



UNAIDS PROGRAMME COORDINATING BOARD

UNAIDS/PCB (36)/CRP4

Issue date: 18 June 2015

THIRTY-SIXTH MEETING

Date: 30 June – 2 July 2015

Venue: Executive Board Room, WHO, Geneva

Agenda item 11

Thematic segment: HIV in emergency contexts

Country submissions



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INTRODUCTION

The PCB Thematic Segment of 2 July 2015 will focus on concrete initiatives and programmes that have effectively reduced the risk of HIV in emergency contexts. In order for the session to be as up to date and evidence-based as possible, PCB Members, countries, partner organizations and colleagues were invited to submit case studies that illustrate key aspects of successful HIV interventions in the context of humanitarian emergencies.

A total of 42 submissions were received: 23 from Africa, five from Asia and the Pacific, five from Eastern Europe, and three from Latin America and the Caribbean. In addition, six submissions received cover multiple countries.

The submissions reflect the work of governments, civil society organizations, United Nations and other international agencies, as well as collaborative efforts. Many offer innovative approaches to HIV programming in a wide variety of humanitarian contexts. Each one presents a particular focus on the most vulnerable, including women and girls, and other key populations. Together, they provide compelling evidence of the need to prepare for appropriate HIV interventions in all stages of a humanitarian emergency as well as to integrate disaster/emergency preparedness planning routinely in all HIV programmes.

I. African States

1. Central African Republic

Titre du programme: Projet de recherche active des Personnes vivant avec le VIH sous ARV perdus de vue pour leur remise sous traitement

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Le programme est en place depuis: Du 1^{er} Octobre 2014 au 31 décembre 2015

Mis en place par: Gouvernement, Société civile, intergouvernementale

Sujet de la soumission: L'accès à la prévention du VIH, aux soins et au traitement, Les questions liées à la protection, l'équité et les droits de l'homme, La préparation et la planification des mesures d'urgence, La coordination inter institutions, Les effets des situations d'urgence sur les populations clés, Les situations de fragilité, Les données probantes et les informations stratégique, Les contextes urbains

Le programme a-t-il été évalué/estimé ? Non

Le programme fait-il partie du plan national de lutte contre le SIDA? Oui

Dans le cadre de l'accès universel, il est prévu dans le plan national la prise en charge dans la mesure du possible de tous les patients éligibles au traitement ARV et la recherche des patients sous ARV perdus de vue fait partie intégrante du processus.

Le programme fait-il partie d'un plan national d'action d'urgence?

Oui

Ce projet fait partie des actions coordonnées du programme conjoint de lutte contre le SIDA du SNU en Centrafrique dans le cadre des urgences pendant la crise survenue en Centrafrique en 2012-2013.

Contexte :

La mise en œuvre du projet de recherche des patients sous ARV perdus de vue dans la ville de Bangui était mise en œuvre dans le contexte de crise en République centrafricaine où les groupes armés continuaient à s'affronter dans la ville de Bangui.

Approche :

La crise militaro politique que traverse la République Centrafricaine a eu un impact négatif sur la réponse au VIH et au SIDA. 43% des structures de soins qui offraient les services de prévention du VIH, de soins et de prise en charge médicale ont été détruits. L'insécurité a obligé la plupart du personnel à fuir de leurs lieux de prestation. Le déplacement massif des populations tant à



l'intérieur qu'à l'extérieur du pays n'a pas épargné les Personnes Vivant avec le VIH. Près du tiers des Personnes Vivant avec le VIH sous traitement ARV ont été perdues de vue et par voie de conséquence ont arrêté leur traitement. Les conséquences de l'arrêt de traitement chez ces PVVIH sont entre autres le développement des résistances, les infections opportunistes graves et au pire des cas le décès.

La file active des PVVIH sous ARV dans la capitale Bangui avant la crise représentait soixante pour cent de la file active nationale, soit 9 000 sur les 15 000 sous traitement, le nombre de PVVIH éligibles au traitement avoisinant les 60 000. On estime aujourd'hui à près de 1 300 PVVIH sous ARV perdues de vue dans Bangui.

Le présent projet vise principalement dans l'immédiat à rechercher activement les PVVIH sous ARV perdus de vue dans la capitale Bangui et à les remettre sous traitement en vue de réduire les conséquences létales.

Le choix de la capitale Bangui se justifie par : (i) la reprise des prestations de services dans la majorité des sites de prise en charge médicale (16/18 sites) ; (ii) la concentration des PVVIH sous ARV ; (iii) la concentration des sites des déplacés internes ; (iv) l'accalmie plus ou moins relative en ce qui concerne la sécurité et (v) le financement transitoire du Fonds Mondial pour le maintien des PVVIH sous ARV.

La stratégie privilégiée sera l'approche communautaire dans la recherche active et l'accompagnement de proximité de 1245 PVVIH sous traitement ARV perdus de vue. Cette approche permettra de garantir la confidentialité et à terme l'appropriation en vue du passage à l'échelle.

Les fonds coréens ainsi sollicités seront catalytiques pour « faire travailler l'argent du Fonds Mondial ». Ce faisant, le projet contribuera, sans nul doute, à sécuriser les fonds du Fonds Mondial destinés à la RCA.

Portée de l'intervention :

Le programme répond bien au sujet de de la soumission car il s'agit de rechercher et mettre sous traitement les patients sous ARV perdus de vue. Une prise en charge correcte des patients par les ARV constitue une action de prévention de la transmission du VIH.

Impact de l'intervention :

561 patients sous ARV perdus de vue ont effectivement repris le traitement sur la période d'octobre à Février 2015, soit 45% de la cible attendue à la fin du projet à savoir, 1245 PVVIH. C'est à travers la collecte des données de routine que ces résultats ont pu être obtenus.

Défis relevés :

Inaccessibilité dans certains arrondissements due à l'insécurité récurrente,

- des registres de prise en charge non à jour dans certains sites
- Manque de registre dans des sites de prise en charge

Les activités ont été menées dans les zones sécurisées en attendant de faire la même chose dans les zones d'insécurité (quand la sécurité reviendra).

Le Fonds mondial est dans le processus de fabrication des registres de prise en charge.

Financement et gestion :

Le projet est mise en œuvre par GIP ESTHER et coordonné globalement par l'ONUSIDA en collaboration avec le Comité National de Lutte contre la VIH et SIDA et le Ministère de la santé. Les résultats de cette phase de projet aideront à la recherche d'autre financement pour une éventuelle extension dans les villes de province.

- Leçons apprises et recommandations : Quels facteurs ont contribué au succès de l'intervention, y compris le cadre institutionnel, l'environnement législatif et politique, la coordination, la mobilisation et le soutien politique, la sensibilisation ?
- Adhésion et implication hautes autorités de l'Etat, des leaders communautaires, des leaders des structures associatives et des Media
- Implication du Comité de pilotage composé du Ministère de la Santé, du Comité National de lutte contre le VIH et SIDA, et du réseau centrafricain des personnes vivant avec le VIH
- Disponibilité des intrants pour répondre aux besoins de prise en charge des PVVIH grâce au Grant en cours du Fonds Mondial

2. Central African Republic

Ensuring Continuation of ART during Acute Instability, challenges and dilemmas; the experience of MSF OCBA in Central African Republic

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Introduction: Complex emergencies, particularly in rural areas, present significant logistic and strategic challenges to ensuring continuation of ART as the case of Central African Republic (CAR), a country with fragile health structures, scarce human resources, and regular picks of violence. Through this descriptive study we pursued to reflect the experience and results of the implementation of a contingency plan during the recent violent situation in CAR during 2013.

Project: Since 2008 MSF introduced HIV care in 3 regular programmes in a conflict area of Central African Republic. HIV care was integrated within medical activities at primary and secondary health care. In these programmes 1.567 patients were diagnosed with HIV and enrolled in care. 1128 (72%) commenced ART, including 90 (8%) children. In 2010 a contingency plan for HIV and TB patients was settled in order to respond to the volatile security situation of the area. In September 2013 when context became unstable 683 patients were under ART, the team rapidly react to implement the plan.

Outcomes: In September 2013 HIV activities where frozen except for PMTCT services. As the level of insecurity was different in the 3 sites, implementation of the plan was not equal in all. Explanation on "what to do" in case insecurity arise was included in the regular counselling sessions along the year so patients would be conscious on this regard. "Emergencies bags"



containing 2 months ARV buffer stock plus 1 week tail protection with TDF/3TC was distributed to the patients who could reach the MSF facility.

On January 2014, 594 (86%) patients received emergency bags to ensure continuation of treatment; by February 2014 313 (52%) of those patients presented for consultation.

Conclusions: for our cohort the implementation of the plan was effective being able to provide continuation of treatment to the majority of patients on ART; however few patients have come back after for follow up. Still our internal debate and concern is whether continuation of ART is the success indicator in these settings being aware that retention in care cannot be granted.

3. Côte D'Ivoire

Title of the programme: Project preparation for ANS-CI for the continuity of key programmes to the next elections in October 2015

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Programme is being implemented since: 2015

Implemented by: Civil society

Scope of submission: Access to HIV prevention, care and treatment, Preparedness and contingency planning, Effects of emergencies on key populations, Situations of fragility, Urban contexts

Has the programme been evaluated /assessed? No

Is the programme part of the national AIDS plan? No

Is the programme part of a national emergency response plan? No

Background:

In October 2010, in Côte d'Ivoire, a period of conflict began, following contested presidential elections.

Ensuing violence, mainly in the South and West, caused more than 3,000 deaths, led to one million people becoming displaced and 161,000 becoming refugees in Ghana, Liberia and Guinea. Instability continued between October 2010 and March 2011 with some areas completely inaccessible. Sporadic outbreaks of violence occurred mainly in the capital Abidjan.

In March 2011, a wave of military offensives led to besieging of key urban targets. In 2011, Côte D'Ivoire was ranked tenth in the Global Fragility ranking and is also a fragile state as defined by the World Bank and DFID.

During the conflict, humanitarian activities were coordinated under a cluster arrangement. There were sub-clusters on HIV, GBV, health and protection. But there was lack of coordination within the

HIV cluster. The merging of Ministry of Health with the Ministry for HIV following the crisis hugely impacted the multi-sectorial, decentralised response.

ANS-CI's responded to the post-election crisis by:

- Advocating for the needs and highlighting the vulnerabilities of key populations
- Highlighting human rights violations
- Mobilising funding from UNFPA to evaluate the vulnerability of key populations
- (interventions related to income-generating activities, reproductive health, GBV)
- Strengthening its partnership with the UN peacekeeping mission (ONUCI) to ensure the safety of staff who travelled to conflict areas
- Conducting security training with the support of the Alliance Secretariat
- Developing an emergency plan with support from the Alliance Secretariat.

The HIV and AIDS estimates¹ for 2013 are :

- Number of people living with HIV: 370,000 [330,000 - 410,000]
- Adults aged 15 to 49 prevalence rate : 2.7% [2.4% - 3.0%]
- Adults aged 15 and up living with HIV : 300,000 [260,000 - 330,000]
- Women aged 15 and up living with HIV : 170,000 [150,000 - 190,000]
- Children aged 0 to 14 living with HIV : 72,000 [63,000 - 82,000]
- Deaths due to AIDS : 28,000 [25,000 - 32,000]
- Orphans due to AIDS aged 0 to 17 : 400,000 [770,000 - 450,000]

Approach:

The next presidential elections in Côte d'Ivoire will take place in October 2015. After the events following the previous presidential elections in 2010, there are concerns that the elections will lead to tensions in some specific areas in the country.

ANS-CI is therefore concerned about the interruption of its interventions as consequences of a potential crisis in the country, and plans to strengthen its capacities for an adequate response to crises.

ANS-CI, as a partner organisation of the International HIV/AIDS Alliance, has been working with the Alliance in developing and strengthening their preparedness and response capacity.

It is against this backdrop and the need to ensure continuity of HIV services during these situations that the International HIV/AIDS Alliance held a week-long workshop titled "Contingency Planning and Programme Continuity for Alliance Linking Organisations Working in Fragile and Conflict-Affected Countries", in Nairobi , 8th - 12th December 2014, aimed at a number of partner organisations, to discuss practical ways to achieve this goal. ANS-CI, participated in the workshop aimed to provide important input into the development of the Alliance's response to HIV related needs in crisis situations.

Moreover, ANS-CI has developed a project aiming at ensuring the continuity of its essential services in case of troubles during the upcoming presidential elections in October 2015.

To successfully continue services in conflict situations, ANS-CI noted that the following are critical:

- Development of a contingency plan;
- Building strategic partnerships with humanitarian actors to leverage resources, knowledge and skills;
- Partnership with community based organisations to leverage networks, contextual knowledge and relations with the community members.

¹ UNAIDS



ANS-CI works in 42 of the 82 districts, covering 25 districts with service for the general population and 17 districts with services specifically for key populations (People Living with HIV, Men who have sex with Men, Sex Workers). The ANS-CI is a principal recipient Global Fund in the HIV segment therefore activities in the contingency plan primarily concern essential services supported by them.

Reach of the intervention:

The specific goals of the project are:

- Capacity building of partner organizations and the ANS-CI staff:
 - Organize a workshop of preparation and planning with 35 key partners of ANS-CI in order to define roles, responsibilities and activities of everyone in the preparation and implementation of the contingency plan. This pool of people contributes within their respective organizations in the implementation of the measures taken.
 - Organize a training session for 26 members of ANS-CI staff on safety.
- Improve access to treatment for beneficiaries in crisis. (Key populations in particular have higher HIV infections than the general population. They are marginalized and hidden, have limited access to health and social services. Conflict and disaster exacerbate vulnerability of people living with HIV/AIDS because of source of infection, disruption of treatment leading to resistance and fast disease progression. Contingency planning for HIV is critical in emergency situations to avoid disruption of treatment.)

Impact of the intervention: What did the intervention achieve in terms of HIV outcomes in prevention, treatment, care and support for people living in emergency contexts? How was this impact measured?

As the specific project is still being developed and not implemented, the impact cannot be measured yet.

Challenges faced: Describe the challenges faced and difficulties encountered in the implementation of HIV programmes in the context of humanitarian emergencies. How were these overcome?

In the context of humanitarian emergency, some of the challenges are:

- Prioritisation of many different issues other than HIV, resulting in the absence of HIV as an issue for further planning



- Funding and programming, disruption of many structures and services during an acute conflict
- Lack of good quality data for monitoring and evaluation reporting
- Hesitance of humanitarian actors to become engaged in antiretroviral treatment provision, because it is seen as something long-term
- Lack of standards and guidance on what works in HIV response in conflict affected countries
- Very few local NGOs get support and are involved in emergencies and the HIV response
- Prevention strategies are inadequate due to low capacity at public health centres and poor community systems.
- Interventions are not always well coordinated, leading to gaps in services.
- Technical and financial partners do not always align support with national priorities.
- Limited financial resources allocated to HIV response, both internally and externally.

Financing and management: How is the intervention managed, coordinated and financed? How is financial sustainability of the project addressed? Who are the major partners? What challenges were faced with funding? Were any innovative approaches to funding employed?

This project is funded by the Secretariat of the International HIV/AIDS Alliance. It is managed and coordinated by ANS-CI and reported to the Secretariat of the International HIV/AIDS Alliance.

Lessons learned and recommendations: What factors helped success of the intervention, including institutional set-up, legislative and policy environment, coordination, political mobilisation and support, advocacy?

After the crisis in Côte d'Ivoire 2010-2011, the learnings are as following:

- Disaster preparedness is of utmost importance, yet the capacity of many organisations in disaster response planning is under-resourced and needs strengthening.
- Connections between networks and platforms working on HIV need strengthening so that the needs of PLHIV are better tracked, considered and advocated for.
- An approach that integrates HIV response with services for IDPs, demobilisation and disarmament of combatants and social cohesion needs developing.
- As poverty increases so does transactional sex. It is important to develop and strengthen HIV work with sex workers and their clients including those more recently involved in transactional sex and with a focus on IDP camps.
- Further development of approaches that include GBV, stigmatisation towards sexual minorities and sex trafficking is needed.
- Coordination, monitoring and evaluation in line with national programmes are needed.
- The partners of the Secretariat of the International HIV/AIDS Alliance are well placed to establish a sub-regional network to provide HIV services to refugees coming from neighbouring countries.

The work being developed by ANS-CI on the course of 2015 aims at addressing a number of the recommendations and lessons learned from the intervention carried out in 2010-2011.

4. Democratic Republic of Congo

Title of the programme: HIV, Sexual and Reproductive Health Care and Protection for Sex Workers and Sexually Exploited Children in the Humanitarian Context of Masisi, DRC

Programme is being implemented since: October, 2013

Implemented by: Government, Civil society, UN or other inter-governmental organisation

Scope of submission: Access to HIV prevention, care and treatment

Protection issues, equity and human rights, Community resilience, Inter-agency coordination

Has the programme been evaluated /assessed? No

Is the programme part of the national AIDS plan? Yes, Decentralisation of HIV activities is an objective and sex-workers are key populations

Is the programme part of a national emergency response plan? No

Background:

For the past 20 years, instability and conflicts resulted in major population displacement in particular in South-Kivu. Four Internally Displaced camps can be found in Masisi, in between areas where the local population was already leaving. Reproductive health services and awareness is very poor, for example family planning awareness and utilisation is extremely low and STIs are the 4th most frequent diagnosis in the closest local health centre. HIV services are inexistent, except in the regional hospital supported by MSF, however only hospitalised patient benefit from testing. South-Kivu is also one of the regions where rape is a major issue.

In order to have baseline information, a randomised survey among 582 displaced women and girls aged 15-49 was performed in December 2013, and showed an accumulation of risks of HIV transmission:

- 33% of minors and 48% of adults had sex for money in the past 3 months
- 37% of women/girls had been sexually abused in the past 12 months: 44% by an unknown person, 27% by a client during sex work and 13% by an intimate partner
- 13% of women/girls had 4 to 10 partners in the past 3 months. Among those, 38% never used condoms.
- Only 13% could name one or more mode of HIV transmission and only 12% mentioned more than one mode of prevention.
- 86% of participants had never been tested for HIV
- A prevalence survey performed by the HIV national programme showed a prevalence in Masisi district of 1.2% (identical to prevalence according to people tested by MSF in the general hospital and by UNHCR among the displaced people) and in the mining town of Rubaya, where the sex-workers go on regular busses for client was 17%

Approach:

In order to cover the socioeconomic needs of their families, some girls and women don't see other options than sex-work. The project intend to address the problems associated with sex-work and sexual exploitation, taking into account both medical and protection aspects.

It aims to contribute to the reduction of HIV and STI transmission, and reduce the number of unwanted pregnancies. It also promotes respect for the human rights of sex workers and sexually exploited children (under-18 doing sex-work), and aims to reduce sexual violence.

The project is articulated around 10 strategies:

- Sensitization and buy-in
- HIV, STIs and family planning interventions in the general population
- Sex-workers identification, hot-spot mapping and snowballing
- Profiling, individual risk reduction, child protection
- Multi-Functional Team
- Peer-led approach

- Comprehensive HIV and Sexual and Reproductive Health services
- Venue-based intervention
- Male involvement
- Monitoring and Evaluation

Reach of the intervention:

Access to HIV prevention, care and treatment: The project could not happen in a vacuum, sex-workers could not be targeted when the general population had no awareness, no access to testing and treatment. UNHCR therefore supported the HIV national programme to decentralise their activities to Masisi health zone.

Protection issues, equity and human rights: Some of the sex-workers are as young as 10 years old, raising obvious serious child protection concerns. Girls and women sell sex because they cannot see any other option to cover their basic needs. The project is working with sex-workers as a group to find alternatives to sex-work. Although the main group targeted by the services is IDP, the general population benefits from the new availability of HIV and family planning services.

Community resilience: The project is a community-led project. It helps to restore women confidence and dignity and therefore help them to adapt to the displacement environment.

Inter-agency coordination: One of the project strategies is to build on each partner capacity. The cornerstone of coordination is the multisectorial team which includes all health partner, national and international, as well as protection, education and livelihood.

Impact of the intervention:

A routine data collection system was set-up at the onset of the project. The analysis of the data collected between December 2013 and 2014 shows the following results.

- 880 sex-workers/sexually abused children are included in the programme.
- 68 (7%) received PEP after rape during the first year of the project
- 83 (9.4%) received emergency contraception
- No sero-conversion to date.
- 100% are going for their quarterly reproductive health check-up.

880 women and girls are given life skills, accurate information on HIV, sexual and reproductive health and rights, through the peer education supervised system.

ARVs and CD4 count are now available in Masisi and in several points in the district.

All actors are now trying to work together on the bigger picture, access to income generating activities, men and boys education on women and children rights as well as sexual rights.

Challenges faced:

Service providers and other stake-holders language and attitude are easily judgmental or paternalistic.

Sex-workers take risks (discrimination, violence) in being in the programme because they are more visible, although all efforts are made to protect their anonymity.

Clients acceptance to condom is still very low, except for female condoms.

Clients are often violent and working on positive masculinity is challenging.

Sexually abused children and children of sex-workers are in great danger and require rapid interventions.

Alternative sources of income are limited.

Financing and management:

Programme costs are limited as the sex-workers are trained and empowered to do all the awareness and prevention activities. The health activities are build-in the health services. HIV activities have been decentralised respecting the national system, sex-workers are user of those services among the rest of the population: The programme is not parallel. The protection and livelihood activities are supposed to reduce overtime and the remaining ones integrated into the national legal and social system. The activities are coordinated by UNHCR. All relevant national and international health, legal and livelihood organisations are participating to the project.

Lessons learned and recommendations:

Key elements of success are:

- Spending all the necessary time to explain the approach and get the buy-in from all stake-holders before actually starting the project ensures that language, attitudes and commitment are appropriate.
 - A coordinated and respectful approach
 - The full involvement of the HIV and the health programmes
 - Empowering women and girls result in appropriate, adapted and innovative solutions.
- Projects for this “small group” actually impact positively on the all population, and in the Masisi case, even on the all district through set-up of HIV, cervical cancer, family planning and SGBV services.

5. Democratic Republic of Congo

Titre du programme: Accès à la prévention du VIH, aux soins et traitement dans la zone en conflit de Bukavu, Sud Kivu, RDCongo.

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Le programme est en place depuis: 2009-2012

Mis en place par: ONU ou autre organisation intergouvernementale

Sujet de la soumission: L'accès à la prévention du VIH, aux soins et au traitement

Le programme a-t-il été évalué/estimé ? Oui

Le programme fait-il partie du plan national de lutte contre le SIDA? Oui, Le plan national de lutte contre le SIDA considère les violences sexuelles comme l'une des portes d'entrée de la contamination. De ce fait le volet prévention du VIH prévoit la formation/sensibilisation et l'utilisation du kit de Prophylaxie Post Expositionnelle.

Le programme fait-il partie d'un plan national d'action d'urgence? Non

Contexte :

La RDC est un pays en voie de développement et en post conflit immédiat. Elle a connu une série des guerres dans sa partie Est. L'agriculture et l'exploitation artisanale des minerais constituent les activités principales au Sud Kivu. Les différentes guerres ont été à la base des conséquences dont le déplacement des populations, les cas répétitifs des violences sexuelles ainsi que les mariages de fait. La prévalence nationale du VIH (2.57% : rapport PNLIS 2011) était nettement inférieure par rapport à celle de ses pays voisins.

C'est ainsi que sous financement de PEPFAR à travers l'USAID, le Programme du VIH intégré au Congo (ProVIC), avait retenu la province du Sud Kivu comme l'une des provinces pour l'implémentation des activités de lutte contre le VIH particulièrement dans la ville de Bukavu. ProVIC est un consortium regroupant cinq Organisations Non Gouvernementales internationales dont la Fondation Elisabeth Glaser pour la Lutte contre le SIDA Pédiatrique. PATH est l'organisation leader de ce consortium.

Approche :

Le Programme du VIH Intégré au Congo avait mené ses interventions dans les structures sanitaires ainsi que dans la communauté.

Sur le plan communautaire, ProVIC, à travers les ONG locales, menait les activités de prévention notamment par le dépistage et l'enrôlement aux soins des populations clés et populations à risque à travers la stratégie avancée. La stratégie avancée consistait à

déplacer les équipes des prestataires des soins vers les populations cibles pour le conseil et dépistage mobile. Les personnes dépistées VIH positives avaient bénéficié des soins dans les différentes structures sanitaires selon une cartographie élaborée à l'avance.

Le Dépistage et Conseil Initié par le Prestataire était aussi proposé pour enrôler les PVVIH aux soins.

Les Personnes Vivant avec le VIH étaient réunies en groupes d'auto support pour l'appui psycho social d'abord dans les structures sanitaires pendant 6 mois. Ensuite, elles se réunissaient dans les communautés où elles avaient accès aux activités génératrices de revenu pour leur épanouissement économique.

Le message de prévention faisait particulièrement mention des interventions clés que les structures sanitaires et le projet offraient pour les fréquents cas de violence sexuelle qui étaient souvent enregistrés.

Portée de l'intervention :

Les prestataires des soins au niveau des structures sanitaires ainsi que les acteurs communautaires ont été formés sur l'approche de la mise en œuvre des activités. Un accent particulier a été mis sur la sensibilisation, la prise en charge médicale et psycho sociale des cas des survivants des violences sexuelles qui étaient fréquemment enregistrés dans cette province. Les populations clés, à risque et la population générale avaient tous accès aux services de prévention et des soins et traitement.

Impact de l'intervention :

Le rapport de service de ProVIC de 2012 a présenté les données suivantes pour la province du Sud Kivu :

En neuf mois (entre Octobre 2011 et Juin 2012), 36255 des populations cibles tant dans les hôpitaux que dans les communautés ont été atteintes individuellement ou en petits groupes par des messages et interventions de prévention.

Particulièrement dans la communauté 6842 personnes à risque dont 1090 camionneurs, 595 miniers, 1152 personnels de sexe, 1706 pêcheurs et 77 homosexuels (Man having Sex with Men) et 2226 autres personnes.

15146 clients ont reçu le dépistage VIH dont 4902 femmes enceintes et allaitantes et 38 autres femmes ont reçu les ARV dans le cadre de la Prévention de la Transmission du VIH de la Mère à l'Enfant.

2516 Personnes Vivant avec le VIH incluant celles vivant déjà dans la communauté et celles nouvellement identifiées dans la période avaient reçu l'appui psychosocial et spirituel.

Les survivants des violences sexuelles figurent tout aussi parmi les clients qui recevaient les soins de prévention au VIH. Il faut signaler que pendant ce temps, ProVIC n'avait pas un indicateur pour collecter singulièrement les données liées aux survivants des violences sexuelles parmi les personnes qui bénéficiaient des interventions.

Défis relevés :

Les défis majeurs sont d'abord d'ordre sécuritaire. C'est pour cela qu'un représentant du projet était requis de participer aux réunions sécuritaires de la ville, et le personnel était, par moment, interdit de fréquenter les axes routiers jugés moins sécurisés. De fois la fréquentation des bureaux pour les staffs était suspendue jusqu'à nouvel ordre. La planification des activités ne prenait pas en compte les zones à risque. Cela veut dire qu'une partie des populations de Bukavu par exemple n'était pas couverte par les services de prévention, soins et traitement simplement à cause de l'insécurité qui y régnait. Tout déplacement du personnel était subordonné à la disponibilité des vols des agences de l'ONU qui desservaient la région.

Financement et gestion :

Le projet était représenté dans la province par une coordination provinciale dirigée par un coordonnateur provincial. Les fonds de fonctionnement et des activités étaient gérés par une unité financière de la coordination qui recevait trimestriellement les fonds du niveau central du projet. Et il existait une petite caisse avec cash pour les cas urgents, surtout pendant les perturbations sécuritaires et fermetures des banques.

