people affected by HIV/AIDS, their families and caregivers. Influential individuals, such as teachers, health care providers and community and religious leaders, should be engaged in creating a positive and caring environment for people living with HIV/AIDS and their families.

Establish support mechanisms for caregivers. Ensure care and support are shared by as many people as possible.

Address the needs of AIDS orphans and other children affected by HIV/AIDS. Unaccompanied children, left behind because of the conflict or AIDS, are especially vulnerable to HIV and need to be given protection from violence, support and access to services available to other children in the camps, including shelter, food and education.

Key Resource Materials

An Inter-agency Field Manual: Reproductive Health in Refugee Situations.
UNHCR/UNFPA/WHO, 1999.
www.unhcr.ch; www.rhrc.org

Facilitating sustainable behaviour change: A guide for designing HIV programmes.
International Health Unit, McFarlane Burnet Centre for Medical Research, Australia, 1999.

Guidelines for HIV Interventions in Emergency Settings.
UNHCR/WHO/UNAIDS, 1996.
www.unaids.org
(revision underway – due to be reissued in 2002)

Guidelines for the Management of Sexually Transmitted Infections.
WHO/HIV_AIDS/2001.01

Guidelines for Sexually Transmitted Infections Surveillance.
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WHO/CDS/CSR/EDC/99.3

HIV/AIDS and Human Rights: International Guidelines.
UNHCR/UNAIDS, Geneva, September 23-25, 1996.
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Key Elements in HIV/AIDS Care and Support.
Draft working document.
WHO/UNAIDS, September 2000.
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New Data on the Prevention of Mother-to-Child Transmission of HIV and Their Policy Implications: Conclusions and Recommendations.
UNFPA/UNICEF/WHO/UNAIDS Inter-Agency Task Team on Mother-to-Child Transmission of HIV, October 11-13, 2000.
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Theory in a nutshell: a practitioner's guide to commonly used theories and models in health promotion.
Sydney: National Centre for Health Promotion.

UNHCR Policy Regarding Refugees and Acquired Immune Deficiency Syndrome (AIDS).
Inter-Office Memorandum No. 78/98,
Field Office Memorandum No. 84/98.
UNHCR, 1 December 1998.

Voluntary Counseling and Testing.
(Technical Update)
UNAIDS, May 2000.
www.unaids.org

Notes

1. In this document, the term refugee is used for conflict-affected populations, which may include internally displaced persons, refugees or returned refugees.

2. In 1998, WHO and the international community changed the term sexually transmitted disease (STD) to sexually transmitted infection (STI). The word “disease” was considered inappropriate in view of the existence of asymptomatic infections in both men and women. The change was furthermore driven by the new public health approach to contribute to the prevention of transmission of HIV through appropriate management of STIs. (Reference: WHO/HIS/1998)

3. Body fluids containing visible blood, semen and vaginal secretions. Care should also be taken with tissues and cerebrospinal, synovial, pleural, peritoneal, pericardial and amniotic fluids. Feces, nasal secretions, sputum, sweat, tears, urine, saliva and vomitus do not transmit HIV unless they contain visible blood, or when blood contamination is likely, such as in the dental setting where blood contamination of saliva is predictable.

4. Centers for Disease Control. Update: Universal precautions for prevention of transmission for human immunodeficiency virus and hepatitis B virus to health-care and public-safety workers. MMWR 1989;38 (S-6):1-36. www.cdc.gov/publications.htm

5. De Cock, Kevin M. et.al., Prevention of Mother-to-Child Transmission in Resource-Poor Countries, Translating Research Into Practice, JAMA. March 1, 2000-vol 283, No 9, 1175-1181.

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7. McGinn, T, *Reproductive Health of War-Affected Populations: What Do We Know?* International Family Planning Perspectives, December 2000.

8. Tarantola D., Hannum J., Boland R. Berezin B., & Mann J., *Policies and Programs on Sexually Transmitted Infections: The gap between intent and action*, World Health Organization and The Francois-Xavier Bagnoud Center for Health and Human Rights. October 1997.

9. The SPHERE Project, Humanitarian Charter and Minimum Standards in Disaster Response, Geneva 2000.

10. An Inter-agency Field Manual: Reproductive Health in Refugee Situations. UNHCR/UNFPA/WHO, 1999. www.rhrc.org

11. The material resources for the MISP are available in the UNFPA Reproductive Health Kit for Emergency Situations at: www.unfpa.org or email procurement@unfpa.org. The material resources are also available in the New Emergency Health Kit available from WHO at: www.helid.desastres.net

12. WHO Blood Safety, Blood Transfusion: www.who.int/dsa/caf98/blood8.htm

13. An Inter-agency Field Manual: Reproductive Health in Refugee Situations. Chapter 5, Sexually Transmitted Infections including HIV/AIDS. UNHCR/UNFPA/WHO, 1999. www.rhrc.org