Leçons apprises:

Pour mener à bien les interventions dans des zones à conflit il faut :

- Collaborer et coordonner avec les autorités sanitaires, politiques et sécuritaires et les communautés locales ;
- Former à priori les prestataires des soins de santé et les leaders d'opinion et les représentants de la société civile sur la prise en charge médicale des personnes victimes des violences sexuelles ;

Mettre en place une petite caisse pour régler les urgences pendant les perturbations sécuritaires et fermetures intempestives des banques.

6. Democratic Republic of Congo

Titre du programme : « Programme d'appui à l'élimination du VIH et des violences faites aux femmes et aux filles pendant la période de conflit et post conflit dans les provinces de l'Est de la RDC (Nord Kivu, Sud Kivu, Province Orientale, Katanga et Maniema) »

CONTACT

Nom : Mme Marie NYOMBO ZAINA

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Le programme est en place depuis: 2009

Mis en place par: Société civile

Sujet de la soumission: L'accès à la prévention du VIH, aux soins et au traitement, Les questions liées à la protection, l'équité et les droits de l'homme

Le programme a-t-il été évalué/estimé? Oui

Le programme fait-il partie du plan national de lutte contre le SIDA? Oui, Le programme de SGBV et prévention du VIH a été intégré dans le plan stratégique national 2014-2017 de lutte contre le SIDA dans l'axe stratégique 4 : Promotion d'un environnement favorable aux Personnes Vivant avec le VIH et PA.

Nous avons personnellement participé à l'élaboration du plan stratégique nationale comme experte de la société civile formée par l'ONUSIDA pour l'intégration de ces différents aspects du programme.

Le programme fait-il partie d'un plan national d'action d'urgence? Oui, Ce programme est repris dans le plan d'urgence humanitaire de lutte contre le SIDA de l'ONUSIDA.

Contexte :

Les Cinq provinces de l'Est de la RDC ont connues des situations des guerres à répétition depuis 1996. Ce qui a plongé cette partie du Pays dans situation de crises socioéconomiques et humanitaires critiques ; aux violences sexuelles et basées sur le Genre qui ont conduit à un taux de prévalence à VIH élevé et à la vulnérabilité des femmes et des filles par rapport à l'accès aux services de soins de qualité et de prise en charge sur tous les plans. Pour preuve, les taux de prévalence dans ces différentes provinces selon l'EDS - RDC II 2013-2014 sont : (Katanga 1,5 %, Nord Kivu, Sud 0,4% Kivu, Province Orientale 2,3 % et Maniema 4%).

L'interrelation entre la violence faite aux femmes pendant et après les conflits et t l'incidence croissante du VIH et du SIDA est l'un des moins avancés du monde catastrophes signalées.

C'est dans ce contexte que au sein de RENADEF, nous avons conçus ce programme qui nous a permis d'établir la corrélation entre les violences sexuelles et la transmission du VIH et proposer des pistes des solutions efficaces accompagner la population en générale et les femmes et filles en particulier dans ce contexte humanitaire précaire.

Approche :

L'accompagnement psycho-sociale - L'accompagnement judiciaire des victimes - La prévention
- Le renforcement des capacités des leaders communautaires et la police sur la lutte contre toutes les formes des violences faites aux femmes et filles dans la communauté et la sécurisation des victimes et survivantes des violences- La réinsertion socioéconomique et le plaidoyer pour lutter contre l'impunité et l'indemnisation des victimes

Portée de l'intervention :

Ce programme répond aux questions clés incluses dans la catégorie du sujet de la soumission car il permet de mener les interventions holistiques pour contribuer à la réduction de la violence liée au genre et due à la vulnérabilité, ainsi que la stigmatisation et la discrimination faites aux femmes affectées ou infectées par le HIV/SIDA dans cette partie du pays en situation de crise humanitaire constantes.

Impact de l'intervention :

Ce programme a produit les résultats suivants :

- 60 para-juristes formés ont permis d'aiguiller 1500 femmes victimes de violence pour lesquelles les plaintes ont été rédigées et déposées aux instances judiciaires du Parquet et de la Police locale lorsque l'auteur était connu ou inconnus.
- 610 acteurs parmi les officiers de l'armée, de la police, des chefs coutumiers, de chefs de l'administration locales, des leaders de la société civiles ont été informé et sensibilisés sur la nécessité de leur implication dans la lutte contre l'impunité des actes de violences sexuelles contre les femmes et la stigmatisation des femmes PVVIH/SIDA.
- 3635 femmes victimes de violences sexuelles et autres formes ont été dé traumatisées à travers les maisons d'écoutes implantées pour offrir les services de counseling approprié. Ces femmes, hier, déprimées, abandonnées, ont été réhabilitées psychologiquement dans les provinces ciblées par le projet
- 1500 Femmes victimes de violence sexuelle référées vers les hôpitaux et autres structures de soins, 403 ont été contaminées par le VIH ; soit une prévalence de 27% ;
- 100 femmes démunies, victimes des violences et du VIH ont bénéficiées de petit fonds pour la réinsertion socioéconomique dans leurs communautés respectives.

Défis relevés :

- Conflit armé dans les zones d'intervention. Les activités de mise en œuvre du projet ont due attendre des moments d'accalmie pour débiter ;
- Absence dans certaines localités de structures de micro - finance au niveau local sans représentation au niveau national a posé de problèmes de transfert et paiement à temps de fonds ;
- Insuffisance des ressources liées aux AGR entraînant un temps assez long pour générer les ressources pouvant permettre la réinsertion socio-économique des femmes victimes de violences sexuelles séropositives ;
- Nombre faible des femmes sous AGR 100 sur les 403 d'où manque d'équité ;

- Maisons d'écoute faiblement équipées en ressources matérielles et humaines voire en nombre. Les trois unités au lieu de huit ont joué deux ou trois rôle faute des ressources financières suffisantes ;
- Absence de Centre de Dépistage Volontaire dans les maisons d'écoute nécessitant de référence des femmes avec le risque de pertes de vues pour assurer le suivi dans chaque localité ;
- Prise en charge médicale de victimes de violences sexuelles non réalisée faute de ressources financières et/ou de contrat de soins avec les structures de prise en charge ;

Leçons apprises et recommandations:

Sortie de clandestinité de femmes victimes de violences en général et en particulier celles victimes de violences sexuelles suite à la sensibilisation, l'existence d'une structure d'accompagnement psychosocial et judiciaire ;

- Visibilité de l'ampleur du VIH parmi les femmes victimes de violences sexuelles par le dépistage volontaire au VIH ;
- Assouplissement des délais d'identification de victimes de violences ;
- Amélioration du niveau de protection contre le VIH/SIDA par l'implication de la police, les cadres de l'administration et leaders communautaires ;
- Amélioration de la réponse locale aux besoins socio-économiques des victimes de violences sexuelles vivant avec le VIH à travers les AGR ;
- Amélioration de la concertation locale autour de la problématique de violences sexuelles et le VIH/SIDA ;
- Forte perception des autorités politico-administratives, militaires, de la police et les leaders coutumiers et religieux de la lutte contre les violences sexuelles et le VIH/SIDA chez les femmes dans les zones d'intervention ;
- Leadership local sur la question des violences faites à la femme renforcé ;
- Forte mobilisation des partenaires locaux pour la lutte contre la violence faite aux femmes et le VIH/SIDA.

RECOMMANDATION

- Poursuivre le plaidoyer ciblé pour une prise en compte de la dimension des violences sexuelles faites aux femmes et le VIH dans les projets et programmes nationaux et sectoriels ;
- Mobiliser des ressources pour consolider les acquis et étendre l'initiative aux autres localités où aucune intervention n'est enregistrée jusqu'à ce jour ou jugée insuffisante en rapport avec l'ampleur de la propagation du VIH/SIDA et du taux de violence faite aux femmes.

7. Democratic Republic of Congo

Titre du programme : Programme de Renforcement des Capacités des Pairs Educateurs en Matière de Lutte Contre le VIH/SIDA

CONTACT

Nom : Joséphine Charlotte ISALU ISANGI

Fonction : Coordinatrice Nationale

Organisation : CASPOF Renforcement des Capacités des Structures d'Encadrement et de Promotion du Secteur Privé et des Organisations Féminines de la Société Civile.

CASPOF/Ministère du Plan et Révolution de la Modernité

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Le programme est en place depuis: 2013

Mis en place par: Gouvernement, Société civile:

Sujet de la soumission: L'Accès à la prévention du VIH, aux Soins et au Traitement, Les questions Liées à la protection, l'équité et les Droits de l'homme, La résilience communautaire:

Le programme a-t-il été évalué/estimé? Non

Le programme fait-il partie du plan national de lutte contre le SIDA?

Le programme fait-il partie d'un plan national d'action d'urgence? Oui, **PAP :** Programme d'Actions Prioritaires du gouvernement

Contexte:

A cause des conflits armés récurrents et les mouvements des populations, le taux de prévalence du VIH/SIDA dans les régions de l'Est du Congo, est élevé car il est passé de 2,5 en 2012 à 4 en 2014.

Approche:

Avec la sensibilisation et la formation des pairs éducateurs, le programme donna l'information aux populations cibles.

Portée de l'intervention:

le programme cherche à l'amélioration de la santé de la population en général et celle des groupes exposés au VIH/SIDA en particulier (les populations déplacées, les opérateurs de la filière évacuation des produits agricoles...)

Impact de l'intervention:

Formation des 100 pairs éducateurs, distribution des documents donnant l'information sur le VIH/SIDA

Défis relevés:

combat de l'ignorance par le renforcement des pairs éducateurs, implications des zones de santé, partenariat avec l'ONUSIDA (RDC)
Difficultés rencontrées : Insuffisance d'appui financier

Financement et gestion:

Implication du Ministre du Plan et Révolution de la Modernité dans la Coordination et la supervision l'activité. Financement avec 6.000 dollars américains par l'ONU SIDA. Réalisation par CASPOF et les Structures partenaires locales (zones de santé, PNLs, ONG).

Leçons en avertit ET recommandations:

Facteurs de réussite : la paix retrouvé et collaboration des experts du Programme National de Lutte contre le SIDA (PNLS)
Besoins en sensibilisation énorme. Moyens financiers à rechercher auprès des partenaires techniques et financiers.

8. Djibouti

Titre du programme : Stop VIH dans les camps de réfugiés de Djibouti

CONTACT

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Le programme est en place depuis: janvier 2014

Mis en place par: ONU ou autre organisation intergouvernementale :

Sujet de la soumission: L'accès à la prévention du VIH, aux soins et au traitement, Les questions liées à la protection, l'équité et les droits de l'homme, La coordination interinstitutions

Le programme a-t-il été évalué/estimé? Non

Le programme fait-il partie du plan national de lutte contre le SIDA? Oui, Cet projet se focalise sur la prévention des jeunes qui correspond au résultat d'impact 1 du plan national de lutte contre la VIH qui vise la réduction de 50% des nouvelles infections d'ici 2016 à Djibouti.



Le programme fait-il partie d'un plan national d'action d'urgence? Oui, Le projet intègre le dépistage des femmes enceintes dans le cadre de la PTME correspond à l'objectif du plan national d'urgence pour l'élimination de la transmission mère –enfant du VIH à Djibouti.

Contexte:

La république de Djibouti est située dans la Corne de l'Afrique et partage des frontières avec l'Érythrée au Nord, l'Éthiopie à l'Ouest et au Sud et avec la Somalie au Sud - Est. Elle a une superficie de 23.200 km², Elle possède une façade maritime longue de 372 km qui donne sur la Mer Rouge et le Golfe d'Aden et dispose d'un espace maritime d'environ 7 200 Km². C'est un pays traversé par de nombreux migrants en partance pour les pays du golfe, l'Asie et l'Europe. Djibouti est un pays en développement avec un indice de développement humain de 0,462 le plaçant au 170^{ème} rang sur 187 pays (*PNUD, 2014*).

Le pays dispose d'un Plan de Développement Sanitaire 2013 – 2017 qui a prévu de relever les défis de réduction de la prévalence des maladies telles que le VIH.

Djibouti connaît une épidémie généralisée de VIH dont la séroprévalence est estimée à 2,71% en 2010 avec une tendance à la stabilisation de l'épidémie depuis 2003 dans une fourchette de 2 à 3 %.

1743 représente le nombre de patient qui poursuivent un traitement ARV au 31 décembre 2013, 6799 est le nombre estimé d'adulte et d'enfant vivant avec le VIH (Données Spectrum, juin 2013/PLS- SANTE 2013)

L'étude sur les modes de transmission du VIH a mis en exergue que malgré que l'épidémie à Djibouti soit qualifiée de généralisée, une prévention ciblée sur les groupes à haut risque comme les couples stables avec un statut sérologique discordants (39% des nouvelles infections proviennent des couples stables), les travailleuses de sexe et leurs clients (22% des nouvelles infections), les personnes engagées dans le multi partenariat sexuel (22%), les hommes à haut risque d'infection ainsi que leurs partenaires (5%) constituent des cibles prioritaires pour le nouveau plan sanitaire national.

Depuis 1991, Djibouti accueille des réfugiés sur son territoire. En 2014, le nombre total de réfugiés et demandeurs d'asile vivant à Djibouti étaient de 24 425 composés de 95,87% somalis, 2,40% d'Éthiopiens, 1,62% d'Érythréens et 0,11% d'autres nationalités. 82,9% de ces populations réfugiées (soit 20263 personnes) vivent dans les deux camps de réfugiés du pays : 18048 au camp d'Ali Addeh et 2215 au camp de Holl Holl (*Progress report UNHCR Djibouti*).

Les réfugiés vivant dans les camps ont accès aux soins de santé grâce à l'assistance du HCR et ses partenaires. En 2013, la prévalence du VIH chez les femmes enceintes était de 2,1% donc comparable aux chiffres nationaux (*HIS UNHCR Djibouti*).

La situation de réfugiés expose ces populations à des risques majeurs d'infection VIH. De nombreuses femmes vivent en l'absence de leur conjoint dans le dénuement et la pauvreté ce qui pousse certaines à avoir recours à des stratégies de survie notamment la prostitution. Ainsi, les interventions nationales de lutte contre le SIDA les considèrent aussi comme un groupe prioritaire.

Approche :

La conception du programme a suivi un processus participatif incluant les bénéficiaires et les deux agences (UNHCR ONUSIDA). Une évaluation participative dans les camps avec les

bénéficiaires et l'analyse ont permis d'identifier les gaps suivants : l'absence de service CDV au camp de Holl Holl, une faible adhésion des réfugiés au dépistage volontaire, la faible connaissance de jeunes vivant dans les camps des moyens de prévention du VIH, des ruptures fréquents en tests rapides, une incidence élevée des infections sexuellement transmises (693 cas en 2013).

La population cible du projet était tous les réfugiés vivant dans les camps ainsi que la population hôte autour des camps. Le projet couvrait la période de janvier à décembre 2014. Les objectifs du projet étaient d'assurer à 100% des réfugiés vivant dans les camps l'accès aux services de conseil et dépistage et de sensibilisation à au moins 80% des jeunes réfugiés sur les moyens de prévention.

Les principales activités étaient la construction d'un CDV au camp de Holl Holl, l'équipement des CDV des 2 camps et la réalisation d'activités de sensibilisation sur la prévention de l'infection à VIH.

Pour la mise en œuvre du projet, un partenaire national a été identifié conjointement par les deux agences.

Suivi : UNHCR était chargé du suivi de la mise en œuvre des activités sur le terrain. Les rapports du partenaire étaient validés par l'UNHCR avant la transmission à l'ONUSIDA.

Portée de l'intervention :

Les activités réalisées au cours de cette intervention étaient axées sur la prévention du VIH dans les camps de réfugiés. Bien que le plus souvent les populations réfugiées soient prises en compte dans les documents de planification nationaux, cette population n'est pas toujours incluse lors de la mise en œuvre des activités. Cette intervention a permis de corriger ce gap et de permettre aux populations réfugiées d'avoir accès au paquet de services minimum VIH à leur portée, c'est-à-dire dans les camps.

Cette intervention a été possible grâce à la coordination entre UNHCR et ONUSIDA durant tout le long du projet. Cela a permis au projet de démarrer en janvier avec les fonds de l'UNHCR qui a été complété par la suite avec les fonds de l'ONUSIDA. Cette coordination a évité la duplication des coûts avec les mêmes partenaires.

Impact de l'intervention :

Les résultats suivants au niveau des camps grâce aux données collectées par le système d'information sanitaires de UNHCR :

- 15 000 jeunes y compris de la population hôte ont été sensibilisés sur les moyens de préventions de l'infection à VIH
- Un CDV a été construit et 2 CDV ont été équipés. Ceci a permis d'avoir une accessibilité de 100% dans les camps au service de dépistage.
- 44 246 préservatifs ont été distribués contre 17345 préservatifs en 2013 soit une augmentation 155%.
- 2322 tests du VIH ont été fait contre 522 tests en 2013 soit une augmentation de 344%.
- La couverture du dépistage des femmes enceintes dans le cadre de la PTME a augmenté de 87% en 2013 à 95,6% en 2014.
- L'incidence des infections sexuellement transmissibles a diminué de 693 cas en 2013 à 367 cas en 2014 soit une réduction de 47%.
- Cette intervention a contribué à la tendance globale à la baisse de la prévalence du VIH observé dans les camps, 2,7% en 2012 ; 2,1% en 2013 et 0,89% en 2014.
-

Défis relevés :

Changement de partenaire de mise en œuvre du projet : Dans la planification initiale, une ONG internationale avait été sélectionnée mais a ensuite décliné l'offre de la composante financé par l'ONUSIDA car voulant inclure des frais administratifs qui dépassaient plus de 50% du budget. Une ONG nationale a été recrutée pour couvrir cette composante mais avec la même coordination.

Financement et gestion :

La coordination de l'intervention s'est faite à deux niveaux : au niveau des camps, la coordination technique était assurée par l'UNHCR, le niveau inter-agences était assuré par l'ONUSIDA. La composante prise en charge par ONUSIDA était financée par les fonds CERF et celle du UNHCR par les fonds de l'IGAD. Les partenaires de mise en œuvre étaient CARE Canada et APEF (association pour l'épanouissement de la famille). L'approvisionnement des CDV intrants a été fait par le canal de UNICEF avec un appui technique du PNUD.

Leçons apprises et recommandations:

- L'identification conjointe par le HCR et l'ONUSIDA des priorités des interventions à faciliter la coordination inter-agence du projet. Cela a permis aux deux agences de s'aligner les mêmes objectifs et d'éviter les duplications des coûts. La même logistique et le staff déjà fourni au partenaire par l'UNHCR dans le cadre d'un autre programme a aussi servi cette intervention sans frais supplémentaires
- Un suivi régulier sur le terrain des partenaires de mise en œuvre est très indispensable dans un projet de prévention. La présence quotidienne de l'UNHCR dans les camps a permis d'interpeller à temps les partenaires quant aux respects du cahier de charges.
- Les ONG nationales sont plus flexibles mais ont aussi besoin d'un suivi rapproché lors de la mise en œuvre du projet.

9. Guinea

Abstract for UNAIDS PCB-meeting June 2015: Special session on « HIV in crisis »

Title: ARV provision for longer periods in Guinea increases probability of retention in care, including during the Ebola crisis.

Authors: R. Ortuna¹, A. Diallo¹, O. Tiemtori²,

1: Médecins Sans Frontières, Conakry, Guinea.

2: Médecins Sans Frontières, Cape Town, South Africa.

Background:

Since over a year the epidemic of Ebola affects West-Africa and has a knock on effect on health services functionality and utilization. Reports from Liberia and Sierra Leone indicate patients on ARV treatment have faced difficulties to access their treatment without interruption. Although in Guinea health facilities have remained open, utilization rates have reduced and reluctance of



people to attend health facilities has been reported. An increased loss to follow up has been reported in selected health facilities of Guinea.

MSF is supporting 4 health facilities in the capital Conakry with 7639 HIV patients on care within them 7474 on ART. Current analysis is based on data of main ambulatory center which includes 4100 patients on ART.

Methodology:

A pilot activity in providing ARV medication for a period of 6 months to patients (R6M) that are stable (VL<1000 and WHO clinical stage 1 or 2) was going on. Outcomes of its systematic implementation have been monitored since June 2014. Patients only visit health facilities once every 6 months for consultation and viral load checking. They receive a quantity of ARV drugs that last for 6 months of treatment plus a small buffer quantity. Patients living in Conakry are on a 3 month refill scheme. Feasibility and positive results of its application has been described elsewhere, mainly in situations outside crisis.

Outcome measures for this group are recorded in terms of late appointments (patient coming 5 days after his appointment date) and loss to follow up (3 months after his appointment). For the specific purpose of looking at outcomes during this outbreak and the consequent obstacles to attend health facilities, we analyzed outcomes for patients on a R6M ARV provision over different periods before and during the outbreak. These were compared to outcomes for patients that fit the same eligibility criteria but had not yet started the alternative refilling scheme.

Results:

Outcomes among patients on the alternative R6M scheme proved to be encouraging. In 2013, 96.2% patients on R6M are still active on March 2015 (15-24 months period) compare to 75.4 % not on R6M cohorts. During Ebola outbreak in 2014, 97.1 % of patients on R6M were on time for their appointment after 6 months compare to 90.2% for the ones not on R6M. This compares favorably with outcomes during the same period reported by others, reporting 40% of late appointments in the health facilities they investigated.

Analysis is going on to compare outcomes with the group of people on the usual monthly ARV provision scheme, as well as analysis including other health facilities, according to the degree of affection of services by Ebola and retention in care at 6, 12, 18 and 24 months respectively. Preliminary results will be available by June.

The health authorities have been supportive of application of this alternative model during the crisis and discussions are going on to extend its application in order to mitigate the problematic retention rates under the normal program as well as reducing workload.

Conclusion:



As in other countries, in Guinea, an alternative model of refilling stable patients on ARV for a period of 6 months seems promising in terms of retention in care, including during the Ebola crisis when access to health facilities was reduced. This can be a useful instrument to avoid treatment interruption in other crises –including conflict and displacement- where access to health facilities is compromised.

10. Kenya

Title of the programme: Review of Lessons Learned from Multi-sectoral HIV Preparedness and Response in Humanitarian Settings in Kenya

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Programme is being implemented since: August, 2013

Implemented by: UN or other inter-governmental organisation

Scope of submission: Preparedness and contingency planning, Inter-agency coordination, Situations of fragility, Evidence and strategic information

Has the programme been evaluated /assessed? Yes

Is the programme part of the national AIDS plan? Yes, Generating strategic information on key populations infected and affected by HIV; treatment efficacy in high burden counties (Kenya National AIDS Strategic Plan 2009 – 2012/3 and Kenya AIDS Strategy Framework 2014/5 – 2018/9).

Is the programme part of a national emergency response plan? Yes, Evidence generated from the lessons learned research project has substantially strengthened the HIV component of the Emergency Humanitarian Response Plan within the Health Cluster; also as a cross-cutting theme; agenda of the Inter Sector Agency Working Group; the UNISDR regional plan for Disaster Risk Reduction; the PrepComs for the World Humanitarian Summit, 2016.

Background:

The government has long declared HIV a national disaster and chiefly works through the 'National AIDS Control Council' (NACC) and 'National AIDS and STI Control Programme (NAS COP) under the auspices of a National Strategic Plan and Framework. Kenya has a generalized and concentrated epidemic, with national adult prevalence estimated at 6%. There are significant regional variations with ten counties having an estimated prevalence higher than the national average, peaking in Homa Bay County at over 27%. Most of these counties repeatedly face humanitarian crisis and are considered disaster-prone. Kenya frequently experiences



humanitarian emergencies ranging from drought, floods, fire as well as ethnic clashes, population displacement and refugee influxes. A strong economy and rapid urbanization has further fuelled population migration, especially following a disaster, including growth of the informal slum settlement. The current estimated number of populations of humanitarian concern in the country (Refugees, asylum seekers, stateless persons and internally displaced persons is 589,772 (UNHCR, 2015). Kenya experienced unprecedented Disruption to HIV prevention, treatment and care programmes was borne out in the humanitarian crisis of the 2007/8 Post-Election Violence (PEV), and again in the regional drought of 2011 in which resulting in the deployment of negative coping strategies such as transactional sex in exchange for food and accounts of sexual and gender based violence were widely documented. Members of the UN Joint Team on HIV and AIDS (UNJT) were determined to see this situation not repeated during and in the immediate aftermath of the general election of 2013. Consequently, multi-agency concerted efforts were undertaken to ensure the integration of HIV targeted interventions as not seen in the country before. Following the 2013 election, in response to recommendations from the 'After Action' Review by the UNJT, a comprehensive study of action taken – the research project - by AIDS and Humanitarian actors alike was carried out to generate critical information and inform a lessons learned approach relevant to future emergency programming.

Approach:

Within the prioritized framework of the IASC Guidelines on Addressing HIV in Humanitarian Settings, the Research Project: (1) Documented and assessed the effectiveness of activities undertaken by UNJT to integrate HIV into the 2013 humanitarian preparedness and contingency planning process; and showcased contributions and results for each component; (2) Identified areas of strengths, weaknesses and gaps and overall appropriateness of the HIV in emergency strategy; and generated options for redressing bottlenecks; (3) Provided guidance for policy and advocacy and future directions for mainstreaming HIV activities in disaster risk reduction. This was achieved by examining: (1) Coordination, leadership and capacity strengthening; (2) Sector preparedness and contingency plans for HIV services at national and county level including commodity provision (ARV, PMTCT, PEP, condoms, and Testing); (3) Partnership creation/strengthening and linkage between UNJT and a multi-sector cluster approach; and (4) Resources mobilized and funding gaps. Data was collated largely through a qualitative approach that engaged multiple agencies networks of PLHIV and areas with the highest HIV burden.

Reach of the intervention:

Preparedness and Contingency Planning – through an assessment of the nature, content and quality of concerted activities undertaken at all stages of the humanitarian cycle, and noting factors of time and discussion, training of stakeholders and resources availed to meet HIV needs; **Inter-agency coordination** – the level of and consistency of collaboration between agencies over a protracted period of time and measuring a sense of ownership; **Situations of fragility** – the democratic process can be highly volatile and unpredictable and as shown in the context of the 2013 election, de-stabilizing and likely to cause population-level upheaval; **Evidence and strategic information** – this is the first time an evaluation of this kind was carried out – and in real time – and provided critical in-sight into the link between humanitarian and development planning processes; the relevance of national indicators to crisis situations in the NSP; and national capacity to respond to HIV in an emergency.

Impact of the intervention:

Findings from the Comprehensive Review have shaped the form and content of HIV outcomes into subsequent humanitarian plans in the country, and region. Evidence to date has shown no significant rise in incidence in disaster prone areas and aided the national decline in HIV prevalence in focus counties, as shown in national estimates data. More particularly, according to cluster reports, there has been no remarkable disruption in ART supply or uptake. In the case of Turkana County findings have driven the UN 'Delivering as One' agenda, including indicators for rapid assessment. A proactive engagement of PLHIV an innovative approach to measuring success was developed focussing on the experience of being HIV positive and maintaining a SMART regimen of ART in a crisis situation.

Challenges faced:

The movement and displacement of populations of humanitarian concern and inability of evaluators to trace the subject of research at times proved problematic as did access to key areas across the country owing to temporary insecurity. Lead agencies at designated hubs helped identify and assist with individual and group dialogue as well as with key staff from respective agencies and together a critical mass of people contributed to the research, though taking longer than originally planned. As not all data was quality assured, information of dubious nature was filtered out through consensus with all involved in the research. Under the principle of 'do-no-harm,' the research team was mindful not to stigmatize PLHIV through engaging with community brokers to build trust and confidence. Information from focus group discussions / key informant was substantiated with empirical evidence via desk review.

Financing and management:

Through the UNJT the research project was led by UNAIDS and IOM. The conception and design was shared at all stages with key stakeholders, notably, conception, design, feedback and final report. Extensive consultations were held at all stages with national authorities. Private sector companies responsible for the procurement, storage and safe delivery of essential commodities were constantly engaged providing maps and logistics. Methodology and findings from the research project have been accepted by the authorities and integrated into training processes for humanitarian and AIDS actors at national and county level. The programme was resourced mainly through a grant provided by Irish Aid for building national capacity in humanitarian and fragile states. Strategic partners were, inter alia, UNHCR, WFP, UNICEF, UNFPA, UNESCO, WHO; NDOC; NACC/NASCOP; KEMSA/KEMFAR; KRC; National Association of People Living with HIV.

Lessons learned and recommendations:

The Task Force for Preparedness and Response at NACC, the Commodities Steering Committee at NASCOP and the National Disaster Operation Centre (NDOC) helped provide the enabling environment including a channel to influence substantive policy at cabinet level up to end of first quarter, 2013, and then with roll out of the Research Project. With and through these entities, a working collaboration was built with the eight humanitarian hubs. The UNJT further provided the means to coordinate agencies' efforts and ensure a result driven approach was adopted from start



to finish. The Research Project pointed to these priorities: (1) Capacity strengthening on the key elements of HIV in emergencies among stakeholders, informed by DRR principles to help sustain gains and legacy, including risk-informed development reflected in the UNDAF; (2) Working at county level, as well as national, so that the HIV response can be tailored to reflect the nature of the sub-national emergencies and the particular dynamics of the epidemic in each location; (3) Sharing of strategic information through an open portal accessible to stakeholders which identifies “hotspots” and modes of transmission; (4) Resourcing preparedness and contingency planning exercises to be included in the UNJT annual plan as well as at government level through the disaster management committee; (5) In line with the GIPA principle, further substantial engagement of PLHIV networks acting as champions to better facilitate peer led education, awareness and care initiatives; (6) Crafting a communication strategy inclusive of messages of HIV and GBV; (6) Align AIDS and Humanitarian frameworks, including indicators and tracking mechanisms.

11. Kenya

Title of the programme: Improve Access to Health and Human right for People Who Use Drugs and People Who Inject Drugs in Mombasa and Kilifi Counties in Kenya

Programme is being implemented since: 2005

Implemented by: Civil Society

Scope of submission: Access to HIV prevention, care and treatment, Protection issues, equity and human rights

Has the programme been evaluated /assessed? No

Is the programme part of the national AIDS plan? Yes, Key Population programming is defined in the Kenya National AIDS Strategic Framework Plan IV

Is the programme part of a national emergency response plan? Yes, In the context of Alshabab terror attacks especially in the coastal region of Kenya

Background:

Treatment of people who use drug (PWUD) and people who inject drug PWID is a significantly complex process that has social, community, legal, clinical, and public health dimensions that must all be integrated into the provision of effective service delivery. Currently in Kenya, we lack an enabling environment that facilitates such an integration of services mainly due to dissonance between and among policies, political constitution, provision of health rights, protection of human rights and also between stakeholders. Further, the obsessive addiction exhibited by PWID and PWUD predisposes them to deviant behaviours that are socially, politically, legally and economically unacceptable to the communities they live in, local and state authorities, which consequently lead to conflict in the executive, legislative and judiciary systems. The conflicts that exist between the PWUD/PWID and the three arms of government have negatively impacted the creation of supportive legislation, policies, regulations, and strategies.

Coverage rates of core interventions for PWUD/PWID are low in Kenya because enabling environments are not supportive of the introduction and scaling up of the rights of the marginalized minority, MAT, NSP, and other core HIV prevention interventions. More specifically, reasons for the low coverage rates of and limited access to HIV prevention interventions on health and human rights include: unsupportive national policy; lack of adequate funding; restrictive criteria for eligibility; stigma and discrimination; law enforcement harassment; cost of services to user; poor



geographic distribution of services; limited hours of operation; and limited technical capacity. More stringent criminal liability makes PWID even harder to reach and provide health and social services thus undermining HIV prevention, care and treatment, drug dependency treatment and other vital services. Law enforcement agencies and health care workers continue to obstruct the development and operations of harm reduction services, including needles and syringe programs, OST and basic and advanced biomedical interventions.

Service Implementation:

The initiative of Kenyan government to facilitate a conducive environment for the access and provision of human and health rights for Key Populations have been adequately stipulated in the 2010 constitution. KNASP IV is in the process of consolidating the key pillars of addressing access to health and human rights for Key Populations. Driver for these positive efforts, according to KAIS report of 2013 while HIV prevalence rates among the general population stands at 5.8% in Kenya for PWID stands at 18%. We anticipate major reforms on HIV prevention programming following initiation of methadone programme in the region and increased support for all others 11 WHO-recommended essential interventions. For example, the Ministry of Health in collaboration with implementing partners, prepared guidelines contained in Standard Operating Procedures for MAT and NSP in their efforts to prioritize scaling up of NSP and induction to and maintenance of MAT and ART. As implementers we have improved capacity of residential adherence unit for females and their children, expanded community forums, improved programme evaluation, and improved tracking trends in behaviour and transition of PWUD to PWID.

Human Rights Advocacy: The effect on globalisation especially on terrorism has hampered economic growth in coastal region on many fronts but the tourism industry has been severely affected. Decline of tourism has caused major financial disruptions in a region that was almost entirely dependent on tourism. Primary sources of income for PWID/PWUD are mainly through touting, tourist guide and beach dwelling (beach boys); economic activities that were directly affected by low numbers of foreign tourists. This has led to high level of unemployment among the Key Population, the current status of unemployment in Mombasa stands at 44% with dependence rate at 84.8%, which is twice in Key Populations. It is in this regard that high levels of insecurity were witnessed among Key Population as they fall prey to violence to sustain their addiction behaviour. We have had high rates of assault cases from mob justice: beatings and killings, police arrests and incarcerations. To mitigate some of these issues we are providing residential detoxification and temporary shelter housing where our clients are empowered to strive for social, political and economical objectives.

Physical violence against PWID and PWUD is exemplified by police beating and arrests; physical violence by the community; fighting among themselves PWUD against PWID; gender-based violence (GBV) especially against PWID/PWUD sex workers; and from family members. When such violence befalls our clients our much-needed services are severely disrupted. Another form of violence being perpetrated is through stigma and discrimination against PWID/PWUD by police, family members, community and village elders, and health workers.

Integration of Services: Effective integration of services is one key area where service delivery to PWIDs and PWUD can have optimal success. Multi-sectoral collaboration is essential especially through private-public partnership. For instance the government will facilitate the MAT program in Mombasa County before June 2015. For example, additional outreach workers and addiction counsellors have been seconded to work in the health facilitates (DIC, Detox, Rehab, Women shelter) and offer outreach services to facilitate earlier management of anticipated crisis of withdrawal, create a friendlier environment in the facility, promote adherence through scheduled



clinical meeting and maintain a cohort through active case-finding and tracing. ART and Anti-TBs will be issued at MAT site with a continuation of three months accommodation at the residential adherence unit. We also offer social services from food, shelter, showers, and haircuts to paying school fees for 30 children of PWID.

Approach:

Our service delivery is underpinned by our objective to reduce harm caused by drug and substance abuse through prevention, intervention, treatment, and aftercare services to DUs, IDUs and the community at large. Services are currently being delivered through two setups: services we provide in “closed-up” spaces and outreach services. The “closed-up” spaces include our Drop-In-Centre (DIC), Detox Centre, Prisons, and the Rehab Centre, all of which offer behavioural, social and biomedical services. Outreach services target DUs, IDUs, and other actors who cannot access to our limited closed-up spaces. Key services and activities in both setups include provision of needles and injecting equipment (NSP Kits) in the Needle/Syringe Program (NSP); HIV and risk reduction information and education addressing safer ways of injecting; referring and accompanying drug users to Health Care Facilities, HCT Sites, assessment and screening of referred drug users at the Drop in Centre (DIC), admission and treatment of drug users at the MEWA Mtopanga residential drug treatment centre, detoxification of clients who do not meet the criteria for enrolment to outpatient drug treatment; serve incarcerated DUs/IDUs in police custody and prisons; and related outreach and mobile services to DUs/IDUs who cannot come to our DIC. Our core team for service delivery is comprised largely of outreach workers who are recovered drug addicts who also represent finest examples of our success stories.

Reach of the intervention :

Access to HIV prevention, care and treatment

Our primary HIV-related activities include prevention, care, and treatment. Through our outreach workers and clinicians, we offer direct care services to PWID and PWUD (like wound/abscess care), linkages to more specialized services at our DIC or to our partner government facilities (Kisauni CDF hospital) or Coast General Provincial Hospital. Other activities include advocacy to our stakeholders to see addiction as a disease and not a crime; follow up with client to ensure adherence to ARV and anti-TB drugs; female PWID have access to sexual and reproductive health services (screening for cervical cancer/HIV/TB/hepatitis B and C); HTC referrals and services; information and educational communication material for STI/STD; GBV; counselling; safe delivery (pre- and post-natal); and escort services from their dens to healthcare facilities.

Impact of the intervention:

Preliminary data regarding new distributed and returned used needle and syringes; reduced number of abscess treatments due to poor hygiene and shootouts; reduced sharing of needles; increased number of times clients agree to seek medical help from mainstream hospitals and health facilities; improvement of personal hygiene of PWID/PWUD; increased use of condoms by female PWID sex workers as evidenced by the number of condoms requested and its frequency; civic participation of PWID and PWUD in acquiring national ID cards, registering to vote, and voting during the last elections; and number of PWID/PWUD who seek assistance to be admitted into our facilities all present improvement at some level compared to the data about 3-years ago.

Financial and Accounting System



MEWA has a reliable accounting system that ensures project funds are appropriately spent and that all the expenses are directly related to the project. Transparency is highly practiced through preparing and submission of periodic financial reports to the responsible bodies/funders, as per the agreed terms. Our organization has had an excellent accounting record with its donors i.e. UNODC, British Council, Solidarity Centre, Mainline, APHIA Plus Coast and VSO Jitolee.

Sustainability

MEWA focuses on community coalitions to develop sustainability citing principles of harm reduction and human rights. Likewise we believe that sustainability affects all aspects of the above-mentioned objectives and we include it as one of our core competencies for achieving lasting community change. Through collaboration we educate individuals to better understand and drive our agenda to achieve our goals of promoting and achieving health and human rights and reducing abuses to drug users and injecting drug users. There shall be a string of activities that fit into a strategic plan to avoid working in isolation because everyone shall understand how their contribution relates to the larger whole, thus we do not feel that our organization has to take on all the problems of the community but partner with other organizations with the same interest to find ways to reduce redundant efforts and find joint strategies that benefit DUs and IDUs.

While we appreciate the funding we receive to run the project we are faced with specific challenges. For example all funding is program specific because it has been designed according to donor's objectives and are not flexible to address clients' needs. Secondly, we experience significant delay between submission of grants and approval/disbursement/denial due to lack of clear communication protocols between implementers and donors.

We are currently looking at sustainable income generating programs within our organization and from our partners with a view to creating sustainable ways of supporting our work. This will be addressed in our new 2015-2018 strategic plan.

Lessons learned and recommendations:

We have learned that resources should be used only for the purpose it was intended for and seek more funds to improve functional structuralism to enhance capacity building for mobilizing resources for our organization's sustainability. For long-lasting solutions we have resolved to make policy makers more active stakeholders because policies established and enacted by willing legislative members has the potential to improve harm reduction activities more effectively than single organization's efforts to tackle immense problems. This political mobilization will also involve resource mobilization from both the local and national governments, partnership with interest group like Kenya National Harm Reduction Network

12. Kenya

Title of the programme: Integrated Biological and Behavioural Surveillance Survey Among Migrant Female Sex Workers in Nairobi, Kenya

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Programme is being implemented since: 2012

Implemented by: Government, Civil Society, Private Sector, UN or other intern-governmental organization

Scope of submission: Access to HIV prevention, care and treatment, Protection issues, equity and human rights, Community resilience, Effects of emergencies on key populations, Early recovery and development, Situations of fragility, Urban contexts

Has the programme been evaluated /assessed?

Is the programme part of the national AIDS plan? Yes, Key populations (sex workers, men who have sex with men, people who inject drugs) are a priority group identified within the Kenya AIDS response framework. They contribute 33% of new infections. They require targeted interventions for HIV combination prevention as outlined in strategic goal 1 and 2 of the Kenya AIDS Strategic Framework (KASF: 2014-2018).

Is the programme part of a national emergency response plan? Yes, HIV was declared a national disaster in 1999, resulting in creation of the NACC. In addition, within the current Kenya humanitarian architecture, HIV/AIDS and GBV are among the priority issues in the cross-cutting thematic sector to be activated during an active humanitarian emergency.

Background:

Kenya is currently experiencing both a generalized and a concentrated HIV epidemic. It has a national HIV prevalence of 6 per cent and 1.6 million people between the ages of 15 to 64 across the country are living with HIV. According to the Kenya National AIDS Control Council (NACC), female sex workers (FSW) and their clients account for 14.1% of new infections. The Kenyan national response has recently started targeting research and programming efforts towards key population groups due to their "invisibility". However, migrants especially affected by humanitarian emergencies have not been targeted as a distinct category.

Kenya's capital city, Nairobi, and other major urban centres continue to experience an influx of international migrants, including those forced to flee their neighbouring countries of origin, or coming from UNHCR-managed refugee camps into the city. While some will have the required legal registration, many others are in an irregular legal status due to unauthorized entry or lack of requisite documentation which directly impacts upon their access to vital health-care services. The income insecurity of migrant women encourages their adoption of survival strategies such as transactional sex in which short-term benefit of their behaviour is more important than long-term health. Additional causes of migrant women's increased vulnerability include the fact that they are concentrated in sectors that offer less exposure to workplace health and prevention programmes, such as the informal sector and domestic work. Factors such as inability to



negotiate for safer sex due to language barrier and power imbalance only serve to exacerbate the HIV risk.

The National AIDS and STI Control Programme (NASCO), NACC, the Joint UN Team on AIDS (JUNTA), the Kenya AIDS Control Project (KACP) and the International Organization for Migration (IOM) partnered to implement the first integrated biological and behavioral surveillance (IBBS) survey among migrant FSW in Kenya. The objective of the study was to establish information that contributes towards developing an evidence-informed response to HIV/AIDS among female sex workers. The study aimed to: Establish HIV and STI prevalence among migrant female sex workers in Nairobi, Kenya; Determine HIV and STI knowledge, attitudes, risk behaviour, treatment Seeking behavior, and preferred sources of HIV/STI information; Provide baseline HIV and STI behavioral and biological prevalence estimates to measure trends over time.

Approach:

A cross-sectional survey recruited 628 migrant FSW using respondent driven sampling (RDS). A face-to-face, structured interview using handheld assisted personal interviewing on personal digital assistants was completed and blood collected for serological testing for HIV, syphilis, gonorrhoea, and chlamydia. Data on demographic characteristics, risk behaviours, and HIV/AIDS knowledge were collected. Rapid testing was performed which meant that participants were able to receive test results immediately. A linked confidential serial testing strategy was used for HIV, following the Kenya National Guidelines. Data were analysed in RDSAT 6.0 where weighted univariate and bivariate analyses were conducted. Data were exported with weights into STATA 10.0 for multivariate analysis

Reach of the intervention:

This intervention contributes to generation of evidence and strategic information, especially targeting persons in post conflict and situations of fragility residing in Urban contexts. The findings highlight protection issues, equity and human rights issues, and effects of emergencies on key populations, including adoption of coping mechanisms that increase risk to HIV transmission.

Impact of the intervention:

The overall prevalence of HIV was 23.1 per cent and 2 per cent for syphilis. No gonorrhoea and only one case of chlamydia (0.2%) were found. Only three cases (0.7%) of co-morbid HIV and syphilis were found.

Sex work is present in the migrant community in Nairobi, which dispels a common belief that sex work is not practiced in Muslim communities. Overall the utilization of voluntary counselling and testing (VCT) and knowledge of serostatus was low, just over half, and much lower among migrants than among Kenyan FSW. Low levels of education and literacy among migrant female sex workers (FSW) makes it difficult for them to find work in the formal employment sector. Findings of this study were utilized to start a female sex worker programme. Through the support from the UN Joint programme (2008-2014), and in collaboration with the district health management team and NASCOP, IOM partnered with two local organizations: the National Organization for Peer Educators (NOPE) and Umma, a community based organization, to develop a pilot HIV combination prevention programme, with outreach activities for female sex workers in Eastleigh in Nairobi. The project's objectives were: to provide female sex workers with targeted HIV prevention and integrated primary health care services; promote rights awareness, psychosocial support and gender-based violence reduction for migrant female sex workers; support livelihoods and on-going education to migrant female sex workers. At the end of JUPSA funding, the programme has been integrated into the existing health programme implemented by IOM in Eastleigh area of Nairobi that provides primary health care and disease surveillance; comprehensive HIV and TB; reproductive and maternal and child health services at the Eastleigh Community Wellness Centre. The programme integrated a targeted sex worker outreach programme including prevention, treatment, care and support. A drop in centre was established and provides screening for sexually transmitted infections; HIV testing; male condoms distribution and support groups for FSWs and other key populations such as truckers and PWID.

Challenges faced:

Main challenges during the study include difficulty in sampling a highly mobile and invisible population, which were overcome through respondent directed random sampling methodology – migrant tend to live in communities based on country of origin, so respondents especially peers assisted in recruitment. Limited funding has hindered scale-up of the entire package of HIV combination prevention services. Integration with existing clinical and community services has assisted in addressing biomedical and behavioural aspects of prevention.

Financing and management:

Financial support for the integrated biological and behavioural surveillance survey was provided by UNAIDS Programme Acceleration Funds (PAF) and DFID through the Joint UN Programme of Support on HIV/AIDS in Kenya. The Un Joint Team funding supported start up activities for the initial female sex worker programme. Currently, a small component of HIV combination Prevention services is provided through Partnership for Health and Mobility in East and Southern Africa Project (PHAMESA), through Swedish International Development Agency (SIDA), with commodities and IEC material from NASCOP.

Lessons learned and recommendations:

Donor funding is needed for a long-term programme that includes a model for service provision and HIV prevention targeting migrant FSW. Interventions that specifically reach migrant FSW are required to increase knowledge and focus on consistent and correct condom use, including the use of lubrication, and improve health seeking behaviour. Services for this population could be integrated into programmes for general FSW, with special attention to regular STI screening / treatment and universal knowledge of HIV sero-status promoted; however special care must be given to language and cultural needs of the migrants.

Finally, stakeholders should lobby the Kenyan government to provide a legal framework for regulation of sex work which would allow programming for sex work activities to be taken to scale, thereby increasing access to services and providing protection for sex workers that currently does not exist.

13. Kenya

Title of the programme: Development of National Guidelines for Addressing HIV in Humanitarian Settings in Kenya.

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Programme is being implemented since: 2012

Implemented by: Government, Civil Society, Private Sector, UN or other intergovernmental organisation

Scope of submission: Access to HIV prevention, care and treatment, Protection issues, equity and human rights, Preparedness and contingency planning, Community resilience, Inter-agency coordination, Effects of emergencies on key populations, Early recovery and development, Situations of fragility, Innovative funding strategies

Has the programme been evaluated /assessed? Yes

Is the programme part of the national AIDS plan? Yes, National guidelines for addressing HIV in Humanitarian Settings in Kenya are relevant to the Kenya national HIV response. Populations in disaster settings such as internally displaced persons are recognized among populations vulnerable to HIV, and requiring targeted interventions for HIV prevention in strategic goal 1 and 2 of the Kenya AIDS Strategic Framework (KASF: 2014-2018).



Is the programme part of a national emergency response: Yes, HIV was declared a national disaster in 1999, resulting in creation of the NACC. In addition, within the current Kenya humanitarian architecture, HIV/AIDS and GBV are among the priority issues in the cross-cutting thematic sector to be activated during an active humanitarian emergency.

Background:

Although Kenya is no longer in the category of high risk disaster affected countries, populations in Arid and Semi-Arid Land (ASAL) areas, which cover about 88 per cent of the country's total land mass continue to face severe food insecurity and frequent violent resource -based and political conflicts stemming from the devolution process, and county demarcation issues, leading to mass internal displacement, including of vulnerable groups such as women, children and People living with HIV (PLHIV). Some of the affected areas are among those with high HIV prevalence. An example is Turkana county, with a HIV prevalence of 7.6 above the national prevalence (6) and categorized among nine counties contributing to 51% of HIV burden in the country. Humanitarian disasters increase risk of HIV transmission, and contribute to breakdown in the HIV care continuum, due to disruption of prevention, treatment and care services.

In the past, Kenya has experienced wide spread and/or localized humanitarian emergencies ranging from natural disasters (e.g., floods, drought, landslides) to human-made (e.g., ethno-political conflicts), which affect millions of people in the country. Following lessons from the 2007/8 PEV that led to massive displacement of over 650 000 people, and death of over 1000, widespread sexual and gender-based violence with increased risk of HIV transmission, the country was better prepared for the 2013 elections.

A multiagency "After Action" review of HIV inclusion in the humanitarian response to the 2007-2008 post-election violence in Kenya was conducted in May 2008; and follow up review of response to sub-sequent disasters such as the 2011 horn of Africa drought, observed shortcomings with coordination and leadership, including lack of clarity regarding the roles of various partners, as well as overall preparedness, stemming from issues such as inadequate capacity of humanitarian and HIV actors to plan and carry out HIV/AIDS interventions in emergency settings, and lack of systematic integration of HIV into existing government and humanitarian actors' emergency preparedness and response mechanisms. Whereas HIV was declared a national disaster in 1999, the framework for HIV response is not structured within the response to other frequent emergencies such as flooding, drought or conflict. Further, the dwindling resources due to global economic crunch and change of Kenya policy environment call for innovative funding mechanisms such as integration of HIV response within other disaster response programmes that may not necessarily require substantial resources.

Approach:

As part of the larger national preparedness plan for the 2013 elections and frequent humanitarian disasters that affects the country, the National AIDS Control Council (NACC), National AIDS and STI Control Programme (NASCOP) with the support of UN Joint Team on AIDS' HIV in emergency Partners undertook a process to contextualize the Inter-Agency Standing Committee (IASC) Guidelines for HIV in Emergencies to the Kenyan context, in a multi-sectoral and human rights -based process that began in 2012.



The overarching objective of the guidelines is to establish standards for the integration of HIV Prevention, care, treatment and support services into humanitarian assistance activities in Kenya. Specific objectives were to: define a coordination mechanism for integrating HIV in humanitarian response; provide a minimum package of HIV interventions by each sector in emergency settings; and develop a monitoring and evaluation framework for HIV in emergency settings.

The intended users of the guidelines are both government and non-governmental actors involved in HIV and/or humanitarian activities across all sectors involved in emergency programming at the national and county level. Specifically, they include the following: policymakers; national and grassroots-level implementing agencies; county, sub-county and community actors; and critical service providers.

A consultative approach was adopted, with both Humanitarian and AIDS actors, who provided the content of the guidelines based on their extensive practical experience. The guidelines were further subjected to a peer review process and a final validation workshop. The outline of the content used a Phase Approach for Mainstreaming HIV Activities in Emergency Sector Programming:

- Phase I: Preparedness;
- Phase II: Emergency response at the onset of the emergency, prior to rapid assessments;
- Phase III: Emergency response after the establishment of the emergency situation through sectoral needs assessments; and
- Phase IV: Recovery and reconstruction activities.

Level of response

In each phase of response, the guidelines provide guidance on interventions to be undertaken at each level, for example national, county, health setting, camp or community level. Interventions include coordination, capacity building, resource mobilization and Monitoring and Evaluation at each level of implementation.

Reach of the intervention: The new guidelines (due for launching) provide a minimum set of interventions and guidance to humanitarian sectors in Kenya on: increasing access to HIV prevention, care and treatment in emergency settings; protection issues, equity and human rights of vulnerable groups such as women, children, persons with disability and PLHIV; preparedness and contingency planning including for HIV prevention and treatment commodities and human resources; managing HIV services in the recovery phase or transition to development and; coordination arrangement for actors at the various levels; and options for funding HIV response in emergency settings.

Impact of the intervention: Components of the guidelines, guided capacity building and training of humanitarian actors from government ministries including the Kenya Red Cross, civil society, faith based organizations, the police, gender officers and PLHIV representatives among others in designated 'hotspot areas.' This facilitated better preparedness especially for health-service providers in selected areas. The impact was measured through qualitative feedback from training participants after the elections, in particular, through the lessons learned review conducted to evaluate the multi-sectoral HIV preparedness for 2013 elections. In addition, review of situation reports of other disasters like floods by humanitarian response actors such as the Kenya Red Cross provided an indication of how HIV needs were addressed by relevant



sectors like health and nutrition. Review of preparedness and contingency planning documents by humanitarian partners such as the national and county level contingency plans also provided a snap short of improved capacity following training using the draft guidelines.

Challenges faced:

The multiplicity of humanitarian actors, low human resource capacity of the NACC, limited resources to roll out orientation on the guidelines or their implementation by stakeholders challenged realization of their objectives. In addition, the process of finalization of the guidelines took quite some time as it was a highly consultative process. Part of the challenges were overcome by setting up of a small technical team (secretariat) comprising the UN, NACC and NASCOP, led by a consultant that addressed bottlenecks arising from the process.

Financing and management: The development of the guidelines was co-funded by NACC, UNHCR and IOM (through the Kenya UN Joint team on AIDS and Irish AID project). While NACC coordinated the process, the UN Joint team on AIDS partners including but not limited to UNAIDS, IOM, UNHCR, FAO, UNICEF, UN Women which together provided technical guidance and expert review of the document. The main challenges with funding, was that, despite the limited resources, the type of available funding (emergency response) was time bound, hence the consultative process was pressed to meet the deadlines. Current funding arrangements for HIV response by government and donors are less flexible to allow re-allocation to emergency response. In addition, the general assumption that HIV is already adequately resourced made it less of a priority among humanitarian sectors, as they focussed their budgets on life-saving interventions. Contingency planning for HIV services was aligned with other critical health interventions.

Lessons learned and recommendations: One major factor that enhanced the commitment of different stakeholders including the government was the lessons learned from 2007/8 PEV, as they were committed to prevent a repeat of the same situation, by ensuring that the national capacity to respond to HIV needs in emergencies is enhanced.

Secondly, availability of resources to support the process from donors and the government made it possible to hold several consultative and drafting sessions. Thirdly, the contribution of senior technical experts for HIV in emergencies from the UN in general and dedicated personnel from the UN Joint team on AIDS provided the necessary technical input to the content and continued advocacy with the government for contextualized guidelines. Availability of global technical guidance from IASC guidelines provided the benchmark.

Most importantly was the commitment of the NACC and NASCOP to spearhead the process through funding and dedication of personnel at decision making level to steer the process and ensure ownership.

14. Libya

Title of the programme: Prevention of drug abuse and HIV/AIDS among drug users, injecting drug users and vulnerable populations in Libya.