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16. An Inter-agency Field Manual: Reproductive Health in Refugee Situations. Chapter 4, Sexual and Gender-based Violence UNHCR/UNFPA/WHO, 1999. www.rhrc.org

17. An Inter-agency Field Manual: Reproductive Health in Refugee Situations. UNHCR/UNFPA/WHO, 1999. www.rhrc.org

18. International Rescue Committee, Protecting the Future: A guide to incorporating HIV prevention and care in refugee settings. New York, NY 2001. www.theirc.org

19. United Nations Population Fund, Reproductive Health Kit. www.unfpa.org

20. Voluntary Counseling and Testing Technical Update. UNAIDS, May 2000.

21. www.actionaid.org/stratshope/sscntent.html

22. WHO Blood Safety, Blood Transfusion: www.who.int/dsa/caf98/blood8.htm

23. Centers for Disease Control and Prevention. Updated U.S. Public Health Service Guidelines for the Management of Occupational Exposures to HBV, HCV, and HIV and Recommendations for Postexposure Prophylaxis. MMWR 2001;50(No. RR-11): inclusive page numbers.

24. Centers for Disease Control and Prevention. Public Health Service Statement. Management of Possible Sexual, Injecting-Drug-Use, or Other Nonoccupational Exposure to HIV, Including Considerations Related to Antiretroviral Therapy. MMWR 47 (RR17); 1-14, 1998. www.cdc.gov/wonder/prevguid/m0054952/m0054952.asp

25. Centers for Disease Control and Prevention. Public Health Services Report Summarizes Current Scientific Knowledge on the Use of Post-Exposure Antiretroviral Therapy for Non-Occupational Exposures, 1998. www.cdc.gov/hiv/pubs/facts/petfact.htm

26. See: www.unaids.org/publications/documents/mtct/mtct_TU4.ppt

27. UNFPA/UNICEF/WHO/UNAIDS Inter-agency Task Force on Mother-to-Child Transmission of HIV, New Date on the Prevention of Mother-to-Child Transmission of HIV and their Policy Implications: Conclusions and Recommendations, October 11-13, 2000. www.unaids.org/publications/documents/mtct/MTCT_Consultation_Report.doc

28. UNAIDS, Technical Update, Access to Drugs, October 1998.

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Monitoring of HIV/AIDS Prevention and Care Activities in Refugee Settings

Score Guide:
0 = no activities being implemented
1 = small amount of activities
2 = moderate amount of activities
3 = comprehensive activity/program in place

NI = No information available
Y/N = yes or no

Place:

Population:

Activities/Situation	Current Situation	Plan for Improvement
A. Basic Information		
1. Prevalence of HIV in Country of Asylum		
2. Prevalence of HIV in Country of Origin		
3. Policies on HIV available?		
B. Human Rights Issues		
1. Human rights of PLWAs* in jeopardy?		
2. Confidentiality ensured?		
3. Mandatory testing prohibited?		
C. Prevention of HIV		
1. HIV blood safety (testing for safe blood transfusion)		
2. Universal Precautions		
3. Condom promotion and distribution		
4. HIV/AIDS awareness campaigns		
5. Behavioral change programs		

Activities/Situation	Current Situation	Plan for Improvement
C. Prevention of HIV (continued)		
6. Youth-specific programs		
7. STI case management and partner tracking		
8. HIV/AIDS integrated in school curriculum		
9. Programs for “risk groups”		
10. Voluntary Counseling and Testing		
D. Care of HIV/AIDS		
1. Treatment of opportunistic infections		
2. Home-based care		
3. Counseling and support of people with HIV		
4. Mother-To-Child Transmission		
5. ARV treatments		
E. Monitoring of HIV		
1. Sentinel surveillance (pregnant women)		
2. Surveillance of HIV/AIDS-related mortality		
3. STI incidence (within expected range)		
F. Coordination and Networking		
1. Active member in UN Theme Group		
2. Other networks?		

* PLWA- People Living With AIDS

Notes:

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This document was produced by the Women's Commission for Refugee Women and Children under the auspices of the Inter-agency Working Group on Reproductive Health in Refugee Situations.

The Women's Commission for Refugee Women and Children seeks to improve the lives of refugee women, children and adolescents through a vigorous and comprehensive program of public education and advocacy. The Women's Commission is the only organization in the United States dedicated to speaking out solely on behalf of women, children and adolescents uprooted by war, violence or persecution. www.womenscommission.org

The Women's Commission coordinates the Reproductive Health for Refugees Consortium, a group of seven agencies that works to increase access to a broad range of quality, voluntary reproductive health services to refugees and displaced persons around the world. www.rhrc.org

The Inter-agency Working Group, formed in 1996, is made up of 30 UN, NGO, government and academic institutional partners. It meets annually to work on expanding and strengthening the provision of quality comprehensive reproductive health services in refugee and refugee-like settings.

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