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Programme is being implemented since:

Implemented by: UN or other inter-governmental organisation

Scope of submission: Access to HIV prevention, care and treatment, Inter-agency coordination

Has the programme been evaluated /assessed? No

Is the programme part of the national AIDS plan? Yes

Is the programme part of a national emergency response? No

Background:

Political and security situation in Libya remains fluid. Following the removal of the former regime in 2011, Libya has gone through a tumultuous transition period. The General National Congress (GNC) was established as the interim legislative body in Libya in August 2012. A contested election in June 2014 resulted in the establishment of a new parliament (the House of Representatives) and government. As the GNC continued to function, Libya is henceforth a country with two rival leaders and two legislative bodies. Fighting between several Libyan factions continued. An unclear number of militias are battling for power amid failing state institutions. The outbreak of violence in July 2014 has escalated through most of the country and driven Libya into crisis as no political consensus has been reached. Due to the deteriorating security situation and concern for security of its staff, the United Nations decided to temporarily withdraw international staff from Libya in July 2014. The humanitarian consequences as a result of months of fighting in the capital city of Tripoli, Benghazi and other towns in the East and South are devastating. Armed groups are reported to have used heavy weapons, anti-aircraft missiles, engaged in full-scale attacks and indiscriminate shelling of highly populated civilian neighborhoods. **The humanitarian situation** is very complex. The daily life in the whole country has been particularly tough due to frequent shelling and air strikes, as well as to recurrent clashes. Living conditions are difficult, as the inhabitants have to cope with frequent power cuts, skyrocketing commodity prices, and cash shortages. The health and social services in peripheral areas of the country have been severely disrupted, as already reported in a WHO survey in 2011. HIV among people living with HIV in emergency contexts in this country: The overall HIV situation in Libya remains limited. The most recent population based survey, which was carried out in 2004-2005 among 65,000 persons, indicated an HIV prevalence of 0.13%. However, the higher prevalence in Al Kufrah in the south (0.67%) and in Tripoli (0.4%) indicated that there were hotspots on migration and drug smuggling routes, and in urban areas. Injection drug use is thought to be the main mode of HIV transmission. According to the National AIDS Programme, an earlier survey among 400 injection drug users in 1996 found none as HIV positive. A similar survey in 2000 among 1182 injection drug users found 50% as HIV positive, indicating a rapid spread of the epidemic among injection drug users sharing syringes and needles. In 2003 60% of injection drug users in detention for compulsory detoxification were found to be HIV positive. In 2006, 18.2% of prisoners were found to be HIV positive. There is also information about injection drug users receiving injections given by drug



dealers from a common source and reusing the syringes and needles without sterilization. Bio-behavioural surveys among key affected populations, including female sex workers (FSW), men who have sex with men and people who inject drugs in 2010 found an HIV prevalence rate of 87% in a sample of 328 people who inject drugs in Tripoli. The study also found prevalence among the heavily stigmatized and hidden MSM at 3.1%, and among the FSW at 15.7%.

Approach:

The Libyan national response is coordinated by the National Centre for Disease control (NCDC) under the Ministry of Health (MOH). The National AIDS Programme (NAP) was launched in 2002, reporting to the Director General of NCDC. The country has not yet adopted a multi-sectoral long term strategy for HIV prevention, treatment and care. Services providing HIV prevention for key populations are underdeveloped. In addition, health services in Libya have been disrupted extensively by the war. Considerable resources are needed to restore the health system. In this context, HIV remains a low priority. However, in June 2012, in light of the emerging evidence of the extent of the epidemic, particularly among people who inject drugs, the then Minister of Health H.E. Dr Fatima Elhamrosh acknowledged the need “to develop and implement comprehensive programmes to respond to the growing AIDS epidemic among key populations in Libya.

Reach of the intervention:

The HIV response is coordinated by the National AIDS Programme in the National Centre for Disease Control.

International support to Libyan HIV and AIDS response:

UNODC support is provided through a project financed by the government under an agreement signed in 2007, which includes a national UNODC staff. Within that framework, UNODC has trained (TOT) national professionals and has developed and printed a training guidance on VCT for PWID. Libyan HIV counsellors are now acting as trainers and conducting training activities in different parts of the country.

UNODC has supported the development of the National Harm Reduction Strategy (within the HIV national strategy framework) which was endorsed by the National AIDS Programme and the Ministry of Health prior to the revolution. Although the current National AIDS strategy (2012-2015) has not included the OST programme, UNODC and the Libyan partners have agreed to strengthen the advocacy efforts to that direction. A pool of trainers has already benefited from several trainings on TreatNet programme in Abu Dhabi, Beirut and Amman)

UNODC has conducted several training sessions to initiate an outreach programme for HIV prevention among PWID in Libya. This has been accompanied by a capacity building workshop for NGOs on managerial and proposal writing skills development in June 2013 and included 30 members from several national NGOs interested in HIV and Drugs issue.

WHO: is supporting the national AIDS programme to promote prevention activities, including support to the civil society and people living with HIV, as an attempt to increase awareness and

to upgrade the knowledge to combat stigma, especially amongst health personnel. WHO remains committed to support the country within the limits of the security and political situation. In 2012 WHO signed an MOU with the Health Minister to establish an International Center for Disease Control (ICDC) in Libya, to be financed by the government. The preparations for establishing the ICDC are still ongoing, several missions during 2013 were conducted by EMRO civil and IT engineers to assess the ICDC premises.

UNAIDS Secretariat: In 2012, responded to an urgent request by the Libyan government and provided support to dealing with the emergency situation, which included facilitating supply of urgently needed ARVs after a stock out of several months due to the emergency. The support included also contribution to drafting of an interim National AIDS Strategy, establishment of UN Joint Team, providing training on M&E for NGOs and public sector agencies engaged in HIV response, support to CSOs and PLHIV support groups and drafting a project proposal on collaboration with UNAIDS for government consideration. This proposal was already signed by DXD UNAIDS, submitted to MoH who forwarded it to Planning Ministry for funding. When the security situation deteriorated the process came to a halt and the proposal remains unfunded. UNAIDS has also led high level advocacy with Ministers of Health on the key programmatic issues including programmes of key populations and sustainability of treatment programmes. Libya is one of the countries that has endorsed the Arab AIDS Strategy under the League of Arab States with specific goals on reduction of HIV new infections among people who inject drugs and universal access to HIV services for displaced people, refugees and population affected by conflict.

UNHCR: has supported services for internally displaced, migrant and refugee populations with and through NGOs. In consultation with the government, UNHCR is working to expand the protection space and re-establish refugee processing activities, including registration, refugee status determination and identification of durable solutions, notably resettlement. One major concern for UNHCR remains the significant internal displacement of people. During and after the conflict, UNHCR has provided emergency shelter, cash assistance, medical care and educational support to people of concern including internally displaced people. Current activities also focus on capacity building in the form of training and information sessions with representatives of civil society organisations.

IOM: in Libya continued to track stranded migrants in Libya and provides repatriation support through the IOM network. IOM's comprehensive migration crisis response includes a migration health prevention and care package to provide a continuum of health and psychosocial services to migrants during the pre-departure, transit, travel, arrival and initial reintegration phases.

Impact of the intervention: What did the intervention achieve in terms of HIV outcomes in prevention, treatment, care and support for people living in emergency contexts? How was this impact measured?

- National Harm Reduction Strategy within the HIV national strategy framework which was endorsed by the National AIDS Programme and the Ministry of Health.
- Promotion of prevention activities, including support to the civil society and people living with HIV.
- Supply of urgently needed ARVs after a stock out of several months due to the emergency.
- Establishment of UN Joint Team
- Providing training on HIV, Harm Reduction and M&E for NGOs and public sector agencies engaged in HIV response.
- Support for internally displaced, migrant and refugee populations with and through NGOs.

- Providing repatriation support through the IOM's comprehensive migration crisis response which includes a migration health prevention and care package.

Challenges faced:

- Ongoing arm conflict and political instability causing disruption of services and affecting sustainability of HIV programmes
- HIV and AIDS are not well prioritized among the agenda of Humanitarian response
- Lack of Government and CSOs capacity to handle the worsening burden of drug and HIV situation in the country.
- Withdrawal of international and national experts from the country
- Limited or no services for key at risk population.
- Limited funding and fund implementation capacity.

Financing and management:

- In case of UNODC, the funding is provided by Government and spent through UNODC. Other agencies can add as well
- UNAIDS used its core resources to support few interventions in Libya

Lessons learned and recommendations:

Lessons learned:

- Joint UN and CSOs emergency response to HIV is critical to respond to the emerging priorities in Libya
- Capacity development on critical programmatic areas such Harm Reduction and M&E targeting Humanitarian and public sectors agencies engaged in the HIV response is fundamental in the epidemiological and political context in Libya
- Information and needs assessments for HIV services in the humanitarian context in Libya are needed to guide the response including advocacy and programmatic interventions

Recommendations:

- The evolving situation in Libya would require a tailored and systematic response to ensure HIV and AIDS are positioned and integrated with the many humanitarian agenda.
- There is a need for enhanced partnership and coordination among the various stakeholders with ultimate goal of strengthening the national programme and response and identifying entry points for HIV integration within the protection, health services and other related services in humanitarian settings

There is a need to integrate HIV within the existing humanitarian mechanism in Libya included through health and protection clusters.

15. Malawi

Title of the programme: Continued access to HIV prevention, care and treatment services during national disaster

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Programme is being implemented since: January 2015
Implemented by: Government, Civil Society, UN or other intergovernmental organisation
Scope of submission: Access to HIV in prevention, care and treatment
Has the programme been evaluated /assessed? Yes
Is the programme part of the national AIDS plan? Yes, The Country Programme supports the National Strategic Plan
Is the programme part of a national emergency response? Yes, UNICEF coordinated with the government-led Health Cluster

Background:

Malawi's HIV prevalence is 10.3%, with the highest prevalence rates recorded in southern districts. Although Malawi has a robust National HIV Strategic Plan, there is no HIV-specific preparedness plan in place. In January 2015, Malawi experienced heavy rainfall, causing severe flooding, particularly in the southern region. The President of Malawi declared a State of Disaster in 15 districts, primarily located in the southern region. At that time, there were:

- 638,000 people affected countrywide
- 174,000 people displaced in the 3 most affected districts
- 79 confirmed deaths
- 64,000 hectares lost to flooding
- Approximately xxx people were stranded in locations accessible only by boat or helicopter

As of April 2015, 162,062 people remain displaced nationwide and there have been 106 deaths. Cholera has become a concern, with 504 cases and 7 deaths.

In the 4 most affected districts, approximately 86,271 people were alive and on ART at the time of the flooding.

Approach:

UNICEF's response was designed to ensure that displaced persons received information on HIV prevention, care and treatment and access to HIV services. UNICEF developed partnership agreements with NGOs to provide HIV-related information, support through counselling and edutainment, and HIV testing and counselling, family planning, and STI screening and treatment. People testing HIV positive were then enrolled in pre-ART. People living with HIV already on treatment received a confirmatory HIV test and then provided with ARVs. In addition, UNICEF supported districts with integrated health service delivery at the camps, including HIV services (including HIV testing and counselling, care and treatment), nutrition, malaria, and maternal/child health. Antenatal care services continued to integrate HIV, providing HTC for pregnant women and ARVs for those testing positive. Pregnant women were then referred to fixed facilities for labour and delivery.

Reach of the intervention:

Information

Activities included radio messages encouraging young people to avoid unprotected sex and advocating for protection against transactional sex and a toll-free national hotline that displaced persons used to report mismanagement within the camps. In addition, theatre/edutainment, dialogue-sessions with adolescents and counselling were used to address a range of topics, including sexual abuse, the importance of ARV adherence, and condom use. Displaced persons, including young people, were trained to deliver appropriate information on HIV prevention, particularly condom use.

Service delivery

Integrated service delivery was provided through both government and NGO partners. Displaced persons received HIV testing and counselling, care and treatment, as well as STI screening and treatment and family planning. At the same time, healthcare workers provided primary health care. In addition, condoms were distributed throughout all the camps. Young people were trained as condom distribution agents in order to facilitate access by adolescents.

Impact of the intervention:

Communication

In the 4 most affected districts, at least 153,298 displaced persons were reached with information on HIV prevention, care and treatment (Target was 100,000).

Condoms were distributed throughout all of the camps, using multiple mechanisms (healthcare workers, peers).

Through outreach and static services, people continued to access treatment. In April 2015, the Ministry of Health collected ART data from all of the facilities. The final analysis will be available in June.

Mobile clinics

Integrated services were provided in the 4 most affected districts. Towards the end of April around 15,000 patients had been treated in the camps with basic services such as ANC, family planning services, nutritional assessments, HTC, provision of ARVs, malaria treatment and health promotion activities, particularly for cholera. In addition, BLM provided outreach family planning services, reaching 398 women within the first month (35% were new users). Final data will be available first week of May.

Challenges faced:

Coordination within District

Initially, support was requested for HIV, health and nutrition outreach as separate activities, despite the same healthcare workers providing all services. UNICEF's response to provide integrated services improved the efficiency and effectiveness of the mobile clinics, and created opportunities for synergies, such as screening malnourished children for HIV. For example, any child admitted to the Nutrition Rehabilitation Unit was also tested for HIV. On average, one in every five children admitted tested HIV positive.

Stock outs (condoms)



Health facilities routinely have condom stock outs, due to both lack of storage and inadequate planning. As a result, it was difficult to ensure steady condom supplies in the camps. Nonetheless, consistent monitoring resulted in condoms being available most of the time.

Reaching adolescents

Adolescents required specialized services for both HIV prevention and treatment.

Fees for services proved to be a barrier to access services:

- Church-related facilities: Although maternal/child health and HIV services are supposed to be free, the Church Hospitals charged displaced persons, particularly for maternity services. In addition to safe motherhood concerns, there were concerns of women not receiving HIV testing and counselling or HIV positive women being initiated onto treatment. User fees are currently being addressed through the government's health sector reforms.
- Child and women's health passports were lost during the floods. Reports were later received that some healthcare workers were refusing to provide services unless clients bought new health passports (despite passports being free.) UNICEF continuously advocated to district health officials to monitor the situation and prevent the sale of passports or the availability of passports as a barrier to services. Nonetheless, these practices continued.

Continued access to HIV treatment

- Despite national policy that people on treatment can access ARVs from any facility, some facilities initially refused services to people who had lost their health cards. The District Health Office intervened and facilities began accepting people without health cards. Temporary registers were developed for persons accessing ARVs through both static facilities and mobile clinics.

Healthcare workers were also affected; many lost their homes during the flooding. UNICEF supported the deployment of healthcare workers from non-affected areas to provide services at the camps.

Receiving reliable data was an on-going concern, ranging from the numbers affected and the numbers reached, particularly through mobile health clinics. In April, UNICEF supported the Ministry of Health's quarterly supervision and monitoring exercise which will provide data on how the floods affected access to services.

Financing and management:

Three approaches were employed to provide funding and management support:

1. UNICEF's HIV Section was in the process of developing Partnership Agreements with NGOs for HIV and adolescents. Emergency agreements were quickly put in place with these partners, using thematic funding, to provide services to the camps.
2. The HIV Section used regular resources to co-finance emergency agreements, leveraging funds with the Health, Nutrition and WASH sections.
3. The HIV Section provided technical support to the districts to provide integrated services.

Lessons learned and recommendations:

Preparedness:



UNICEF has been supporting distribution of ARVs for several years. Responsibility for distribution was handed over to the MoH in September 2015. Part of the hand-over plan included lessons learned during the rainy season. As a result, drug deliveries were made in early-December, prior to the rainy season, ensuring that health facilities had adequate stock levels.

In addition, the MoH has a national toll-free ARV hotline in place which health facilities can use to report imminent stock outs. Affected districts used the hotline to report stock damages and to request additional stocks. Stocks were then delivered from the national stores to the districts to replace damaged stocks and ensure sufficient supplies for new clients.

Flexibility:

Initially, communications activities focused on displaced people in the camps. As the camp population disbursed, activities were redesigned to include communities. Similarly, the mobile outreach services provided by implementing partners initially occurred within camp settings. As demand from nearby communities grew and camp populations lessened, the outreach services were extended to community members.

Advocate for no user fees policy during emergencies. Publicize that child and women's health passports are a) free of charge and b) not required to access services.

16. Mozambique

Title of the programme: Lessons learned for HIV programming: Flood response in Mozambique

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Programme is being implemented since: 2013

Implemented by: UN or other inter-governmental organisation

Scope of submission: Access to HIV prevention, care and treatment, Early recovery and development

Has the programme been evaluated /assessed? Yes

Is the programme part of the national AIDS plan?

Is the programme part of a national emergency response?

Background:

In January 2013, Gaza Province, Mozambique experienced severe flooding. Although this area is prone to annual flooding, the 2013 floods caused large-scale destruction and displacement. The total number of people affected by the flood is estimated at 150,000 (87,500 women; 67,500 men; 29,500 children under five). Many health facilities were affected and patient records and supplies, including ARV drugs, were damaged or destroyed. Approximately 13,000 people living with HIV (PLHIV) were put at risk of losing access to HIV treatment. Despite the high HIV prevalence in Gaza Province, HIV was not accounted for in the initial emergency response and assessments. This oversight affected treatment continuity and other services for PLHIV.

In January of 2015, Mozambique experienced floods in the Central and Northern regions of the country. The flooding severely impacted public infrastructure, including damage to schools and health facilities. Floods have isolated approximately 32% of health facilities in Zambézia and destroyed 7 health centres with respective maternities at district level. Five health facilities were affected in Nampula and Niassa provinces.

Approach:

This analysis reviews how the 2013 floods impacted HIV programming in Mozambique, takes stock of the HIV response, and identifies lessons learned for UNICEF. It also seeks to highlight areas where adjustments to programming can be made to improve future HIV response for children, pregnant women and adolescents in other emergency situations.

Reach of the intervention:

The programme is organized around the following three Core Commitments for Children (CCC), which guide UNICEF's response during a crisis:

- CCC1: Children, young people and women have access to information regarding HIV and AIDS prevention, care and treatment.
- CCC2: Children, young people and women have access to HIV and AIDS prevention, care and treatment.
- CCC3: HIV and AIDS prevention, care and treatment services for children, young people and women are continued.



When possible, UNICEF also strives to ensure that pregnant women and children are initiated into services, including HIV services, in the wake of a crisis.

Impact of the intervention:

In terms of **access to information regarding prevention, care and treatment**, UNICEF implemented a number of successful interventions in both camps and communities. These included:

- C4D community outreach and camp-based activities such as radio broadcasts, and mobile multimedia units to transmit HIV messaging in local languages and distribute condoms. Messages focused on information about where to find health services, preventing and responding to violence, family tracing, reunification and psychosocial support. The two multimedia mobile units that were dispatched to the flood-affected communities were already operating in the province pre-emergency, which made it easy to quickly redirect them to affected areas. The radio spots included topics such as stigma, discrimination, multiple concurrent partnerships, testing and condom use. For adolescents, a “junior-to-junior” radio programme was offered.
- Community activists were mobilized in first days following the floods to quickly reach affected communities with information and supplies. They helped to distribute information and supplies including health and nutrition leaflets, condoms and water treatment kits. They also identified vulnerable households and provided pregnant women and PLHIV with information about where to go for services.
- Child-friendly spaces were established in the camps, which offered recreational activities and support services. Efforts to reduce sexual violence in the camps included circulating violence prevention messages and ensuring that facilities were within safe walking distance. UNICEF distributed Family Kits (containing basic cooking and hygiene supplies) to vulnerable households (including HIV-affected households), torches to women and girls and recreational kits to children.

In terms of **access to prevention, care and treatment services**:

- UNICEF set up six large tents for use as temporary health clinics, which helped the local health center provide care and treatment for chronic diseases including HIV and AIDS.
- Nutritional support was offered to patients receiving ART at the community health center and camps.
- HIV testing and counselling services were set up close to recreation areas in an effort to increase the number of young people using the services.

Regarding **continuity of care and treatment services**:

- Community groups conducted campaigns in the camps and communities to identify people who lost access to treatment during the flood. Innovative methods were also used to help defaulters get back on treatment—for example, health care workers devised a system to enable patients to recognize the type of treatment they were on by showing patients the different types of pills.

Leading up to 2015, it was necessary to guarantee a continuum in healthcare provision, including through community outreach services, in partnership with NGOs already established at provincial level as well as with temporary emergency clinics to provide basic health services and emergency care in all areas affected by the floods including prevention and treatment of HIV-infected pregnant women and children living in catchment areas.

UNICEF continued its advocacy to national authorities to streamline integration of HIV in emergencies in the preparedness plan by the third trimester of 2013 and 2014. The plan highlights continued provision of antiretroviral during the onset of an emergency for people living

with HIV and AIDS, particularly for pregnant women whose priority is indicated in the universal access to ART regardless of the immunological status (Option B+ under implementation since June 2013 and more HIV+ mothers now accessing treatment at least in ART sites). The plan included ARVs in the logistics component in case of an emergency. The supply chain remained challenging; it was difficult to ensure additional supply for patients in emergency prone areas for more than three months.

Challenges faced:

A number of challenges were faced, including lack of clear roles and responsibilities, inadequate monitoring, lack of adolescent-specific services, frequent stockouts, missing treatment records, and lack of awareness of the latest WHO guidelines on infant feeding in the context of HIV among health care workers. A few of these challenges are described in more detail below:

- **Roles and Responsibilities:** Because HIV was not included in contingency planning, there was initially confusion among partner organizations about who was responsible for what. The National AIDS Commission was slow to react to the emergency, and some partners were unable to provide support because it was not in their workplans.
- **Monitoring** prevention activities was weak due to lack of human resources. In addition, acquiring accurate data on the numbers of pregnant women and children who were on ARV treatment at the time of the floods was not possible due to a lack of a centralized database and delays in reporting.
- **Adolescent-specific services:** Few services were offered specifically for adolescents— for example, the child-friendly spaces did not include an adolescent-specific component.
- **Stockouts:** Some camps and health centers experienced stockouts of HIV tests, ARVs, PEP and drugs for treating opportunistic infections. This affected access to testing and treatment initiation. Service utilization was difficult to predict as some health services were overcrowded, while others were not accessed. For example, pregnant women in the camps only sought services if they were sick or in labour.
- **Treatment services and records:** Most patients needed treatment refills within one month, however many had lost treatment cards in the flooding. There was no formal protocol for re-establishing access to treatment when patients lose documentation, and no data is available on the impact of the treatment interruptions.

Financing and management:

UN agencies and partners are supporting the Government (through INGC) and NGOs with logistics. The National Institute for Disaster Management (INGC) is the government institution responsible for coordinating the response locally, through the Provincial Emergency Operation Centres (COE).

For instance as a result of continued advocacy support to national authorities was conducted to streamline integration of HIV in emergencies during the preparedness plan by the third trimester of 2013 and 2014. In principle HIV interventions are mainly indicated under health component. Capacity building were conducted in most prone provinces, namely in Zambezia and Gaza integrating key partners namely government sectoral institutions focal points and supported, national AIDS committee (NAC), local/international NGOs to raise their awareness in programming for HIV in the onset of an emergency. This action brought HIV as a sensitive priority issues to be addressed.

Lessons learned and recommendations:

Support risk informed programming: To ensure emergency preparedness, more advocacy is needed to encourage partners to incorporate risk into future programming

- **Focus on adolescents:** Developing a package of adolescent specific services and establishing adolescent peer-to-peer counselling for HIV prevention is a necessary part of risk-informed programming. Partners should work with NGOs and youth coalitions to plan for these activities.
- **The NAC should engage with the health cluster** to ensure a more rapid response.
- **Strengthen capacity of partners:** Follow-up trainings in two provinces included sessions on mainstreaming HIV in provincial plans. As a result key staff from government institutions and NGOs are more familiar with contingency planning and what to do for HIV at the onset of an emergency.
- **Support innovation:** Explore the feasibility of using SMS in emergency situations—for example, to provide adolescent-to-adolescent counselling for HIV testing and prevention.
- **Monthly estimates** of people on treatment are critical for preparedness and aid in the planning of treatment continuation in the wake of a crisis.
- **Further explore issue of nutrition as an entry point to HIV treatment** (in both emergency and non-emergency settings). Routine testing of children with SAM and providing referral and verification for initiation of treatment for those testing positive can help to integrate and streamline services.
- **Conduct interviews** with pregnant women to determine why they were not accessing ANC services. Based on responses, consider ways to address these issues as part of preparedness.
- **Engage in discussion at national level** for what to do when people lose their treatment records and come to facilities without treatment information. There should be a protocol to re-establish treatment immediately, even for patients without treatment cards.
- **Ensure that drugs are stored** in a safe place out of the flood plain. Clarify procedures to follow regarding disposal of medications that were damaged in the flooding
- **Strengthen the use of radio, TV and mobile phone** technologies for preparation, warning, and support during an emergency.
- **Integrate mechanisms for continuation of mother support groups** in the wake of a crisis. For example, develop mechanisms within regular programming to track patients and deliver appropriate messages.
- **Determine feasibility of providing advance supply of ARTs** before the rainy season starts to prevent treatment disruption. Barriers include stocks-outs, but UNICEF can provide advocacy and technical assistance to determine the best solutions.

17. Sierra Leone

Title of the programme: HAPPY – Patient Tracing Project (PTP)

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Programme is being implemented since: May 2014

Implemented by: Civil Society

Scope of submission: Access to HIV prevention, care and treatment, Preparedness and contingency planning

Has the programme been evaluated /assessed? No

Is the programme part of the national AIDS plan? Yes, The intervention was part of the reprogramming programme for the Global Fund

Is the programme part of a national emergency response plan? Yes

Background:

The outbreak of Ebola Virus Disease (EVD) that hit Sierra Leone in May 2014, ravaged communities throughout Sierra Leone, severely disrupted the health services and reduced health care attendance by the communities. The epidemic rapidly spread to all districts, with varying intensity. As of 10 April 2015, the number of laboratory confirmed cases was 8,560 while the number of confirmed deaths was 3,488. The already weak health system in Sierra Leone was shaken by the EVD outbreak, causing the dropping of the provision of health services by the national health system. The infection and death of large numbers of health workers, and reluctance among communities to seek care compounded the challenges to the fragile health system.

A rapid assessment of health facilities in October 2014 found significant decline in the uptake of maternal and child health services such as 23% decline in the number of PMTCT visits, 50% decline in HIV testing and 21% patients lost to follow up.

Sierra Leone's HIV epidemic has been categorized as mixed, generalized and heterogeneous— meaning that HIV affects different population sub-groups and all sectors of the population through multiple and diverse transmission dynamics. In 2013² the prevalence rate for men was 1.3% while that for women was 1.7%. HIV Prevalence among female peaked at 35 to 39 years (2.6%) while their male counterparts peaked at 30 to 34 years (2.9%).

HIV prevalence among pregnant women attending antenatal clinics (ANC) also declined progressively from 4.4% in 2007 to 3.5% in 2008 to 3.2% in 2010 respectively. HIV prevalence levels tend to be significantly higher in urban than rural areas in both the population based surveys and ANC sentinel surveillance surveys.

An estimated 60,000 Sierra Leoneans are living with HIV³ out of which 34,000 are women and 5,000 are children. This indicates that women are disproportionately infected. At the end of 2014 (GARPR report) 10,672 patients (adults and children) were on treatment (46.8% of those eligible) and 2,901 pregnant women were estimated to be in need of ARV in 2014 (spectrum).

HAPPY HIV AIDS Prevention Project for Youths) is a national non-governmental organization supported by UNICEF. It aims to mitigate the impact of AIDS on the lives of children and adolescents affected by AIDS through ensuring access to quality care, treatment and support. The six HAPPY centers deployed in six districts are open to children and young people affected or infected by HIV and their caretaker.

² DHS2013

³ 2012 Spectrum Estimates



The centers provide support (educational, psychosocial and health) to the children and adolescents to give them opportunity to make full use of their potential. The project is building capacity of caretakers, informs and sensitizes the general population on HIV and AIDS and supports the children and adolescents as peer educators.

Approach:

With the general reluctance of the population to seek care at health facility level we rapidly understand the necessity to put in place a system to reach out people living with HIV to continue providing them with their life saving drugs.

The objective of the intervention was to reduce defaulters and prevent loss to follow up and improve access to HIV and AIDS services for both pregnant /lactating women and children infected and exposed to HIV in the area of HAPPY intervention, with the addition of two districts that were the most affected at the start of the Ebola outbreak.

In the 6 districts targeted by HAPPY we had 541 exposed / infected children and 1,444 pregnant / lactating mothers to monitor.

The strategy was to create an enabling environment for both the healthcare staff and HIV positive patients to go the health facilities to continue to take their ARVs, receive adherence counselling and seek other health care services amidst the fear around Ebola.

Key activities implemented have been as follow:

First we trained 16 social workers and 30 district HIV counsellors and volunteers from the 6 HAPPY centres on HIV defaulter tracing in the context of Ebola. Defaulter tracing is defined as contacting (by any means) a person living with HIV who did not come for her / his treatment on time. The social workers and HIV counsellors would get the information about name, telephone contact and address from the HIV clinic and would proceed in contacting the person. It was important to train them on signs and symptoms of Ebola and how to approach a person without having close contact to ensure safe practices of staff and volunteers. They would also know how and where to refer a person with sign and symptoms of Ebola, providing them first with counselling.

After the training the teams worked together to ensure HIV positive children, adolescents and women continued to adhere to their treatment during the Ebola outbreak. They had weekly meetings with the HIV clinic to collect all information from patients and report back on the results of their investigations. The teams were also trained to give adherence counselling and dispensing of ARV in case clients refused to go to the health facility. In those cases, the teams brought the medication to their home and provided them with counselling sessions and information.

The teams were informed on other activities implemented by other partners in the context of Ebola. If they encountered a person living with HIV who was put in quarantine because they were in contact with a confirmed Ebola positive case, they would know who to be in touch with to provide all requested support to the family (surveillance officer, quarantine support – food, water and non-food items). And they continued to provide some support (keeping a distance away) until the end of the quarantine period (21 days).

A system was also established to record all phone calls and home visits made and document outcomes which were reported back to the HIV clinic. It is also a way to monitor their work and report on results achieved.

The six HAPPY facilities were equipped to enable treatment for children in situations where the regular ART clinic was unable to continue to provide services. All patients entering the facility were screened for



Ebola (temperature taken and questionnaire). Hand washing facility (chlorine soap and buckets), protective gears- gloves, Bins for sharps and other wastes and IEC materials on Ebola were made available in all centres.

The programme also included regular community sensitization through radio programmes, Community outreach and meetings with PLHIV support groups to inform them on the risk of Ebola, while encouraging them to continue to attend health facilities for any other conditions.

Reach of the intervention:

The EVD outbreak in West Africa especially in Sierra Leone was unprecedented. The region was unprepared to respond and hence the patient tracing project was used as a framework to ensure continuous response to the needs of patients on treatment for HIV. The project facilitated continued access to treatment and care for people living with HIV by tracing patients, bringing ART to patients on treatment, and providing HIV services at HAPPY facilities when health facilities were closed. The services provided then were limited to dispensing drugs and routine consultation. The patient would be referred to another health centre for any critical condition or need of diagnosis.

Impact of the intervention:

When the program began in August 2014, of the 686 child patients caseload in 12 facilities, 206 (30%) had defaulted on taking their treatment for HIV. By the end of the project intervention 60% of defaulting children and 84% of pregnant women were put back on treatment. The figures were achieved through matching the existing facility data with the tracing activities.

Challenges faced:

The following are the key challenges faced during the implementation of the project:

- Some patients were not receptive to their PLHIV peers reaching to them but preferred their counsellors.
- Some contacts were either false, non-existent or patients have changed addresses.
- Difficulties to access patients in quarantined homes
- Patients fear that tracers are part of the EVD surveillance team

Financing and management:

- HAPPY Centres worked in close collaboration with the HIV health staff from the HIV governmental clinics
- Weekly feedback meetings held with tracers and health care staff at the HAPPY Centres
- UNICEF fully funded the Patient Tracing Project and the project has been factored into a one year proposal awaiting funding by UNICEF
- HAPPY worked with the National AIDS Control Programme- Ministry of Health, Network of HIV Positives, AIDS Healthcare Foundation and SOLTHIS (Solidarité Thérapeutique et Initiative contre le SIDA, French NGO working in Sierra Leone).

Lessons learned and recommendations:

- It is critical that people living with HIV are used as contract tracers. As peer they were able to face the resistance from defaulter patients. They easily gain confidence from defaulter patients to bring

them back to treatment

- Proactive tracing of defaulters improves access to treatment, care and support to patients.

COMPARISON OF CASE LOADS OF HIV POSITIVE CHILDREN AT HEALTH FACILITIES AS AT AUGUST 2014 AGAINST THE DISTRICT/FACILITY CASE LOADS;

No.	DISTRICT/FACILITY	CASE LOAD	ACTIVE	DEFAULTED TREATMENT	% DEFAULTED
Children					
1	PORTLOKO	20	7	12	60% Excludes figures for adults on ART
2	KAILAHUN (adults and children)	169	123	46	27%
3	KENEMA	49	28	21	43%
4	BO	35	8	27	77%
5	PUJEHUN	36	26	10	27%
6	BOMBALI*	51	37	14	27%
7	WARURAL* (Waterloo HC)	27	22	5	19%
8	DR. TAQI'S CLINIC	31	19	12	39%
9	JENNER WRIGHT CLINIC*	12	10	2	17%
10	LUMLEY HOSPITAL	24	15	9	38%
11	OLA DURING HOSPITAL	232	184	48	36%

The tables below summarizes the achievements of the intervention.

Indicator	Children	%	Pregnant women Lactating Mother	%

No. Patients in targeted facilities	541		1,444	
No. patients who came to clinic to take their treatment	292		942	
No. patients who had their medication delivered at home	40		277	
Total received treatment (clinic + home)	332	61.4%	1,219	84.4%
No. Deaths	39	7.2%	40	2.7%
No. lost to follow up	170	31.4%	185	12.8% (30% national)

18. Sierra Leone

Title of the programme: Prevention of sexual transmission of Ebola virus

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Programme is being implemented since: 2014
Implemented by: Government, Private Sector
Scope of submission: Protection issues, equity and human rights
Has the programme been evaluated /assessed? No
Is the programme part of the national AIDS plan? No
Is the programme part of a national emergency response plan? No

Background:

Whilst there are no confirmed cases of sexual transmission of Ebola virus, sexual transmission from convalescent patients cannot be ruled out. Live Ebola virus has been isolated in seminal fluids of convalescent men over 80 days after onset of symptoms. Ebola RNA has also been detected by RT-PCR in semen of one patient up to day 101 after symptoms onset. There is no evidence of live Ebola virus in vaginal secretions: only Ebola RNA, detected in the vaginal secretions of a woman on the 33rd day after symptoms onset. It is unknown whether this RNA represents live virus, or for how long it may remain in vaginal secretions (WHO, 4th April, 2015).

In Sierra Leone, there have been alleged cases of Ebola transmission to survivors' partners via sexual intercourse, but none of these have been scientifically proven. As the risk of sexual transmission cannot be ruled out, men and women who recover from Ebola virus disease (EVD) are advised to abstain from all types of sex (including anal and oral sex) for at least three months after onset of symptoms. If sexual abstinence is not possible, condoms are recommended to offer some protection. Correct and consistent condom use by Ebola survivors is recommended beyond three months for prevention of other sexually transmitted infections.

UNFPA, together with WHO, UNICEF, Sierra Leone Ministry of Social Welfare and other partners continue to work together to raise public awareness for preventing sexual transmission of Ebola whilst ensuring that the principle of non-stigmatization and non-isolation of Ebola survivors is upheld. Key activities have included development and dissemination of media messages, training of social mobilization teams for one-to-one and community sensitization, and provision of condoms and counselling to Ebola survivors.

Approach:

Efforts to prevent sexual transmission of Ebola virus have included three elements: mass media prevention messaging, training of community social mobilisation teams, and individual counselling of Ebola survivors, including supply of condoms.

A consolidated guide for Ebola Communication has been developed in Sierra Leone, including the following mass-media messages:

- Ebola survivors cannot spread the virus through casual contact. Although the virus is gone from blood and most other body fluids, the virus can stay in semen and in vaginal fluids for 3 months or longer.
- Research continues as to whether or not Ebola virus can be spread through sex, and if so, for how long.



- As a safety measure, Ebola survivors (both men and women) should not have any sexual contact (oral, vaginal or anal) for at least three months. If they do have sex, they should use a condom every time.

UNICEF has taken a lead role in developing Social Mobilization teams – to educate the public about Ebola transmission and prevention mechanisms, including concerning sexual transmission. Door-to-door outreach and small public gatherings have been organised. Contact tracers include information on possible sexual transmission during their community outreach activities.

UNFPA has worked with its key implementing partner (the National HIV/AIDS Secretariat) on condom programming to ensure sexually active Ebola survivors are provided condoms and counselled on their use. At least ninety condoms are included in each Ebola survivor discharge package, together with IEC materials on correct condom use. UNFPA also provides condoms for quarantined homes to make them available for sexually active quarantined persons.

Reach of the intervention:

Over five thousand contact tracers have been trained by UNFPA in collaboration with the Ministry of Health and Sanitation. Contact tracers also educate their communities on Ebola transmission and prevention. By the end of 2014, a total of 1,135 survivors had been counselled and 158,796 condoms distributed to quarantined homes and Ebola survivors.

Impact of the intervention: What did the intervention achieve in terms of HIV outcomes in prevention, treatment, care and support for people living in emergency contexts? How was this impact measured?

To date, no cases of sexual transmission of Ebola virus have been verified. Sexual transmission if it does occur is secondary to the primary modes of spread via exposure to persons during incubation and symptomatic phases of EVD, and corpses of persons subsequently dying from Ebola infection.

In terms of equity and human rights, the prevention and treatment response has focused on reducing transmission whilst also upholding the rights of Ebola survivors to live free from stigma, discrimination and marginalisation, and on preventing secondary transmission to sexual partners. Social and behaviour change communication campaigns and provision of condoms have occurred to prevent sexual transmission of Ebola – as well as HIV and other STIs.

Challenges faced:

Stigma and discrimination faced by Ebola survivors has been a significant challenge, this arising from community-level anxiety and fear in the face of perceived risks and desire to avoid infection.

Financing and management:



UN agencies involved – UNFPA, WHO, UNICEF and partners have re-programmed regular resources and thematic funds for responding to the Ebola crisis – dedicating staff time, equipment and resources for this response.

Lessons learned and recommendations: What factors helped success of the intervention, including institutional set-up, legislative and policy environment, coordination, political mobilisation and support, advocacy?

This situation is very similar to perceived community fears about HIV during the early stages of the HIV epidemic. Our experience and knowledge on mobilising community awareness and encouraging societal mobilisation and behaviour change, gained from the AIDS response, have been usefully applied in response to the newly emerged challenge of Ebola.

19. Somalia

CONTACT PERSON

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Programme is being implemented since: SORDA has been implementing HIV/AIDS response, Support PLWHA and coordination programs in South Central Somalia from 2006-2015.

Implemented by: Civil Society

Scope of submission: Access to HIV prevention, care and treatment, Protection issues, equity and human rights, Preparedness and contingency planning, Inter-agency coordination, Effects of emergencies on key populations, Early recovery and development, Situations of fragility, Innovative funding strategies

Has the programme been evaluated /assessed? Yes, Community awareness raising on prevention and control of HIV/AIDS Spread, peer education and mass media program funded by Global Fund in war ravaged community of Somalia from 2016 -2009 as sub-recipient –UNICEF (PR).

- 2010-2011. Targeted HIV/AIDS risk groups on education of HIV mode of transmission as sub-sub recipient of IOM/UNICEF/ GF.

- 2010 2013 SORDA implemented Integrated protection and livelihood support projects in War effected IPDs in South Somalia funded UNHCR. From 2013- 2015. From 210.

-2012-015 Stigma reduction and Support PLWHIV/AIDS

-2013 -2015 Basic Emergency Obstetric and Neonatal Care (BEmONC) funded By MoH/ UNFPA

-2013-2016 Malaria Prevention and control project Funded by UNICEF/GF.



-Inter-agency and technical coordination meetings.

Is the programme part of the national AIDS plan? Yes

Is the programme part of a national emergency response plan? Yes

Background:

Generally, it was believed that the HIV/AIDS prevalence rate in Somalia is relatively low, but latest reports on humanitarian situation revealed the current infection rate in Somalia rise drastically. The survey found the lawless nation's average HIV infection rate in 2003 was 0.9 percent but with Zonal variations particularly in its two semi-autonomous regions of Puntland and Somaliland, where the average was one and 1.4 percent respectively. But current reports shows South central Somalia gained high rate of HIV infections is in South central Somalia.

The last Strategic Plan (SP) of HIV and AIDS for the Somali response was from 2009 to 2013 and is being used until the new plan is launched. A new National Strategic Plan has therefore been developed to cover the period 2015 to 2019. The Round 8 Global Fund HIV grant comes to an end in December 2014. Following declaration of eligibility by the Global Fund, a new HIV grant for the Somali response is under development for the period 2015 to 2017. This Strategic Plan for the Somali AIDS Response 2015 to 2019 defines how we as Somali all sectors of society at all levels – are going to respond to HIV and AIDS in the next five years. HIV and AIDS remains a major development challenge as much as they are a health and human rights challenge. The planning for HIV and AIDS in the context of the SP has taken cognizance of the development dimensions of the response and the need to align and harmonise the NSP with other national strategic policy frameworks such as New Deal and the Health Sector Strategic Plan at the national level. At the Global Level, the plan takes cognizance of the UN 2011 Political Declaration on HIV and AIDS, The UNAIDS Investment Framework and the Global Fund New Funding Model

Limited bio-behavioral surveillance of higher-risk (and often invisible) populations (called Key Affected Populations throughout this strategy document) has been conducted in recent years in Somalia. However, the last such survey conducted amongst female sex workers in 2008 in Hargeisa in Somaliland reported prevalence rates of 5.2%. A second round of the survey in Hargeisa was in progress at the time of the development of this strategy. In light of the fact that interventions to date focusing on female sex workers (FSW) have not achieved sufficient coverage, intensity and duration to have public health impact, it is probable that HIV prevalence rates amongst them are not likely to have changed from those reported in 2008. There have been no other epidemiological surveys conducted amongst the other KAPS prioritized and identified in the strategic framework 2009-2013⁴.

HIV incidence

It is estimated that in 2013, approximately 2, 691 Somalis were newly infected with HIV (1,350 females and 1,341 males). Within these overall estimates however, South Central zone had the highest number of new infections (1,434) followed by Somaliland (980). Puntland had the lowest estimate of 278 new infections.

⁴ The strategic framework identified the following additional KAPS: Prisoners, street children, uniformed personnel, militia, and mobile populations such as truckers, seafarers, port workers, internally displaced people, refugees and returnees.

Approach:

- Reduction of HIV/AIDS Spread through increased through increased level of understanding of HIV/AIDS modes of Transmission.
- Reduction of stigma /taboo through community education for collective collaboration and mercyness for the people living with HIV/AIDS.
- Encourage and call for the people visit VCT for HIV/AIDS check up and counselling.
- Integrated intervention and coordination of targeting HIV/AIDS risk groups and Hot spot areas and those living with HIV/AIDS.

-

Reach of the intervention:

Wide range of community mobilization, alert/awareness on HIV risks, and modes of transmission were conducted.

- Access to IEC materials on HIV/AIDS modes transmission and directions for the locations available for VCT and ART in urban and semi-urban areas were increased.
- Programs targeted IDPs locations are Protection issues, equity and human rights

-

Impact of the intervention:

Among the Impacted observed during HIV responses.

- Prevented new HIV infections;
- Increased access to and utilization of optimally efficient, effective and integrated treatment, care and support services;
- Strengthened monitoring and evaluation of the response;
- Ensured an enabling environment for the response; and
-
- Strengthened management and coordination of the response

Challenges faced:

Among the challenges faced are:

- Inadequate fund available for the HIV/AIDS responses.
- Reluctant among the local communities to work program voluntarily
- Lack of capacity with government institutions in terms allocation of funds, commitment and required skills for timely and appropriate responses.
- UN, GF and international aid agencies was only force pushing forwards for HIV/AIDS responses and health facilities.

Financing and management:

In generally, HIV/AIDS responses in Somalia is based National Strategic plans that coordinated jointly by the Zonal HIV/AIDS commissions and UNICEF/GF. Competitive process is selected the partners implementing the HIV/AIDS responses donors/Government. Innovative approaches to funding was part of competitive selection process. The major challenges is donor UNICEF/GF so far. Although is other small funds maintained other protection interventions,



For the management of the funds, SORDA has financial policies and procedures that safeguard the execution of the program expenditures. Besides, all programs implemented by SORDA was audited external institution in yearly bases.

Lessons learned and recommendations:

- Organisational policies and procedures in place.
- Qualified and experienced personnel and commitment from the management of the organisation.
- Clear national strategic plans and coordination of all stakeholders.

20. Somalia

Title of the programme: Somaliland Hotline Information call centre for HIV/AIDS

CONTACT PERSON

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Programme is being implemented since: June 2014

Implemented by: Civil Society

Scope of submission: Access to HIV prevention, care and treatment

Has the programme been evaluated /assessed? No

Is the programme part of the national AIDS plan?

Is the programme part of a national emergency response plan?

Background:

This intervention is being promoted as a means to address social and security barriers to HIV and AIDS services. Somaliland, Puntland and South Central Somalia offer some of the most technologically advanced and competitively priced telecommunications and internet services in the world. Ownership and access to mobile phones is widespread and presents an opportunity for application in HIV programmes in emergency settings.

Somaliland is a breakaway region which is independent of the rest of politically unstable Somalia. The country has an estimated population of 3 million people. The HIV/AIDS response in Somalia started in the late 1990s with very few people coming out with their HIV/IDS positive status. The brave few were met with a lot of stigma and hostilities in a highly stigmatising society. In a Muslim country with strong cultural ties HIV has been mostly being condemned as a disease for the immoral and foreigners.

Having achieved a sense of normalcy and peace Somaliland is however susceptible to the spread of HIV/AIDS. According the WHO HIV prevalence surveys the rate of HIV is 1.1% in Somaliland among antenatal clinic (ANC) attendees. This figure is also generalised among the population and is a cause of concern in a closed society where stigma is very high.



The most at risk populations in Somaliland include youth, sex workers, cross boarder truck drivers and refugees from neighbouring Ethiopia and Eritrea. Bio-behavioural surveillance was undertaken among sex workers in Somaliland in 2008 and in early 2014 and findings indicate an HIV prevalence of 5 times that in the general population. Data from the 2014 round of the survey amongst sex workers in Somaliland found that lack of comprehensive knowledge amongst them to be very low, with only 11.1% of those surveyed able to correctly identify ways of preventing transmission and reject major misconceptions. From the survey in Somaliland SGBV is an important behavioural factor with reports of forced sex. Data from the 2014 round of the bio-behavioural survey amongst sex workers in Somaliland indicate that only 59.4% of had ever heard of a condom, whilst only 34.6 % reported condom use at last sex. HIV-related stigma and insecurity in some parts still deters many Somalis from utilizing prevention services or from being tested for HIV, severely limiting the efficacy of current SBCC interventions.

Approach

Somaliland HIV/AIDS Network (SAHAN) developed and is implementing a hotline call centre for HIV/AIDS information. This is a first such call centre in Somaliland and is an innovation which has been tested in other countries. The call centre provides the anonymous callers with comprehensive information on HIV/AIDS and other related social issues and links the callers to services.

The key elements to a successful call centre intervention are training of dedicated counsellors in comprehensive HIV/AIDS information. An efficient referral system to services and strict adherence to confidentiality.

Access to information by callers in key and the centre approach seeks to have information available 24 hours a day.

Reach of the intervention:

The programme addresses access to HIV prevention, care and treatment by overcoming the barriers of stigma, distance and security concerns. Due to the high stigma associated with HIV/AIDS in Somaliland it is absolutely paramount for a project to provide client confidentiality. Hence the call centre uses codes to identify callers and provide a safe environment for callers to obtain information and be referred to health services.

Since inception in June 2014 the call centre has received 8,500 callers inquiring about health information. The callers are mostly between the ages 14 to 45 and calls are received from both males and females with. The percentage of women calling for information is higher confirming the hypothesis that women are more health seeking than men.

Impact of the intervention:

The HIV/AIDS information call centre has tremendously broken the information barrier for the HIV in the country. People of all ages can now easily access information and counselling on HIV/AIDS at the comfort of their homes and with no stigma fears and challenges associated with travelling to obtain consultation. The sheer numbers of callers indicates the success of the project and preliminary information from tracking the referral system suggests an increase in the numbers of people seeking health services on HIV related issues in the country.



Couple testing has been witnessed for the first time in Somaliland with indications of increased knowledge about the epidemic. An increase in demand for condoms among sexual active young people indicates to openness and need for sexual protection among the young people.

Challenges faced:

Mobile populations are not easy to track and ensure continued services such as treatment of HIV/AIDS. The call centre has established a referral network to link clients from one area to the other so as to ensure continuity in care and treatment for positive people. Demand for information is overwhelming sometimes as the call centre is considered to be the safest source of information. On average 32 callers per day call to get counselling and information. This results in burnout on the limited numbers of trained counsellors. Training of more counsellors is needed to increase the human resource base for the call centre.

Running a call centre requires a lot of financial resources to cover such expenses as telephone bills. This has been made possible by communications cooperate social responsibility in Somaliland.

Financing and management:

Cooperate social responsibility has been an innovation for SAHAN to sustain the high cost of telephone communication. The organisation tapped into the communication industry CSR for support.

External support was obtained from UNICEF and Froumsyd to kick start the project.

Infrastructure support and human resources costs are still a challenge which the organisation is seeking long term solutions for. The organisation has a dedicated team which supports the counsellors and work with partner organisations and health care providers to ensure an effective referral system and services to the clients.

Lessons learned and recommendations:

The project used a comprehensive consultative process before its establishment which enabled the buy in from stakeholders and community members. The project learnt that communities are willing to get information on HIV/AIDS if it is provided in a safe environment which is not stigmatising and confidential. Multi sectorial engagement is key to providing a comprehensive HIV/AIDS response in emergency settings. The project benefits from a wide range of supporters from government and private institutions.

It is recommended that this application of communications technology be replicated in contexts of HIV in emergency settings as a means of overcoming physical and social barriers to information and services.

21. South Sudan

Title of the programme: UNFPA Emergency Response – Supporting reproductive health and prevention of gender based violence

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Programme is being implemented since: 2013

Implemented by: Government, Civil Society, UN or other intergovernmental organisation

Scope of submission: Access to HIV prevention, care and treatment, Protection issues, equity and human rights, Community resilience

Has the programme been evaluated /assessed? No

Is the programme part of the national AIDS plan? Yes

Is the programme part of a national emergency response plan? No

Background:

Ten thousand people have been killed and over 1.6 million internally displaced since civil war broke out in South Sudan in December 2013. Ignited by a political struggle, the conflict escalated into ethnic violence between Dinka and Nuer – the two largest ethnic groups in South Sudan. The civil war has caused nationwide food shortages, with a third of South Sudan's population affected and up to fifty thousand children in danger of dying of hunger.

In December 2013, the UN Security Council authorized a deployment of 6,000 security forces, in addition to 7,600 peacekeepers already in the country. In May 2014, the Security Council voted to shift operations from nation building to civilian protection, authorizing UN troops to use force. Both sides in the conflict have failed to reach a power sharing agreement.

It is estimated that 150,000 people are living with HIV in South Sudan, an adult prevalence of 2.2%. In 2013 there were 13,000 deaths due to AIDS and approximately 100,000 orphans due to AIDS, aged 0-17 years (UNAIDS country data, 2013).

Despite the conflict, UNFPA South Sudan Country Office continues to operate, delivering an emergency response, with focus on provision of sexual and reproductive health commodities and services for impacted communities.

Approach:

UNFPA is helping to sustain a range of sexual and reproductive health (SRH) services, including antenatal care, emergency obstetric care, postnatal care, post-abortion services, family planning, and adolescent SRH and HIV/STI services. HIV/STI programming includes HTC, STI treatment and EMTCT services. New EMTCT registers have been set up with



associated protocols and guidelines in collaboration with WHO. UNFPA is also engaged in prevention of gender based violence and provision of clinical management for women and girls experiencing sexual assault.

Reach of the intervention:

During the latest reporting period (March 2015), a total of 9,867 pregnant women accessed antenatal care, including 1,196 assisted deliveries. No maternal deaths were reported. In terms of access to HIV services, there were 2,267 consultations for HIV testing and counselling and treated for STIs. A total of 545 young people (14-19 years) were reached with messages on adolescent SRH, HIV/STIs prevention and teenage pregnancy. A total of 9,490 condoms were distributed for triple protection against HIV, other STIs and unplanned pregnancy. Fifty-two mothers were identified for followed-up via the EMTCT registers.

In Mingkamann, host to over 75,000 internally displaced people, UNFPA, WHO and partners are working on formation of support groups for 52 mothers living with HIV, identified from the EMTCT services. This has helped people living with HIV to come forward and also be considered among other vulnerable groups, hence increasing their chances for livelihood support.

With regard to protection issues and human rights, UNFPA continues to deliver a mass media campaign against GBV, aiming to change attitudes and behaviours of men to reduce violence including rape against women. During the reporting period, over 28,000 people were exposed to GBV prevention messaging.

Impact of the intervention:

UNFPA and implementing partners' humanitarian response is directly improving sexual and reproductive health outcomes in South Sudan, specifically reducing maternal mortality, HIV incidence, STI-related morbidity and the impact of violence in the community. Provision of reproductive health and dignity kits containing essential life-saving commodities as well as personal hygiene items are improving the quality of life of South Sudanese women who remain extremely vulnerable to obstetric complications, HIV as well as violence associated with the conflict.

Challenges faced:

Low awareness and risk perception, coupled with limited funding continue to hamper efforts to prevent and manage HIV in the community. UNFPA Country Office has addressed this by providing information and communicating benefits of interventions e.g. EMTCT, ART and livelihood support for people diagnosed as living with HIV. UNFPA has also integrated HIV interventions within SRH and GBV services to deal with the issue of limited funding.

Financing and management:

UNFPA's humanitarian response is supported by Canada, Denmark, Japan, OCHA and UNFPA's Emergency Fund. Recently Japan provided USD 3.22 million in new funding for emergency obstetric and neonatal care services to support pregnant women, girls and newborn receive referral services in addition to protection from GBV. OFDA-USAID provided a further



USD 0.75 million to support coordination of services to tackle GBV. However the unmet need for further services is acute with UNFPA seeking a further USD 25 million to scale up comprehensive SRH services, including countering HIV and other STIs, for internally displaced persons and their host communities.

Lessons learned and recommendations:

The clear benefits of HIV interventions for improved SRH can be used to advocate for scaling up of HIV services in emergency settings and also raise awareness and the acceptability of interventions by the population in crisis.

22. South Sudan

South Kordofan (Nuba Mountain) area – technically located in Sudan but not under governmental control of Sudan and often bombarded and blockaded by the Sudanese military

Title of the programme: Mother of Mercys y Hospital (MMH) – Diocese of El Obeid, South Kordofan/ Nuba Mountain Area, Sudan

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Programme is being implemented since:

Implemented by:

Scope of submission: Access to HIV prevention, care and treatment.; Protection issues, equity and human rights, Community resilience, Situations of fragility

Has the programme been evaluated /assessed? Yes, Evaluations have been performed regularly by private, mainly Catholic Church-based/ Caritas donors.

Is the programme part of the national AIDS plan? No, The programme was part of the Sudanese National AIDS Programme until fighting between the Sudanese military and the SPLN resumed in 2011; since then the programme has been deprived of all HIV test supplies and ART supplies. The hospital has been required to provide these through private donors.

Is the programme part of a national emergency response plan? No

Background:

In July 2011 the SPLM-North (SPLM-N) and Sudanese Armed Forces (SAF) recommenced fighting in South Kordofan and Blue Nile states. In late-May and early June 2013, aerial bombardment in SPLM-N-controlled areas of South Kordofan resulted in civilian casualties and massive displacement. Approximately one million people (over 45% of the total population of South Kordofan) are currently affected by the conflict.



It is estimated that there were between 10 and 15 INGO supported health clinics before the conflict, and medical supplies and staff salaries were provided to the Secretariat of Health (SoH) by the Government of Sudan (GoS). While the standard of health care was basic, services functioned and people were free to travel to additional support services e.g. they could go to the hospital in Kadugli or in El Obeid. They could buy paracetamol in the market. They were less dependent on assistance.

With the onset of the conflict, humanitarian actors were expelled and support from the GoS was suspended.

As the Nuba Mountains endure intense sustained bombing campaigns since the beginning of the conflict, they have become completely isolated and are denied the most basic services. Few people can travel freely or have the means to make a journey to the hospital for anything that is not seen as 'life-threatening', e.g. injuries from bomb attacks. The SoH continues to function but is extremely limited without resources and assistance. Staff remain committed and available to provide some form of health service but have little support and few supplies.

Despite the conflict, several partners have continued to provide support to the communities in the rebel controlled areas. The Diocese of El Obeid (DoE) operates the only functional hospital in this area, Mother of Mercy Hospital (MMH), with 400 beds and theatre facilities. In 2013, the hospital provided health services to over 40,000 people.

For the case of the area in which the Diocese's hospital is located, prior to the onset of armed conflict, HIV medicines and treatment protocols were parts of a national program and were received from the state government by several medical facilities in the state. It may be that this program continues, but as there is no cross-border support available, our Hospital no longer has access this program (as is also the case for medicines for TB and leprosy). No mandated agency has contacted us to follow-up on whether or not our treatment program continues.

There are no available statistics for the level of HIV among the South Kordofan catchment population (estimated to approximately 800,000), but as the Hospital's statistics in 2014 saw an increase of 6.5 per cent infection rate in HIV, the Diocese's Health Program has responded by scaling up its HIV approach in 2015.

As with HIV treatment, the Diocese is the only institution providing testing, medicines and treatment for TB. There has been an increase in the number of patients suffering from TB since the Diocese opened its hospital in 2008 as indicated below (the current conflict started in June 2011)

2009	2010	2011	2012	2013	2014
67	34	109	83	101	126

Approach:

Through the Mother of Mercy (Gidel) Hospital and the Outreach Program the Diocese is establishing provider-initiated HIV counselling and testing services, and the continuum of care and treatment, targeting ANC for PMTCT and other high risk groups. A two-pronged approach is utilised, by strengthening of the supply side through capacity building of health workers and provision of the necessary resources required for HIV CT services on the one hand, and by creating demand through awareness raising activities within the communities on HIV prevention and availability of services at the clinics on the other hand.

Voluntary testing is available through the Hospital and will also be made available through the supported clinics, as well as ensuring that any blood donations are safe for use. Counselling will be provided for those who have tested positive and awareness on safe practices given.

General Health Services, including HIV services provided through Mother of Mercy (Gidel) Hospital are provided under the following framework:

Patient response – treatment and care of patients that present at Gidel Hospital, which is the referral hospital for all other medical/clinical/nutritional interventions in the area.

Protection – including:

- a) Provision of appropriate food and non-food items to patients on discharge for their continued convalescence at their home place;
- b) Vaccination campaigns for children (in coordination with other health organisations)
- c) The use of aggregate patient data to conduct vulnerability assessments around geograpoc clusters, seasonal priorities, etc.;
- d) Provision of protection rations (food and non-food based on need) to families and communities through the parish network.

Prevention – including:

- a) Outreach services through the proactive provision of assistance to families, based on vulnerability clusters, seasonal priorities, etc.;
- b) School feeding programmes (linked to enhanced nutrition) to encourage both attendance at school and improved nutrition
- c) Health and hygiene education through radio, schools, and hospitals;
- d) Ongoing monitoring and reporting of security situation (linked to advocacy, risk and information management)

Reach of the intervention:

Currently the Diocese has six patients on treatment, 50 per cent are female.



Impact of the intervention:

Treatment has been initiated for these patients in 2015 after the scaling up of the Diocese's HIV program (within the first quarter). The Diocese coordinates the scaling up its HIV program with the local health authorities, who are simultaneously scaling up awareness-raising on HIV, but do not have the available resources to include testing and treatment in their approach.

Challenges faced:

A significant challenge involves the supply and cost of HIV tests, which are expensive and seem to always have a short expiry date when procured through commercial providers of medical supplies. A large supply will be required in order for the Diocese to obtain a sense of the extent of the problem, and of course the key is timeliness. A second hurdle is once people are committed to treatment, on-going supply of medicines are essential and will due to the lack of supply through mandated government and agencies to the local health authorities, only be available through the Diocese. This creates a precarious dependency on donor funding and interest in our area of operation.

The challenges placed by the blockade of the area by the Sudanese military and the frequent bombardments by the Sudanese military are most significant. The hospital itself and the Catholic school located close to the hospital have frequently been bombed.

Since international AID programmes (especially those that are UN-based or –associated usually are channelled through governments, procedures are not in place for dealing with areas of South Kordofan where the Sudanese government is not in control and in fact considers and enters into military conflict with the residents of this area. To date, attempts to access tuberculosis medicines through the Global Drug Facility (with the help of staff in the Global TB Programme of WHO), vaccines through GAVI (which purchases vaccines for UNICEF and specifically requested UNICEF to make special arrangements for the Diocese to obtain donated vaccines in Nairobi) all have been blocked. In 2013, assistance was requested from UNAIDS for help with access to HIV testing supplies (in large quantities) as well as reduced-cost anti-retroviral medications. UNAIDS staff said they would look into the situation with MSF or the Sudanese government – even though they were informed that MSF had withdrawn from this area and that the diocese maintained the only functioning medical facilities in the area. To date, no further word has been received from UNAIDS.

Financing and management:

In 2013, Caritas Internationalis launched an Emergency Appeal to its network for Diocese of El Obeid operations in South Kordofan – the amount of that appeal was 3 million Euros. Major donors include Trocaire (Caritas Ireland) and Secours Catholique (Caritas Frances). The USA- based Catholic Medical Mission Board has paid the staff and lodging costs for the Medical Director of the hospital. In 2014, USA-based Medicines for Humanity began funding of some medical and other programmatic costs of the programme.



Supplies, including medicines are brought by plane and truck when roads are passable. Many of the supplies are purchase Nairobi.

Through the Caritas Internationalis network, the emergency programme has been actively monitored since its inception. In July 2011 Trócaire/DoE deployed a staff member to verify cargo being loaded in Nairobi and leaving for Lokichoggio, and sent another staff member to check cargo in the stores of Diocese of El Obeid (DoE) in Lokichoggio. These visits confirmed that cargo being transported was consistent with manifests and store records. In May/June 2012

Trócaire Humanitarian Manager and the South Sudan Country Representative made a monitoring visit to Yida to track the route of goods being provided. In 2014, the Emergency Director of Caritas France made an on-site visit. In 2015, the Programme Director of Medicines for Humanity made an on-site visit.

Procedure Monitoring: The Diocese continues to maintain up to date distribution lists which inform final beneficiary numbers and status. Trócaire has employed remote monitoring techniques that include constant radio and phone updates with diocesan staff, written and oral debriefings from both evacuated and in-transit personnel, and regular participation in coordination mechanisms in-region and in Nairobi. Trócaire procurement guidelines (including pricing and receipt retention) have also been followed to ensure best practice in the purchase and delivery of supplies. In addition, every waybill is verified to ensure that any stock shipped to the field is received in full and any primary expense incurred and paid by the Diocese head office (Nairobi) is verified by both the accountant and a member of the senior management team.

Lessons learned and recommendations:

The major lesson learned from this submission is the rigidity of international aid programming that is almost exclusively linked to national governments even though, in certain countries, the respective national government is not in control of, or is in military conflict, with the population residing in a particular area of its territory.

In this particular case, the only remaining health services are provided by a faith-based organization that has sought help from several UN agencies and from GAVI to access the diagnostic supplies, anti-retroviral medicines, the TB medicines necessary for it to continue its unique response to HIV and TB in the area. In a similar way, the same organization has tried to access vaccines through GAVI/ UNICEF. With the help of Caritas Internationalis, the organization also brought its situation before the UN Human Rights Council. To date, these efforts have achieved no success and the population of South Kordofan continues to be bombed, be affected by serious infectious diseases, and to have access only to the diagnostic supplies, medicines and vaccines that could be garnered through funding provided by Catholic Church and other philanthropic organizations. Even when funding from these sources is available, the Diocese often experiences problems with funding available supplies of these important commodities.



This offers ample evidence that creative, alternative solutions are needed for certain areas of conflict or of “failed” and otherwise fragile States or particular populations or ethnic or racial groups within such States.

23. Zambia

Title: Understanding the driving factors of client retention and drop-out in HIV/AIDS programmes in Zambia, with primary focus on PMTCT

The study was conducted by the University of Zambia, Institute of Economic & Social Research in Collaboration with Anthrological an anthropological research Institution from the UK. The research was funded by Clinton Health Access initiative in Zambia and supported by the Ministries of Health and Community Development Mother and Child Health.

The Investigators included; Chishimba Mulambia serving as the PI, Prof Mubiana Macwangi as the co-investigator from the **University of Zambia Institute of Economic & Social Research**. Dr Juliet Bedford & Dr Kelley Sams from **Anthrological** serving as expert reviewers.

The aim of the study was to identify and address challenges of client retention in PMTCT by undertaking qualitative research to understand the driving factors of loss of clients in care from the perspective of HIV+ individuals, and the community at large. This was in view of Zambia initiating Option B+ in 2014 to find out the acceptability of this treatment option in the community. The study sought to enhance support to the government by addressing poor retention rates in the HIV/AIDS program as a whole.

Methods

The study was conducted in five districts in Zambia, targeting the catchment areas of three health facilities per district. Study participants included HIV+ individuals who were currently participating in PMTCT or ART programs, as well as those who had dropped out or never participated since being recommended for treatment (pregnant women currently enrolled in PMTCT, women who had completed the PMTCT program, HIV+ women who had given birth without being involved in PMTCT, etc.). Community members and key opinion leaders (Pastors, Catholic Priests, Spiritual healers, Political leaders at local levels, Village Headmen, Traditional Healers etc.) and individuals living in the research communities who had experiences with HIV/AIDS services. The data was complemented by a total of 30 case studies.

Participants were identified through purposive sampling in collaboration with health facilities. The study employed semi-structured questionnaire and in-depth interviews, and focus group discussions to generate data over a period of three weeks.

Results

Women that did not default their PMTCT appointments reported to have had strong family support and never felt stigmatised within the community. Typically they had disclosed their status to close family members upon finding out. They were also aware of various support programmes available in the communities for HIV/AIDS positive people and a number of them had access to the support services. Community leaders especially from the church also highlighted that seeking treatment highly depends on the kind of people that surround the patient and how that patient shares the information with those that they are close with. People normally stay away from the clinic and from support programmes for fear of being identified as being positive by other community members. For others they prefer to seek divine healing and stop their medications. Divine healing was commonly mentioned as a reason why there were PMTCT and ART drop-outs. It was reported that there was an influx of Spiritual healers in most communities enticing people to believe that they were healed of their HIV, as a result most people stop their medications and end up dying. Food programmes and clinical outreach programmes were mentioned as key to keeping people to adhere to ART and PMTCT programmes

Conclusion

Option B+ was widely acknowledged as a better way of managing PMTCT programmes in communities because of continued interaction with the health workers. It was reported that the interaction with the health workers gives confidence to expectant mothers that their child will be born uninfected. The information given by health workers also helps patients to manage themselves. However it was feared by many to say that if the drop-out rates were high, were mothers going to still adhere to option B+. Our study recommended that it be integrated in outreach services and also support services within the communities using Safe Motherhood Action Groups. Community leaders also have a big role to play when it comes to acceptability of new health programmes especially in rural areas where dissemination of information is limited.

II. Asian States

24. India

Title of the programme: PPTCT Program (Prevention of Parent to Child Transmission) of HIV/AIDS

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Programme is being implemented since: 2012

Implemented by: Civil Society, Private Sector

Scope of submission: Access to HIV prevention, care and treatment, Early recovery and development

Has the programme been evaluated /assessed? No

Is the programme part of the national AIDS plan? Yes, To enhance coverage, a joint directive from the National AIDS Control Programme (NACP) and the National Rural Health Mission (NRHM) was issued in July 2010, explicitly stating that universal HIV screening should be included as an integral component of routine ANC check-up. The objective was to ensure that pregnant women who are diagnosed with HIV would be linked to HIV services for their own health as well as to ensure prevention of HIV transmission to newborn babies under the PPTCT programme.

Is the programme part of a national emergency response plan? No

Background:

There are an estimated 2.1 million (2011) People Living with HIV (PLHIV) in India, with National adult HIV prevalence of 0.27% (2011). Of these, women constitute 39% of all PLHIV while children less than 15 years of age constitute 7% of all infections. As on March 2013, 0.1 million HIV positive children had been registered under the antiretroviral therapy (ART) programme and 38,579 are receiving free ART. There has been a significant scale-up of HIV counselling & testing, Prevention of Parent-to-Child Transmission (PPTCT) and ART services across the country over last five years. Between 2004 and 2013, the number of pregnant women tested annually under the Prevention of Parent-To-Child -Transmission (PPTCT) programme



increased from 0.8 million to 8.83 million and reach of the services has expanded to the rural areas to a large extent. Concurrently, there has also been a significant decentralisation and scale-up of the ART services, with 7.34 Lakhs PLHIV receiving free ART across the country through 409 ART centres and 860 Link-ART centres (LAC). Mother-to-child-transmission of HIV is a major route of HIV infection in children. However, out of an estimated 27 million pregnancies in a year, only about 52.7% attend health services for skilled care during child birth in India. Of those who availed health services, 8.83 million ANCs received HIV counselling and testing (March 2013) out of which 12,551 pregnant women were detected to be HIV positive.

Source: NACO (National AIDS Control Program)

Approach:

The objective of the program is to prevent HIV transmission and mitigate the impact of HIV by expanding access to testing, counselling and prevention of parent to child transmission. The activities include:

- a) Detection of HIV positive pregnant women in terms of testing coverage, detection coverage and testing early in pregnancy.
- b) Linkage of detected HIV positive pregnant women to Care, Support and Treatment services in terms of enrolment at ART centre, efficiency in pre-treatment evaluation and initiation of ART and retention in care,
- c) Institutional delivery of HIV positive pregnant women and immediate initiation of Early Infant diagnosis coverage in terms of testing using Dried Blood spot (DBS) testing Nevirapine prophylaxis to the baby up to 6 weeks.
- d) Among HIV exposed Infants and testing for Whole Blood Specimen (WBS) collection in those DBS positive infants and early paediatric ART initiation.
- e) Linkages and mechanisms to ensure lifelong adherence and follow-up of both HIV positive pregnant women and child, covering the ante-natal, labour and delivery, post-natal and breast feeding period.
- f) Follow-up of HIV exposed infants for confirmatory testing at 18 months and follow-up thereafter.

Reach of the intervention:

The PPTCT program is bring the pregnant women diagnosed as HIV +ve to be brought under treatment and care and the babies born are to be followed up to 18 months so that are free of any infections.

Anita, a graduate in Nutrition, was married with a local Diver, was tested HIV reactive at T.L.Jaiswal ICTC, Howrah, West Bengal. Coordinators and Out Reach Workers of Jabala met counselled to receive regular PPTCT services though she was highly traumatized. She delivered a baby at Medical College, Kolkata who finally found HIV non reactive (ELISA Test).

Renuka Saha was detected as a HIV reactive at LB Dutta Muchisa ICTC, South 24PGS, West Bengal in May, 2013 during her ANC check up. Simultaneously her husband was also tested HIV reactive. She was lost to follow up though she delivered a baby at Hospital. After receiving the information; Out Reach Worker of Jabala started continuous follow up of the said client and finally her baby tested (ELISA TEST) HIV non reactive. Now Renuka's CD4 count is also very good (1035) and continuing her treatment.

Impact of the intervention:

In the targeted area the following outcomes were achieved from the intervention:

Reduction in infection among the new born=96%

Tracking and Tracing of lost to follow up increase by = 89%

Increasing general awareness among Survivors and General community members

Extension the reach of the programme to other districts not directly covered by the Program

The impact is measured by verifying hospital data, state date and base line data

Challenges faced:

1. To bring all the pregnant women under Counselling & testing services
2. Availability & supply of ART and testing kits in rural areas
3. ART centres in all districts
4. Nutrition support for children and mother diagnosed as reactive

Solutions:

1. Spreading awareness & linking the women to Janani Suraksha scheme to increase institutional delivery
2. Lobbying with State AIDS cell for supply
3. Starting escort services for reactive mothers
4. Spreading awareness and linking the families to Right to Food scheme.

Financing and management:

Intervention is managed & coordinated by Jabala in active support from IL&FS(Industrial Leasing & Financial Services) a company. Project is for three years and IL& FS being a big corporate hence, sustainability is ensured. The major partners are WBSACS(West Bengal State AIDS Cell), NACO, Health department Govt. of West Bengal. Funding has been distributed on the basis of requirement and number of cases handled in each district and slowly scaled up.

Lessons learned and recommendations:**Factors that helped:**

1. Appointment of Reactive people as ORWs(Out Reach Workers)
2. Prioritisation of PPTCT program in NACO guideline and NACP IV
3. Funding handled by corporate ensuring smooth fund flows
4. Support from State and District Health departments
5. Active coordination between ICTC and PPTCT

25. Lebanon

Title of the programme: Stepping Stones: minors and young people sexually exploited or selling sex.

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Programme is being implemented since: July 2014 until December 2015

Implemented by: Civil Society, UN or other intergovernmental organisation

Scope of submission: Access to HIV prevention, care and treatment, Protection issues, equity and human rights, Effects of emergencies on key populations, Situations of fragility

Has the programme been evaluated /assessed? No

Is the programme part of the national AIDS plan? No

Is the programme part of a national emergency response plan? No

Background:

Compared to worldwide estimates, the Middle East and North Africa (MENA) region has one of the lowest HIV prevalence rates in the world (0.1 percent). In 2012, an estimated 260,000 people were living with HIV in the region. Yet in the same year, there were roughly 32,000 new HIV infections and 17,000 AIDS-related deaths. MENA is increasingly becoming a region of concern regarding HIV and AIDS. Furthermore, AIDS-related deaths more than doubled in comparison with a worldwide fall of 16 percent. According to the UNAIDS 2009 epidemic update, the number of people in Lebanon estimated to be living with HIV is 3760. Lebanon is a small middle-income country with an estimated 4 million Lebanese and today more than 2 million refugees and paperless persons. It is a low-prevalence HIV country with a prevalence rate estimated at 0.1%. However, there are indications of a clearly defined concentrated epidemic among key populations.



Aside from the internal conflicts Lebanon faced, the conflicts in Israel and the Palestinian territory, the war in Iraq and the violence in Syria have triggered large flows of refugees into Lebanon, including young people (10-17 and 18-24) selling sex or being sexually exploited. Especially since recent influxes, data on HIV prevalence among young people and hiv- services in emergency contexts of refugee camps remain limited.

The Syrian crisis has posed a new challenge to an already difficult situation in the Palestinian camps. UNHCR estimates that as per April 2015, Lebanon is host to more than 1,196,560 Syrian refugees. On top of these there are large numbers of Palestinian refugees from Syria (PRS), and many of them are children. The result is a fall in the quality of services, including basic education and information on sexual and reproductive health and HIV prevention, intervention and protection. Meanwhile, widespread discrimination and violence (in school and at home), the economic situation and the poor curriculum, are leading many peers to drop out of education. In many cases, frustrated and despaired young Palestinians decide that education is pointless, feeling that the restrictive labour laws will anyway prevent them from finding good jobs or any jobs at all.

Domestic violence and sexual harassment is a major problem, yet the legal system and other state institutions offer little protection for women or children from violence. Discriminatory practices are permitted in Lebanon under personal status laws, nationality laws and laws in the Penal Code related to domestic violence. Working children, moreover, are inadequately protected against workplace exploitation and physical, sexual and psychological abuse. In the home environment, parents' violence towards their children is often known to exacerbate the situation. Most parents lack skills in dealing with the challenges when raising children. They often believe that the use of violence is acceptable both for disciplining and for releasing stress. Many children fear their parents, as they are regularly treated with physical, verbal and sexual violence which in turn increases the risk of turning to selling sex, or when 18 years and older, sex work.

Approach:

The programme objective is improved security, dignity and livelihoods of young people (including children under 18 years) vulnerable for and/or affected by sexual violence or exploited when selling sex. The approach is holistic, human rights-based, non-moralistic, participatory and community-based in order to entitle young people the right to health, wellbeing and protection from sexual exploitation or, when 18 years and above, to refrain from sexual exploitation when selling sex. Key elements are mapping and research, care and support, lobby and advocacy and organizational capacity building. Noteworthy, a vital component is to invest in grass-root organizations empowering them to sustain and professionalize as they are often main entry points to key populations.

In Lebanon specifically, to protect children and young people in the Shatila Palestinian camp from sexual abuse and sexual exploitation, strengthened life skills, knowledge of their rights and increased protection from the family and the community is offered.

This programme directly targets Palestinian refugees (from Lebanon and from Syria), Syrian refugees, Lebanese vulnerable and non-IDs children between the age of 9 - 15, living in the refugee camp of Shatila and its gathering also referred to as Sabra and Shatila on the community level. The specific focus is on boys and girls who are at risk of sexual exploitation and sexual violence, and abuse. Research by War Child's partner Dar Al Amal (DAA – 'House of



Hope') shows that this target population holds circa 400 children boys and girls in the Palestinian Camp of Shatila. Among this group, approximately 30 children are known to be sexually exploited by selling sex. The project targets the entire population "at risk" of 400 children. As a secondary target group, 250 parents will be trained to give adequate support and care to their children. In addition 22,000 people will be reached through local awareness raising campaigns among the community inside the camp.

Access to HIV prevention, care and treatment: social workers of Dar Al-Amal conduct outreach activities in refugee camps where they offer health or social services to young people and minors engaged in selling sex or sexually exploited, via its own referral system. Also, a manual for health care and social service providers, working with minors and young people engaged in selling sex or sexually exploited will be developed. This manual includes tools for staff on how to provide (and/or refer) this target group to needed HIV care and treatment.

Protection issues, equity and human rights: War Child Holland (WCH) organizes and facilitates the capacity building activities, such as trainings and workshops on the Deals methodology (Psychosocial Support methodology) and facilitates various meetings and contacts among Dar Al Amal (DAA), local NGOs, and the international networks. Moreover, WCH leads the development of media activities in (campaigns) and the organisation of the advocacy activities at the international level. The local partner DAA will be responsible for the provision of life skills to the children, using the DEALS methodology. Moreover, they will provide literacy and numeracy classes and vocational training courses to the targeted children and will facilitate the development of awareness raising activities with the children and their parents. These activities are in line with protection issues, equity and (child) human rights.

Effects of emergencies on key populations: The programme addresses the effects of the emergency situation of Lebanon, particularly in the refugee camps, on young key populations selling sex/sexually exploited, by offering psycho-social support, education/information and identifying needs of minors on care and support.

Situations of fragility: situations of fragility are addressed by psychologists and social workers and related professionals of War Child and Dar Al Amal through counselling sessions, making the target group comfortable to speak out about their situations and informative sessions on sexual and reproductive health and rights. Situations of fragility are sexual exploitation and may include young people being part of overlapping key populations.

Impact of the intervention:

WCH and its implementing partner DAA are focusing their work on the prevention of sexual exploitation and social workers of Dar Al-Amal provide young people selling sex/sexually exploited with treatment and care. Impact of the intervention is to be measured end of year 2015.

Challenges faced:

A national Study is conducted by ECPAT, DAA, Ministry of Social Affairs in collaboration with War Child. This will allow to identify the target group's most important risks and needs regarding their health, safety and well-being. There is a delay on the launching of the study and in addition, related activities. Challenges faced are delicate themes of the study that might reveal contexts of sexual exploitation of minors and young people, considered as taboo and unspoken of on community-level while also hindered by political instability. Also, offering HIV and STI services in refugee camps are generally not allowed. In these camps unofficial authorities are hesitant to allow unfamiliar parties to enter, making it even more difficult to offer HIV- health and



social services. The project-period of 18 months is limited to fully overcome these challenges, however efforts are made by social workers and staff of Dar Al Amal and War Child. They hold trusted relations with communities of these refugee camps, allowing them to enter and creating more opportunities to offer their services to children at risk of sexual exploitation, although approached carefully.

Financing and management:

Stepping Stones is coordinated by Aids Fonds on invitation by The Dutch Ministry of Foreign Affairs (MofA). In addition, Stepping Stones is funded by the Dutch MofA. The project is being implemented by WCH and its local partner Dar Al-Amal (DAA). Aids Fonds invests in collaborative partnerships with local partners.

The project initially started in July 2014. However, the implementation has been delayed until October 2014. The project is funded until December 2015. Financial sustainability is addressed by periodic financial reporting, financial audits, organizational capacity scans and Financial departments of War Child and Aids Fonds monitoring and evaluating budgets and expenditures. Innovative approaches to funding are regular long-distance calls monitoring and evaluating budget and expenditures, discussing financial challenges and creating room for more flexible spending by local partners within each project objective. This allows more ad hoc alterations to be made, which especially tend to arise in emergency contexts, addressing them accordingly and more efficient. Local partners and donor discuss, and where possible, agree on changes being made.

Lessons learned and recommendations:

The violation of children rights is becoming more frequent in Lebanon. This phenomenon is mainly due to poverty, family and social problems, lack of awareness, and lack of consistent intervention and coordination by all the public sector, and Civil Society Organizations (CSOs). The Ministry of Social Affairs (MoSA), the Higher Council of Childhood, signed a Convention of agreement in March 2013, with the Lebanese NGO Dar Al Amal (DAA) and International NGOs such as War Child Holland (WCH), Ecpat France, Acting for Life, Diakonia, to reinforce the capacities of the actors working directly with the children to protect them from sexual violence. While this is the largest study on sexual abuse in Lebanon, which also covers the Palestinian camps in Lebanon, its uniqueness simultaneously creates situations of discussion among stakeholders, differing in their commitment to allow for such a study to launch, including *all* research results to be published.

Together with Aids Fonds, who holds expertise on combatting Aids and providing HIV treatment from a human rights perspective, including for those engaged in selling sex, it is recommended that organizations in emergency contexts join forces, combine expertise and collaborate in partnership with implementing partners and stakeholders to provide the best possible support to this fragile target group. Main lesson learned: in program planning flexibility should have a prominent role when implemented in emergency contexts. This allows you to anticipate on unforeseen developments and dynamics of emergency contexts.

26. Philippines

Title of the programme: REHEARSAL FOR CHANGE: Theatre for Development as an Approach in Adolescent Health and Sexuality, and HIV and AIDS Education

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Programme is being implemented since: July 2013 for six months and a follow up program which starts July 2014 until present.

Implemented by: UN or other inter-governmental organisation

Scope of submission: Protection issues, equity and human rights, Preparedness and contingency planning, Community resilience, Inter-agency coordination, Effects of emergencies on key populations, Evidence and strategic information

Has the programme been evaluated /assessed? Yes

Is the programme part of the national AIDS plan? Yes, The project is part of the National Country Programme of UNICEF.

Is the programme part of a national emergency response plan? Yes, The project is part of the National Country Programme of UNICEF.

Background:

HIV/AIDS surged high in the recent years and emerged as a worldwide pandemic with an increasing number of people testing positive every year. In the Philippines, based on the latest HIV Registry from the National Epidemiology Center reveals that for the month of February 2015 alone, 646 new cases were registered. This was 33% higher as compared to February 2014. This translates to 20 new cases per day or simply 1 HIV infection in every one and a (National Epidemiology Center- DOH, 2013). Education plays a very important part in informing people about the disease, the spreading thereof, and how to successfully live with HIV/AIDS is key in the prevention, management and the de-stigmatization of the illness.

To “spread” awareness and address the pressing issues of increasing HIV/AIDS related cases in our country, Tanghalang Pilipino, Inc. together with UNICEF Philippines had come up with a pilot project that will utilize theatre as an instrument of behavioural change and self-reflection, exploring a non- threatening form of education, raising awareness and enabling positive change amongst young people with a special focus on adolescent sexuality, HIV and AIDS education.

The project aims to mobilize young key affected populations and the general youth and other key affected communities for a more meaningful and active participation in the HIV and AIDS response. Consequently, it also aims to produce a comprehensive, viable theatre and creative arts curriculum and process which include performances, workshops, forums and discourse – contributing to the achievement of national goals for the prevention of HIV and AIDS.



Approach:

THEATER OF THE OPPRESSED and FORUM THEATER

Theatre of the Oppressed is a form of popular theatre where people engage in struggle for their liberation and to resist oppression in everyday life which is developed by Augusto Boal, a Brazilian dramatist. His principle is that like language, theatre can be appropriate to anybody as long as the methods are passed on to them. The aim is to understand social realities and be able to transform and change it. This theatre form uses series of exercises, games and drama forms to communicate with the audience. It is also a very powerful tool for promoting self-expression, consciousness-raising, personal development and collective empowerment. Boal drew up a set of method and guidelines for provoking discussion and audience participation in his theatre form, which is called the “forum theatre”.

Forum Theatre is a type of theatre where people assemble to discuss and analyze social and political issues. Its purpose is to create a space where people can express their thoughts, feelings and concerns. In Forum Theatre, the oppressed knows how to confront the problem, knows what is happening and what actions are to be done to avoid or change his or her situation, unlike a victim who does not fight back. This type of theatre aims to transform passive “Spectators” into more active participants, known as “Spect-actors”, who has common responsibilities with the performers of the piece. This whole participatory process is important in opening the minds of the participants to take ownership of the issues and their solutions and avoid behaviours that have negative consequences after carefully dissecting and debating about the issue.

Forum Theatre Utilization

Botha and Durden (2004) said that Forum Theatre methodology has been used in different parts of the world to communicate different social and political issues, this including HIV/AIDS. In the Philippines, this methodology has been in use since 1970's through the Philippine Educational Theatre Association (PETA). During the Martial Law, theatre has been a potent vehicle for raising awareness and collective action and for both social and political expressions. Artists went to different communities to give theatre workshops and perform using forum theatre to mirror Philippine social realities and to communicate the state of the nation under Martial Law (Josef, 2014).

Through its success, the use of Forum Theatre had become the chosen methodology of Tanghalang Pilipino, Inc. for HIV/AIDS and Sexuality Education in their pilot project together with UNICEF Philippines, entitled T4D4HIV- A C4D Approach (Theatre for Development for HIV - A Communication for Development Approach) with their pilot theatre production entitled “Melanie” and another project also with UNICEF, Theatre For Development in a Post-Haiyan Context (T4DPHC): Empowering Survivor-Communities Towards Recovery, Disaster-Preparedness, and Resilience which used the same methodology but just expanded the topics to include health and nutrition and child protection issues and concerns.

Reach of the intervention: The activities were carefully planned considering Philosophy of Man and Theories of Human Development. Through this the team was able to “represent and present” the HIV situation and strategies to end stigma and discrimination in a humane and non-threatening way, and with the help of theatre, a fun and creative journey. Through information sharing and transfer, we are able to capacitate participants on creating awareness and



consciousness about the issue, and also empowering them to know their bodies, its status, strengths and limitations. The project was also able to mobilize young people to enhance their community participation through a “collaborative problem solving” and inculcate the importance of exercising their rights and acting on their responsibilities to end all forms of oppression and work on the sustainability of the project. The project was also able to create strong partnerships and linkages to different LGUs, NGOs, community leaders, artists and cultural workers.

Impact of the intervention:

The participants identified were trained on Theatre for Education. Subsequent repertory theatre guidance and facilitation training was provided by the artist-facilitators, all from the Tanghalang Pilipino Actors’ Company. To replicate the Theatre Forum Techniques and Process, the participants underwent six workshop sessions on how to use theatre and performing arts as participatory approaches to create awareness and to engage the community to participate in the discussion and information dissemination on important facts and trends on HIV and Sexuality education. An orientation and pre-assessment program was conducted and facilitated by the artist-facilitators using different theatre games in the community. This strategy was used to serve as a release exercise for the participants before the actual orientation. It helped the participants to be more grounded and to have a background on different games used in theatre both for actors and non-actors. All in all, there were ninety-eight (98) young people who have participated in the Theatre for Development project from communities in Pasay, Tacloban, Cebu and Panay. A total of four different Forum Theatre piece was produced which toured a total of twenty-eight (28) communities with “Melanie” being chosen as part of the 28th Season Offering of Tanghalang Pilipino, performed at the prestigious Cultural Center of the Philippines. The performances reached a total of a thousand people and counting with initiatives of the groups to replicate the process in their own communities. The performances were evaluated through questionnaires distributed amongst the audience, interviews and FGDs in selected areas.

Challenges faced:

The process that the participants have undergone is truly collaborative in its nature thus, we like it to be across all levels. Part of the process is involving the LGU officers on health and population to be involved as resource speakers during the lecture series, to make the participants learn the basic situation and key issues that will be integrated in the forum theatre piece that they will mount and during the performance when the audience are expected to ask questions based on what was presented to them. The gap in terms of education and understanding of key terms and issues is very glaring not just with the participants but also of the people that should have been fully abreast of these topics. What is commendable about these people though, is their honest admittance of this shortcoming. This was addressed during the workshop process where we see that together with the participants, they too are learning new and updated things on the issues.

One challenge that has been recurrent in the project is how coordination and mobilization on the part of local government units were always challenging and unreliable that results to miscommunication that further delays activities and implementation. UNICEF with their contacts assisted in this aspect and worked closely with us in terms of making necessary follow-ups to heads of municipalities, LGUs and government offices. Though it was very helpful, some government units preferred infrastructure projects than capacity-building initiatives. This became the ultimate barrier especially when the project were rolled out to areas affected by



Super Typhoon “Haiyan”.

Financing and management: Tanghalang Pilipino Inc., is the resident theatre company of the Cultural Center of the Philippines and has produced more than 200 musicals and plays in its almost 30 years of existence which ranges from original Filipino works to classic dramas that are socially relevant and ultimately speaks to our common humanity. The artistic director is responsible for the repertory and artistic guidance of the project while a Project Coordinator, Asst. Project Coordinator and Admin Officer took care of the everyday business of the project. The company also have a pool of artist-teachers, The Actors’ Company, which serves as the project’s resident workshop facilitators.

To date, we have managed to partner with two national community theatre organizations and one NGO that works on LGBT rights that created its theatre arm with TP giving them repertory and artistic guidance. This is part of the sustainability plan that TP and UNICEF have envisioned. With our strong collaboration with local NGOs, LGUs and community partners, some even have integrated Theatre for Development in their succeeding initiatives. One strength of working with community theatre is that they are not just merely actors, but also cultural and social workers. We do what we can on what was little that is given to us.

Lessons learned and recommendations:

The enthusiasm of community theatres that we tapped for the project is always inspirational. These are groups that have performed in front of their own people and were typhoon survivors themselves. The help and support of some of the LGUs and educators are very necessary and detrimental as our target audience are students and the general youth who were the most displaced and affected by the super typhoon and also the most vulnerable populations when it comes to HIV and other STIs.

Filipinos are very visual and respond tremendously on TV dramas and this is where they get their news and sometimes, their dose of reality. Two landmark movies that tackled the issues of HIV and AIDS happened 20 years ago. For many years, the image of death and trouble became the face of HIV and AIDS in the general public. The much important story of hope, understanding and love was overshadowed by death even with the advances to prolong a PLHIVs life through ARV medication, most people look at HIV as a death sentence.

“Art makes a person whole and happy. Both the artist and the audience come out better persons”, said Antonio Cojuangco, Chairman of the Board of Trustees of Tanghalang Pilipino. It is a fact that art is one powerful tool for social change and to raise awareness on important and pressing issues. Unfortunately, this power is under-utilized, not only in the Philippines, but also in the Asia-Pacific Region.

27. Philippines

Title of the programme: Project Sirak - Promoting Sexual Health, Child Protection and Community Building for Young Key Affected Population in Haiyan/Yolanda-Affected Areas

Sirak in the local dialect means sunshine, symbolizes new beginning and hope for Young MSM and TG

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Programme is being implemented since: August 2014

Implemented by: Civil Society

Scope of submission: Access to HIV prevention, care and treatment, Protection issues, equity and human rights:

Has the programme been evaluated /assessed? No

Is the programme part of the national AIDS plan? No

Is the programme part of a national emergency response plan? No

Background:

Over-all, access to HIV services, especially among those who are under 18, is severely low in the Philippines and services are of poor quality: the reach of HIV testing for minors is almost negligible⁵; meanwhile, assessment of national programs point out that young key populations have low knowledge on HIV prevention⁶. Legal barriers prevent minors from accessing HIV testing and other HIV services without parental consent, which practically inhibit the delivery of HIV services to young key populations. For those who are 18-24 years old, based on the 2013 IHBSS, only 11% has access to Social Hygiene Clinics, the main HIV service delivery point in the country.

These barriers are compounded in Yolanda affected areas. Even prior to the disaster, layers of barriers were already manifest: in prior consultations conducted by TLF Share with MSM and TG advocates in Eastern Samar and Leyte, the dearth of HIV services in a region that hosts some of the poorest of the poor has already been flagged. The very limited HIV and reproductive health services offered by public facilities in the region, mainly concentrated in Tacloban City, were inaccessible to key populations, especially young MSM and TGs.

With Yolanda, HIV-related vulnerabilities have been amplified. The devastation caused by typhoon Yolanda (and subsequently, by another typhoon, Ruby) has exposed key populations in Eastern Visayas to other sexual health issues and human rights violations. Legal and other structural barriers hamper access to HIV services, and in resource-constrained settings and disaster-affected areas, young key populations are oftentimes in the margin. According to anecdotal reports from TLF partners in the area, risky sexual behaviour among young MSM and TGs is prevalent and requires immediate attention.

Approach:

The project follows an integrated community strengthening and mobilization and HIV service provision design. In partnership with a local MSM and TG group called Katlo, the project

⁵ IHBSS 2011; For the 2013 IHBSS, 5% of those belonging to the 15-17 age bracket has accessed Social Hygiene Clinics.

⁶ Evaluation of HIV and STI prevention interventions for MARCY, 2009. The evaluation was conducted by UNICEF/PRIMEX.



involves conducting peer-led HIV prevention services (training of peer educators, outreach, learning group sessions) to deliver prevention messages and collateral and refer to other HIV services. These activities will also serve the bridge to community mobilization and organizing (Youth Assemblies, to develop agenda and facilitate organizing; planning sessions for incipient groups; and multistakeholder's forum to connect them to key stakeholders that can facilitate access to programs or to develop programs).

Reach of the intervention: Please elaborate on how the programme addresses the key issue(s) included under the "Scope of Submission" categories above

The project aims to fill in a gap in the Yolanda disaster response. Specifically, it aims to:

- Ensure access to HIV services for young key populations (MSM and TGs), especially HIV education through peer-led outreach interventions, in 14 Yolanda affected areas in Eastern Samar, Western Samar, and Leyte.
- Increase demand for HIV services while the areas are being rebuilt through YKAP community organizing and bridging community groups with stakeholders, especially local governments.

Impact of the intervention: What did the intervention achieve in terms of HIV outcomes in prevention, treatment, care and support for people living in emergency contexts? How was this impact measured?

- Young key affected population were reached out through peer education, outreach and LGS. Condoms and lubes were distributed;
- Core issues among MSM and TGs in disaster context were identified
- YKAP Agenda was developed and presented to different stakeholders (local government officials, health providers, development partners)
- Organisations for young MSM and TGs were supported or established.

Challenges faced:

- Disaster context is not included in the National AIDS response; similarly, existing disaster plans do not include HIV prevention and access to services for key populations as an issue
- Low level of awareness on STI, HIV and AIDS, Health and Sexual Rights among MSM and TG in general
- Low health seeking behaviour of the MSM and TG communities
- Lack of HIV services/absence of Social Hygiene Clinics and Local AIDS Ordinance or Council, especially in disaster affected areas
- Stigma and discrimination even among health care providers
- Health is not the top priority of MSM and TG, economic and survival are the concerns during emergencies
- MSM and TGs are invisible during humanitarian emergencies
- Access to services such as testing (e.g. distance of testing facilities, limited services at Social Hygiene Clinic, number of medical personnel proficient to conduct testing)

Some Local Gov't Officials aren't supportive of the program (i.e. we shouldn't be promoting services such as distributing condoms because it promotes promiscuity, etc.)

Financing and management:

The project is currently financed by UNICEF. However, the idea behind community organizing is to generate demand for services and programs from local government units.

Lessons learned and recommendations: What factors helped success of the intervention, including institutional set-up, legislative and policy environment, coordination, political mobilisation and support, advocacy?

- Positive linkage with partners and stakeholders
- Strong MSM and TG community involvement, linkage and support
- CBO resilience
- LGUs/regional and local agencies recognize the CBO
- Active partnership with implementing partners (e.g. Regional AIDS Assistance Teams, Regional Epidemiological Surveillance Unit, Regional Hospitals)

28. Yemen**Contingency Plan for Continuation of ART during Yemeni Clashes: the experience of MSF OCBA**

C Ferreyra, Abdul Baset, L Di Stefano

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Background:

In urban contexts with unstable security situation a contingency plan to ensure continuation of ART should be designed in advance to efficiently react when security situation deteriorates. In this study we describe the implementation of the plan designed during the violent situation affecting Yemen during 2011.

Project:



In 2010 MSF started supporting ART centre at Al-Gumhuri Hospital; the only health facility providing HIV care in Sana'a. In January 2011, wave of protests and clashes against government began and continued for several months. In April 2011 medical activities couldn't continue and the contingency plan had to be implemented.

Outcomes:

Since April 2011 new ARV inclusions were stopped. Patients under ART received 2 months buffer plus 1 month "emergency stock" treatment to be used in case of difficulty to reach the ART centres; also a "tail protection bag" was distributed to safely interrupt ARVs if needed.

Every patient who reached the ART clinic received a health card including a personal code, ARV regimen, cotrimoxazole prophylaxis, tuberculosis treatment and an emergency phone to arrange where to get ARVs in case they could not get to the clinic.

Two sites for ART distribution were established, Al-Gumhuri Hospital and an "extra ART point". Health card allowed patients to receive treatment at the "extra ART point" where medical files were not available. Unfortunately, both sites were not accessible during the most violent period so patients used the emergency phone to ask the staff where to receive the drugs. Counselling activities were done to explain the use of emergency package.

From April to November 2011 363 patients received the drug package. By February 2012 9 (2.5%) patients were lost. At the end of the emergency no patients coming to the ART centre complain of drugs shortage.

Conclusions:

Previously defined contingency plan and well-trained team can allow the continuation of ARVs during the emergency phase of a conflict; patients should be regularly informed on what to do in case instability arises. The use of mobile phone was strategic to ensure that patients did not run out of drugs.

III. Eastern European States

29. Georgia

Title of the programme: HIV prevention program/Needle and syringe program–, „Delivering HIV preventing services to people who injects drugs” under the Global Fund project

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Programme is being implemented since: 2008

Implemented by: Civil Society



Scope of submission: Access to HIV prevention, care and treatment, **Inter-agency coordination, Effects of emergencies on key populations, Early recovery and development**

Has the programme been evaluated /assessed? No

Is the programme part of the national AIDS plan? Yes, According to the document it is overseen to ensure uninterrupted delivery of high quality prevention, treatment and care services in Abkhazia region

Is the programme part of a national emergency response plan? No

Background:

As a result of ethnic tensions and war Georgia had lost its control on territory of Abkhazia (region) from 1994. On 28 August 2008, the Parliament of Georgia passed a resolution declaring Abkhazia a Russian-occupied territory. According to the last census in 2011 Abkhazia have 240,705 inhabitants.

In comparison to other parts of Georgia, Abkhazia has free borders with Russia; as a result relatively it is free accessibility to illegal drugs. Number of people who injects drugs is significant, but unfortunately no size estimation of high risk groups had been conducted so far. Totally 670 people are registered as HIV positive in Abkhazia, among them 112 was detected by HIV prevention program. 321 persons are receiving ARV treatment (source: national database, March, 2015), way of transmission mainly (more than 50%) reveals Injecting Drug use.

Approach:

Currently, the Georgian Harm Reduction Network is engaged in the management of needle and syringe Program in the 11 cities of the country: Tbilisi (4 centers), Gori, Telavi, Rustavi, Ozurgeti, Kutaisi, Samtredia, Batumi, Zugdidi, Poti and **Sokhumi** (one center in each city) – totally 14 sites. The program is implemented by the 10 member organizations of the Network and provides the coverage of significant portion of PWIDs (10,000-12,000 per month), and offers different services for HIV/AIDS prevention. As for Sokhumi site the annual program coverage represents 1201 in 2014, monthly average coverage varies 550-600 PWIDs (see the attached slides on program achievements in Sokhumi). Despite the political tension and disagreement over the status of Abkhazia delivering of HIV services is provided by Georgian Harm Reduction Network, costs are covered by GF program operated on territory of Georgia.

Reach of the intervention:

The range of delivered services consists of the following: Distribution of the sterile injection equipment, mostly in the form of the needles and syringes, and distribution of alcohol swabs (distributed during the outreach programs as well as the stationary distribution from the centers); Provision of condoms and distribution of educational material; Anonymous testing free of charge on HIV infection, B/C Hepatitis, and Syphilis; Medical, psychological and legal consultations with different profile; Prevention of the overdose via the First Aid trainings and distribution of Naloxone;

Impact of the intervention:



People living in Sokhumi are receiving harm reduction services uninterrupted from 2008 – among them free HIV testing services, that give possibility to increase HIV detection in this region (670 HIV positive in Abkhazia, their needle and syringe partners are screened on HIV, 321 persons receiving free ARV treatment). About 50-60 people annually receives stationary treatment on opportunistic infections in Tbilisi AIDS center (totally more than 450 persons), as well they receive needed additional laboratory and clinical observation. As no behavioural surveillance and size estimation studies are provided in this region, it is difficult to measure any impact of prevention programs. We can only analyze the program data we have (Needle and Syringe program; HIV treatment program).

Challenges faced:

Different challenges are faced during the program implementation process:

- Delivering of needed materials needs preliminarily agreement with the government of Abkhazia and preparation of act of acceptance. This procedure is time consuming and as a rule can't be done any more than twice in a year;
- External evaluation is difficult to accomplish, it also needs different unwanted procedure to be carried out and no guarantee of safety for foreigners;
- Difficult to provide HIV care procedures according to Georgian standards and protocols, as it needs appropriate environment and additional financial sources (maybe more support by local government side);
- Difficult to evaluate the impact of the program, provide BSS studies, estimate the size of PWIDs;
- Anyway existence of threat that external unpredicted factors (local government change, exacerbation of the conflict, third party's unwillingness) will negatively interference the project implementation.

Financing and management:

HIV program (Needle and syringe program, as well HIV treatment program) in Abkhazia, fully supported by the Global Fund, is implemented by local NGO „Zura Danelia's Union Tanadgoma” from 2008. The program is fully financed. The founder of this organization was origin from Abkhazia, mainly from Sokhumi, a doctor, had close relations with representatives of local government, ministry of health and health facilities. This organization represents the SSR of Global fund project.

On the first stage of implementation of HIV projects in Sokhumi the Coordination Commission from Abkhazia side was included. The Coordination Commission that is represented by Abkhazian authorities represents itself as a political structure that performs the function of the bonding between the rest two parties. The work of the Coordination Commission is officially approved by government of Abkhazia, among them Ministry of health Totally the project is being implementing on a tripartite agreement basis – NGO Tanadgoma on the base of GHRN contract, the Coordination Commission and the local partners. On the base of this official



agreement Georgian Harm reduction Network and AIDS centre (the both are SR of GF project) participate in State tenders announced by NCDC (represented as PR) and receives finances from Global Fund to fund these projects.

Major partners to accomplish the both prevention and treatment projects are Narcology centre and AIDS centre of Sokhumi. The projects are implemented according to standards and protocols approved by Georgian side. Projects' implementer partners provide monthly reports on accomplished work, use the same electronic database for registration of beneficiaries, and use the same registration and notification forms, as it is being used by other SSRs within Global Fund project. Targeted informational educational materials (according to local drug scene) for Abkhazian beneficiaries are prepared in Russian and delivered within the project. The demand on materials (quality of syringes, condoms, other consumable materials) coming from Abkhazia service site are envisaged during project planning and procurement process. Study and monitoring visits of Sokhumi projects are carried out by the representatives of Tbilisi on a semester base. Besides, study tours for employed staff of Abkhazia are implemented in Tbilisi on a regular base.

Lessons learned and recommendations:

The factors that helped with the success: a) local NGO that had close relations with the representatives of Abkhazia government and can implement a mediation role between the sides b) Creation of the Coordination Commission and tripartite agreement c) Willingness to collaborate effectively from the both governmental authorities. (Georgian Prime minister in 2014 released a special order to facilitate the successful implementation of the projects in Abkhazia; Minister of Health of Abkhazia releases special order to support this program); d) Effective coordination by PR-SR-SSR and major partners.

Today many concerns associated with financial stability of HIV program exist in Georgia, as after 2018 GF will leave the country. This concern is deepening regarding Abkhazia, here we have worry about financing, management and implementation processes at the same time. Georgia is in its preparation stage to elaborate a transition plan, where HIV prevention and treatment component for Abkhazia is envisaged. According to thoughts of representatives from Abkhazia, they can't receive direct financing from Georgian government after the GF. Special discussion on this issue between the both governmental authorities has not been conducted yet. As for future implementation of HIV programs in Abkhazia we suggest that the agreement for effective collaboration in HIV prevention and treatment field should be continued and the experience and achievements already done should be used and strengthened by Georgia.

30. Russian Federation

Title of the programme: Provision of assistance in getting ARV treatment in Russia for HIV positive unwilling migrants from Ukraine.

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Programme is being implemented since: The first request for the NGO's assistance was on May 27, 2014. The first formal status of the unwilling migrant was issued to the HIV positive Ukrainian on September 24, 2014

Implemented by: Civil Society

Scope of submission: Access to HIV prevention, care and treatment, Protection issues, equity and human rights

Has the programme been evaluated /assessed? No

Is the programme part of the national AIDS plan? No

Is the programme part of a national emergency response plan? No

Background

UNAIDS Report presented in Geneva on November 23, 2013 named Ukraine as the country with the highest HIV incidence in EECA region, Ukraine and Russia are responsible for about 90% of all new HIV infections in the region and have the highest HIV prevalence among adults: 1,1 %.

Official representative of the Russian Federal Emergency Ministry Mr. Alexander Drobishevskiy reported that 223 accommodation centers for the Ukrainian unwilling migrants in Russia host about 16,5 thousand people, mainly women and children. The total number of the unwilling migrants from Ukraine according to the federal ITAR-TASS news agency exceeds half a million, ИТАР-ТАСС.

Russian Informational Agency reports that 1,737 of 37,63 thousands of unwilling migrants in Rostov Oblast are lodged in eight accommodation centers. The number of migrants is always changing, since the beginning of year 2015 over 6,000 persons were moved to other Russian regions, <http://ria.ru/society/20150417/1059185558.html#ixzz3XbK1asVt>

According to UNAIDS reported 1,1 % HIV prevalence in the Ukrainian adult population the approximate number of HIV positive persons among the unwilling migrants in Rostov Oblast shall be 408. These people need medical assistance and ARV treatment. But unwilling migrants are challenged to disclose their HIV status or get HIV testing due to the threat of being deported as it is required by the Russian Federal Law # 114-FL from August 15, 1996. By March 15, 2015 only 30 HIV positive persons not including pregnant women and newborns out of expected 400 turned to the medical institutions of Rostov Oblast. 9 of them were assisted by "Kovcheg-AntiAIDS" NGO in obtaining the formal status of the "temporary unwilling migrant" that allows to get medical assistance and ARVT without the threat of deportation. Remaining 21 persons haven't returned to the AIDS Center or referred to "Kovcheg-AntiAIDS" for assistance for the unknown reasons.

Many HIV positive Ukrainians at the territory of the military conflict get ARVT through GFATM programmes but these resources aren't sufficient for all those in need for ARVT.

Also according to Rostov Oblast AIDS Center the Oblast experienced unusual rise of the new HIV infections in 2014 year (818 cases) with the continued tendency in the first quarter of 2015 year, when newly diagnosed HIV cases were 1,9% higher than during the same time period in 2014 (375 and 177 accordingly). The issue hasn't been profoundly studied for cause-and-effect relationship with the unwilling migration. But in any case HIV positive migrants who don't get medical assistance and ARV have higher risk of infection transmitting in comparison with people on ARVT.



Approach:

PLHIV organization “Kovcheg-AntiAIDS” became the only and unique agent between the frightened and desperate group of HIV positive unwilling migrants and providers of the medical services, Federal Migration Service. We contacted all parties to organize the process and oversaw its successful completion. At the same time we provided support, counseling and accompanying of the HIV positive migrants to the required organizations to ensure implementation of all required procedures.

People living with HIV usually turn to the local PLHIV communities to assist in solving the issues that are complicated, lack clear operational procedures and/or regulatory ground, lack of funding, insufficient intersectorial and interagency collaboration.

Anti AIDS NGOs help to lower the threshold to get the government funded services to people in need.

Reach of the intervention:

“Kovcheg-AntiAIDS” NGO is working with target group as people living with HIV and people affected with HIV to improve their access to HIV prevention, care and treatment. We also come for the HIV positive people equality in getting assistance and services and in preserving and protecting their human rights.

Since May 2014 our organization has received several requests for assistance from the HIV positive unwilling migrants from Ukraine who could not get ARV treatment neither in Ukraine nor in Rostov Oblast. We assessed the issue and contacted for advice Coordination council for HIV/AIDS with the RF Ministry of Health, Rospotrebnadzor, Federal Migration Service in Rostov Oblast, Oblast AIDS Center.

We found out that currently HIV positive unwilling migrants from Ukraine aren't being deported from Rostov Oblast. And the person can get the general and specialized medical aid including ARVT in the Oblast medical institutions. This requires a person to obtain a status of the “temporary unwilling migrant”. Although the Federal Migration Services issues a limited number of these statuses, we convinced it to go above standard limits and issue the needed status to all those who need it for getting medical help and ARVT.

At the next step we faced the issue of informing the unwilling migrants about the possibility of getting medical aid and ARVT. “Kovcheg-AntiAIDS” NGO began to conduct informational campaigns to attract the target audience to get counseling, assistance and ARVT, although the scope of our work is not wide due to the limited financial and human resources.

Impact of the intervention:

All 8 unwilling migrants who turned to “Kovcheg-AntiAIDS” NGO for assistance received psycho-social and organizational support, obtained formal status of the “temporary unwilling migrant” and were helped to get registered in the local AIDS Center where they have got medical checkup and ARVT.

To help more people with HIV to preserve health and decrease the risk of HIV transmitting to their sexual and/or injection partners, the NGO began the informational work among unwilling migrants to inform them about availability of legal medical assistance and ARVT as well as legal, social and psychological help from the “Kovcheg-AntiAIDS” NGO staff.

The information and examples of those who have already got ARVT shall increase the unwilling



migrants' trust and appeal ability for the medical and social aid, decrease the overall level of anxiety and help to preserve health of the HIV positive migrants and their partners.

Challenges faced:

1. Situation of the military conflict causes interruptions in the provision of the Ukrainian medical institutions with the HIV test systems and ARVT and prevents people with HIV from timely HIV diagnosis and ARV treatment.
2. To get services and ARVT in the Russian AIDS center the foreigner shall provide to the medical institution the formal status of the "temporary unwilling migrant" or "refugee". But to obtain these statuses from the Federal Migration Service the person shall prove that she/he does not have HIV.
3. A person who gets the "temporary unwilling migrant" or a "refugee" status has to hand over the native country's passport and the person is supposed to stay at the Russian Federation territory. But the majority of Ukrainian migrants plan to return home soon after the end of the military activities and don't rush to apply for the "temporary unwilling migrant" or a "refugee" statuses which would allow them to get medical help in Russia.
4. "Kovcheg-AntiAIDS" NGO is eager to provide information and support to the wider range of unwilling migrants, but our resources are quite limited.

Financing and management:

The Chief Doctor of the Rostov Oblast AIDS Center informed us that the Center currently requested federal funding for the 60 units of ARVT for the unwilling migrants. "Kovcheg-AntiAIDS" NGO as the member of Coordination council on HIV/AIDS with the RF Ministry of Health requested clarification on the procedure to manage treatment provision to the HIV positive unwilling migrants during the Coordination council meeting. As explained by the Director of the Department of Healthcare, Sanitary and Epidemiological Wellbeing Ms. Marina Shevireva, the local AIDS Center shall provide the required scope of services including ARVT (if needed) to the HIV positive unwilling migrant by using the regional budget funds, then the region applies to the federal level to reimburse it for or the spent funds. Currently "Kovcheg-AntiAIDS" NGO's work with unwilling migrants is supported by the "HIV Prevention among IDU and Sex Workers in Rostov-on-Don" Project, GFATM-funded. 9 persons from the NGO staff and invited specialists work in this project. A local audit company is making NGO's accounting reporting to accord the Russian legislation and reporting requirements.

Lessons learned and recommendations:

The work of motivated PLHIV self-organizations as "Kovcheg-AntiAIDS" NGO facilitates timely and careful assessment of the PLHIV-related issues and decisions' making by the government structures.

PLHIV organizations are a reliable link and effective moderator between the affected community groups and service providers.

PLHIV organizations are flexible and can quickly react to the urgent PLHIV-related challenges even with the limited resources.

PLHIV organizations are well fitted to conduct HIV prevention work with different target audiences.

Although funding for the PLHIV organizations in Russia is limited and constantly shrinking. PLHIV organizations have to compete for resources for its programmes with other and stronger NGOs.

It can be helpful to share successful experiences like this with other NGOs and public partners. It would be helpful to have a targeted funding for PLHIV organizations in the scope of the Russian Presidential grants and Oblast Governor's subsidies for the socially-oriented NGOs.

31. Ukraine

Title of the programme: The First Unique Experience of Redesigning HIV Prevention Programs under Emergency Conditions in Ukraine

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Programme is being implemented since: May 2014

Implemented by: Government, Civil Society

Scope of submission: Access to HIV prevention, care and treatment, Protection issues, equity and human rights, Preparedness and contingency planning, Community resilience, Inter-agency coordination, Effects of emergencies on key populations, Early recovery and development, Situations of fragility, Evidence and strategic information, Innovative funding strategies, Urban contexts

Has the programme been evaluated /assessed? No

Is the programme part of the national AIDS plan? No

Is the programme part of a national emergency response plan? No

Background:

International HIV/AIDS Alliance in Ukraine (Alliance Ukraine) is one of the Principal Recipients of the Global Fund in Ukraine, and since 2004 has been providing comprehensive harm reduction (HR) services to over 260 000 people representing vulnerable populations in all the regions of Ukraine, which is the largest HR coverage in the EECA region.

In March 2014, the Russian Federation (RF) illegally annexed the territory of the Autonomous Republic of Crimea, and in April 2014, armed conflict in the East of Ukraine began, leading to the death of 6 thousand people, 15 thousand being wounded and over 1.2 million people forced to abandon their homes and become internally displaced persons (IDP).



At the moment, Alliance Ukraine continues supporting HR services in Donetsk and Luhansk Oblasts, covering 17 000 vulnerable population members, incl. over 15 000 PWID. Over 15 thousand clients representing vulnerable populations still receive harm reduction services in the occupied Crimea and the city of Sevastopol.

In May 2014, the barriers imposed by the RF authorities caused termination of the SMT programs in Crimea (running since 2005), with 803 SMT patients losing the access to treatment. As of April 2015, about 700 SMT patients were forced to stop receiving SMT in the East of Ukraine due to the armed conflict and impossibility of delivering SMT drugs into the region. Hundreds of patients were forced to move to Ukraine-controlled territories as IDPs. Under such extraordinary conditions, Alliance Ukraine had to radically redesign the programs to ensure their sustainability and continuity.

Approach:

Considering the dramatic change of the situation, Alliance Ukraine had, after consultations with the Global Fund, to substantially redesign the harm reduction programs in Crimea and in the East of Ukraine.

HR programs in Crimea are still coordinated and monitored by Alliance Ukraine, and the funds are temporary delivered to partner organizations in Crimea directly from the Global Fund from Geneva, since no bank transfers between mainland Ukraine and Crimea are possible. The Crimean NGOs were forced to re-register as Russian organizations, though most of them have retained their Ukrainian registration by re-registering in mainland Ukraine to be able to continue receiving funding.

Similarly, partner HIV-service NGOs on the territories of Donetsk and Luhansk Oblasts out of Ukrainian control were forced to re-register their banking accounts on the Ukraine-controlled territory and, at the same time, to formally re-register in the self-proclaimed republics of DPR and LPR to be able to continue their operations.

Our experts noticed the need to revise the minimal package of services for HIV/AIDS vulnerable groups in the non-government controlled areas. Thus revised minimal package of services is based on discussions with stakeholders as well as surveys of NGOs. It is planned that the package of services for the risk groups in the non-government controlled areas along with the standard package of services (distribution of condoms, syringes, alcohol swabs, lubricants, social worker consultation, testing for HIV and other STI) will be expanded to provide additional services: basic food packages, premedical aid by nurses and psychological help. Additional services by nurses and psychologists will be provided as outreach services and based on sites for services provision. Medicines will be given to clients based on medical indications or after medical examination by outreach nurse. The list of medicines contains medical goods which are currently unavailable for PWID, FSWs, MSM based in the non-government controlled areas. This will also help to prevent denial of harm reduction services by clients searching for food and survival.

The total amount required from the Global Fund to enhance the support of projects working in the non-government controlled areas is estimated at the level of \$ 150 000 (9 months project) and will cover around 1000 clients (PWID, FSW and 70).

Alliance Ukraine has redesigned its system for monitoring and coordination of regional projects in accordance with the new demands and challenges. International and regional consultants having the access to the uncontrolled territories have been involved.

In May 2014, Alliance Ukraine established a separate humanitarian project to ensure the continuity of SMT for IDP patients from Crimea and from the East of Ukraine using funds of International Renaissance Foundation (local office of the Soros Foundation/OSF).



Reach of the intervention:

Urban/densely populated regions around Donetsk and Luhansk where most clients of HIV treatment and prevention programs are concentrated suffer the most. Accordingly, Alliance is focusing its efforts on these cities.

Over 200 SMT patients who have moved from Crimea (60) and Donbass (over 140) were admitted and received services under the Alliance humanitarian project (medications, food, social/psychological support). Results of the project have proven its efficiency which allowed obtaining additional funds from new donors: Elton John AIDS Foundation and Pompidou Group Council of Europe, which allowed extending the term of the project till 05. 2015.

Human rights protection and advocacy opportunities in the problematic territories are substantially limited, but Alliance Ukraine cooperates with international human rights organizations, registers violations and regularly makes them public, in particular through mass media. A great support in terms of advocacy at the international level has been provided by Michel Kazatchkine — the United Nations Special Envoy for HIV/AIDS in EECA.

Alliance and its partners have initiated hundreds of articles and reports in Ukrainian and distinguished foreign media dedicated to the crisis situation with treatment and prevention programs in the problematic regions of Ukraine.

Since January 2015, Alliance has been issuing regular Situation Reports on the Status of HIV/TB/HCV/OST Prevention and Treatment Programs (SitRep) in Donetsk and Luhansk Oblasts released every 2 or 3 weeks and distributed among stakeholders and media.

Information from the Alliance SitReps has been regularly used in OCHA UN SitReps.

To resolve the problems of ensuring continuity of HIV prevention services in Crimea and the East of Ukraine, continuous coordination with state authorities (most notably, with the Ministry of Health of Ukraine) and UN organizations (WHO, UNAIDS, UNDP, UNODC, etc.) has been maintained. Alliance Ukraine has initiated two discussions of the issue of ensuring continuity of the prevention and treatment programs in the above regions at the meetings of the National TB and HIV Council, which allowed involving other state authorities (in particular, the Ministry of Interior, State Security Service, the Ministry of Defence, State Drug Control Service, State Penitentiary Service, etc.) in the coordination process.

Under coordination with the WHO Office in Ukraine, a special Cluster sub-group on health issues has been established, which developed, together with other stakeholders, a draft Contingency plan in order to ensure adequate response to the crisis.

Impact of the intervention:

The measures taken have allowed preserving preventive services for over 30 thousand clients of the programs, retaining them in harm reduction programs and mitigating risk behaviour. Specific measurable results should manifest later, after it becomes possible to conduct research in the problematic regions. Also, tens of internally displaced SMT patients have been retained in the treatment programs which saved their health or even lives. Several dozens of patients were provided with humane detoxification.

Challenges faced:

Alliance Ukraine, implementing Harm Reduction Programs, was forced to significantly change its approach in the emergency. Correspondingly, GFATM also changed its approach in the crisis situation, for the first time in EECA region.

Key obstacles:

- security problem threatening life and health of clients and staff - no connection with some cities and regions;
- bank and financial system collapse;
- difficulties with the movement and supply of consumables and drugs, inability to transport narcotic drugs;
- lack of state funding to support harm reduction;
- problems with performance monitoring;
- closing specialized hospitals / significant reduction in diagnostics and treatment;
- increased marginalization of PWIDs, FSWs and MSMs;
- inability or lag response of state system and legislation.

Financing and management:

All the activities under these operations were financed within the existing budget of the Round 10 grant of the GF whose regional team has demonstrated certain flexibility in approaches to work under extraordinary conditions.

Individual humanitarian components were funded with the help of newly engaged OSF, Elton John AIDS Foundation and Pompidou Group Council of Europe.

Regretfully, almost nothing was funded by the state budget of Ukraine since the Government was unable to cover even the minimum vital needs related to accommodation and feeding of those stricken by the crisis.

Lessons learned and recommendations:

In Ukraine, the situation with harm reduction programs covering > 260 000 clients under the conditions of military conflict detonated in May of 2014 is a unique one for GFATM programs. The way Alliance Ukraine works now can serve as a model for adequate response to similar crisis situations in other parts of the world. This experience is worth presenting at the profile international events.

Key recommendations:

- developing contingency plan and agreeing it with donors;
- introduction of emergency coordinators, including in regions with a maximum load;
- changing the minimum package of HR services for target groups, schedules and routes;
- integration of humanitarian components, connection to international humanitarian organizations, donors etc.;
- special focus on additional communication channels, ie hotlines, etc.;
- search for new donors for operational support of emergency needs;
- adaptation of legislation norms to the new needs;
- transferring OST patients to safe areas;
- considering peculiarities of high lightening PWID/OST patients' needs in mass media

32. Ukraine

Title of the programme: HIV prevention programs sustainability in the war-affected territories of Donetsk and Luhansk oblasts of Ukraine

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Programme is being implemented since: 2004

Implemented by: Civil Society

Scope of submission: Access to HIV prevention, care and treatment

Has the programme been evaluated /assessed? No

Is the programme part of the national AIDS plan? Yes

Is the programme part of a national emergency response plan?

Background:

International HIV/AIDS Alliance in Ukraine has been implementing harm reduction programs since 2004 providing services to vulnerable populations in all oblasts of Ukraine

Since the beginning of the armed conflict in April 2014 in Donetsk and Luhansk oblasts, harm reduction programs are being redesigned in order to meet the needs of this time and ensure their sustainability. The conflict areas still remain highly unstable, with some of these territories controlled by Ukrainian government and other territories controlled by separatists (so called, DNR and LNR territories).

While we can observe the migration among general population from government-non-controlled areas to other oblasts of Ukraine, which are not affected by war, most-at-risk populations for HIV either stay within conflict areas or move to the neighboring cities of Donetsk and Luhansk oblasts, where the situation is more stable. All humanitarian programs, implemented currently on these territories, are aimed at general population, and do not take into consideration the needs of most-at-risk populations for HIV. In these circumstances it is as never vital to support the existing harm reduction programs and to expand the package of services provided to the client.

National HIV prevalence rates among PWID and CSW in Ukraine are 19,7% and 7,3% respectively (with higher rates observed in Donetsk region - 26,5% and 10,5% respectively). The researches on HIV prevalence rates among risk groups specifically on the territories non-controlled by the government, where hostilities take place, have not been conducted, but it is possible to assume that in the situations of extreme poverty among population of these territories, absence of work, limited supplies to pharmacies and shops on the territories where hostilities take place, MARPs in need of food and survival may reject using sterile syringes while



injecting drugs and condoms during sexual contacts due to absence of money, which in its turn will lead to the spread of HIV to other uninfected representatives of the population.

Approach:

Before the hostilities on the territories of Donetsk and Luhansk regions started, a well established system of harm reduction has already been built through Alliance-Ukraine partner NGOs. There are currently 8 NGOs working in Donetsk region and 3 NGOs working in Luhansk regions (with 5 and 2 of them working specifically on the territories of hostilities). These NGOs organize effective harm reduction services through outreach, community centers, pharmacies and mobile clinics through distribution of commodities (condoms, syringes, alcohol swabs, lubricants), organizing rapid testing for HIV and other STI, referral to medical institutions for positive result confirmation and TB diagnostics.

The following changes to the program implementation have been made/ are being made in hostile territories:

- Partner NGOs in government non-controlled areas were forced to withdraw their bank accounts to territories controlled by the government and to formally register within so-called LNR and DNR territories to be able to operate;
- Where it has become impossible to implement harm reduction through outreach, alternative places have been found (client's home, social worker's home, other quiet place), including changes made to working schedules.
- Due to the curfew introduction on some territories, schedules of services provision to MARPs have been moved to morning or day time;
- Case management projects which aim at timely initiation of ART among PWID in need of ART have been expanded in Donetsk region since January, 2015.

Minimal package of services is being revised for the projects working on hostile territories. The package will include basic food packages, premedical and psychological aid components.

Reach of the intervention:

Despite the hostilities on some of the territories of Donetsk and Luhansk region, the list of cities in which the harm reduction program was available at the beginning of 2014 (when the situation was stable and no indication of hostilities was observed), remained practically unchanged.

Despite the difficulties with supply of commodities to Donetsk and Luhansk regions in Jul-Dec 2014, it was possible to provide high coverage of most-at risk populations with minimal package of services (syringe (for PWID), condom, counseling, information material) – over 30,000 of MARPs (28,824 PWID and 1,972 CSW). If compared to the coverage data for Jan-Jun 2014 a slight decrease in the coverage for Jul-Dec 2014 can be observed, which is higher in government non-controlled areas – around 10% lower.

Among 104 positive rapid tests for HIV in Luhansk region and 238 – in Donetsk region in 2014, 78% and 95% respectively, visited medical institution for result confirmation and further medical observation – this demonstrates high effectiveness of referral and case management.

Impact of the intervention:

No surveys have been conducted to measure the impact of HIV prevention in emergency context.

Despite existing hostilities, it was possible to retain the coverage of most-at-risk populations reached with prevention services and to provide stability in services provision. Targets for



MARPs coverage in 2014 have been achieved by partner NGOs in Donetsk and Luhansk regions and it was possible to retain over 30,000 MARPs coverage with package of harm reduction services.

Challenges faced:

Challenges related to HIV program implementation are:

- With the introduction of permit system to enter or exit government non-controlled areas of Donetsk and Luhansk regions, direct commodities supplies to these territories became impossible. Commodities to these territories are currently being supplied jointly with humanitarian convoys of international organizations having special permits for supplies.
- Permit system has complicated NGO personnel possibility to enter/exit government non-controlled areas with an aim of harm reduction services provision or participation in meetings/trainings. Two solutions have been found: people applied for special permits which allow to enter/exit government non-controlled areas; people exit government non-controlled areas into the Russian federation and enter Ukraine (government controlled areas) from there.
- OST programs in government non-controlled areas are practically terminated due to impossibility to supply drugs. In this respect the dose is gradually reduced and OST patients are suggested to move to other territories with an aim of continuing participation in OST program or to go through detoxification.
- With the introduction on government decree on the termination of banks functioning on the government non-controlled areas, the accounts of partner NGOs have been transferred to other territories of Donetsk and Luhansk oblasts which are controlled by the government.
- Increased marginalization of MARPs (PWID, CSW, MSM) can be observed, making it almost impossible for them to leave hostile territories in search of better life or work. In this respect programs work even in hostile conditions to meet the MARPs need in harm reduction.

Financing and management:

Harm reduction programs in Donetsk and Luhansk oblasts have been financed within the Round 10 GF grant. There are currently 8 NGOs working in Donetsk region and 3 NGOs working in Luhansk regions (with 5 and 2 of them working specifically on the territories of hostilities). Almost nothing has been allocated from the State budget.

Granted money is being transferred to partner NGOs accounts on a monthly basis (other NGOs are transferred money on quarterly basis), which provides additional guarantees that big amounts of granted money are not lost in case of emergencies. NGOs partner accounts are registered only on government controlled areas.

NGO partner projects in Donetsk and Luhansk regions are being monitored on the weekly basis through providing information on project achievements for each week, changes made to program implementation due to conflict escalation on some of the territories or some other reasons.

Lessons learned and recommendations:

Despite the existing examples of work in war conflicts in the world, the example of Ukraine is unique and has many peculiarities which other countries don't have. In this respect it is

important to explore the example of Ukraine in order to develop general methodical recommendations on HIV prevention and harm reduction in emergency contexts.

The following recommendations can be provided:

- Development of national emergency response plan which requires involvement of governmental, non-governmental and international parties cooperating together to provide on-spot reaction to changing situations and finding solutions to clueless tasks;
- Integration of harm reduction component into humanitarian projects enrolled by international donors in hot spots;
- Revision of services package for MARPs living in hostile conditions (food packages, premedical and psychological aid);
- Retention of trained staff and built harm reduction programs in hot spot territories;
- Flexibility in the work of programs in conflict areas including readiness to take quick decisions in changing situations;
- Search for alternative sources of funding to solve problems in emergency contexts;
- Using the experience of countries living in frozen or hot conflicts to develop own country emergency response plan;
- Hiring unbiased experts able to negotiate and find optimal solutions for both sides of the conflict in order to achieve the goals of program being implemented;
- Program implementation beyond the conflict and beyond the beliefs of parties implementing the program;

33. Ukraine

Title of the programme: Access to HIV prevention, care and treatment

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Programme is being implemented since: 2014

Implemented by: Civil Society

Scope of submission: Access to HIV prevention, care and treatment

Has the programme been evaluated /assessed? No

Is the programme part of the national AIDS plan? No

Is the programme part of a national emergency response plan? No

Background:

Brief overview of events in the ATO area: The armed conflict in Donetsk and Luhansk oblasts



led to a humanitarian crisis in the Eastern Ukraine. The infrastructure in many cities and settlements was destroyed; there were power blackouts, water supply and communications interruptions. The stock and supply of food and medicines is being drained. To stop the armed conflict the OSCE initiated the negotiation process. The Trilateral Contact Group was formed out of the representatives of Ukraine, Russia and OSCE. Long-time and large-scale warfare in Donbass led to a mass evacuation. According to the data provided by the UN Assistant Secretary-General for Human Rights, as of mid-December of 2012 more than 1.1 million of people left Donbass territory.

Approach:

With the support of the AUCO «All-Ukrainian Network of PLWH» 14 NGOs are performing project activities on care and support for PLWH in the ATO area.

SITUATION in the penitentiary facilities 6 regional HIV-service organizations (Luhansk oblast branch of AUCO “All-Ukrainian network of PLWH”, Donetsk oblast charitable organization “Variant”, Charitable organization “Club “Svitanok”, Charitable organization “Tvoy Shans (Your Chance)”, Donetsk oblast charitable foundation “Obereg”, Charitable organization “Club “Maibutnye”) continue their operations, covering practically all State Penitentiary Service facilities in Donetsk and Luhansk oblasts, both on the territories controlled and not controlled by the Government of Ukraine.

Reach of the intervention:

On the territory uncontrolled by the Government of Ukraine there are about 8.5 thousand of people receiving antiretroviral therapy. Among them 576 people are in the penitentiary/pretrial detention facilities. The Government of Ukraine did not provide timely evacuation from the penitentiary facilities. If people living with HIV, who were serviced in AIDS centers, have the choice to either leave the territory of armed conflict or stay, the prisoners did not have such a choice. In this situation they turned out to be the most vulnerable category in the armed conflict in the East of Ukraine. NGOs, subrecipients of AUCO “All-Ukrainian Network of PLWH” which continue to provide services to people living with HIV despite the armed conflict, are actually the only sustainable organizations able to implement prevention and treatment programs and cooperate with the penitentiary service and the AIDS centers. Moreover, they became the main coordinators on situational monitoring, delivery and distribution of antiretroviral medicines to ART sites. AUCO “All-Ukrainian Network of PLWH” abstained from any political preferences, prioritizing the patients and their needs; the dialogue with different sides of the conflict was aimed at ensuring necessary medicines and services for people living with HIV. AUCO “All-Ukrainian Network of PLWH”, as a principal recipient of the Global Fund, possesses sufficient expertise in carrying out procurement of medicines/commodities and finding alternative solutions to ensure provision of medicines to the conflict-affected regions. However, the NGOs which remained on the conflict-affected territory are crucial for supporting this process, because without their involvement it is not possible to solve the problem of medicines and medical goods supply to the East of Ukraine.

Impact of the intervention:



As of today we can state that without the HIV-service NGOs in the ATO area and without active participation of AUCO “All-Ukrainian Network of PLWH” in providing antiretroviral medicines and medical goods to the territories not controlled by the Government of Ukraine a humanitarian catastrophe would have broken out in Donetsk and Luhansk oblasts, leveling down all national achievements in HIV/AIDS response. Currently the system of medical services provision to PLWH in Donetsk and Luhansk oblasts is sustained. More than 8,000 of patients continue to receive antiretroviral therapy on the territories not controlled by the Government of Ukraine.

Challenges faced: In connection with the anti-terrorist operation on the territory of Donetsk and Luhansk oblasts the NGOs engaged in project activities faced a number of barriers in medico-social support of PLWH. **The key problem** is the lack of ARV medicines and medical goods supply to the territories not controlled by the Government of Ukraine. The state refused to supply ARV medicines and medical goods to the territories not controlled by the Government, posing a threat to the life and health of about 8,500 PLWH being on ART. The State Penitentiary Service of Ukraine was the first to refuse to supply the medicines. After the Decree of the President of Ukraine No. 875 dated 14.11.2014, Ukrainian Center for Socially dangerous Diseases Control refused to supply the medicines and medical goods procured at the expense of the state budget. Moreover, the state also refused to pay salaries to hundreds of specialists who continue to provide services to PLWH on the sites uncontrolled by the Government of Ukraine in 34 hospitals and 22 prisons.

NGOs face various barriers while providing medico-social support to PLWH in the ATO area: Mobility restrictions; Viral load (VL), CD4, PCR diagnostics is not available; Staff drain (in Luhansk 90% of the engaged specialists (doctors, nurses etc.) have terminated their contracts; In Slavyansk and Severodonetsk, the CD4 and VL testing equipment is physically absent; Many businesses discontinued operation, supply of the products was terminated, it was difficult to fulfill procurement procedures; Due to growing prices for food and other goods the number and contents of aid packages became much scarcer.

Overcoming the problems with ART provision to HIV+ prisoners and detainees in Donetsk and Luhansk oblasts.

ARV medicines and medical goods procured by AUCO “All-Ukrainian Network of PLWH” at the expense of the GF funds were handed over to the State Penitentiary Service of Ukraine which further distributed them across territorial departments. In summer 2014 the issue of the medicines supply to the penitentiary facilities of Donetsk and Luhansk oblasts became urgent. The State Penitentiary Service of Ukraine refused to make supplies to the conflict territory. 490 prisoners faced the ART interruption threat. The joint efforts of the territorial penitentiary service department and Luhansk oblast division of the Network of PLWH succeeded in securing the stock of medicines till the end of the current year. Luhansk branch of the Network delivered the medicines from Kyiv to oblast facilities on their own. In Donetsk oblast the NGO representatives ensured the medicines supply to the facilities where the remaining stock of medicines would have been sufficient till mid-September. At that time 6 facilities became subordinate to the so-called Penitentiary Service of the DNR Ministry of Interior. The medical department staff of the State Penitentiary Service in Donetsk was dismissed and further admitted to work within the Penitentiary Department of the Donetsk division of the Ministry of Interior. These facilities had the remaining stock of ARV medicines sufficient for a month. The matter of Efavirenz and Truvada supply was urgent. Based on the information from regional organizations, there are 27 HIV-positive prisoners, among them 18 are on ART; there is no ART stock; in August the prisoners started to receive other ART regimens (depending on the availability); as of 25.09.2014 the prisoners interrupted the treatment due to the absence of antiretroviral medicines. The same situation is in Yenakiyev - 19 prisoners with HIV-positive status, among



them 9 persons on ART, who interrupted treatment. At the beginning of October an unprecedented action was held on antiretroviral medicines delivery in 6 correctional facilities in Donetsk oblast. 3 NGOs were engaged (Charitable organization "Club "Maibutnye, Donetsk oblast charitable foundation "Obereg", Charitable organization "Tvoy Shans (Your Chance), All-Ukrainian Network of PLWH was in charge of the overall coordination. Previously All-Ukrainian Network of PLWH received 618 packs of Efavirenz as a donation from pharmaceutical companies. The Procurement department of the Network held negotiation with pharmaceutical companies who had provided antiretroviral medicines as a charitable aid. On 14 of October the medicines were received by Donetsk CO "Variant" which further distributed the medicines between the above facilities. After negotiations between the Network and the Central Department of the State penitentiary Service the parties have worked out the following mechanism. The medicines procured at GF cost for treating HIV-positive prisoners in Donetsk and Luhansk oblast will not be taken on the State Penitentiary Service balance. The Network delivers all the supplies to Donetsk and Luhansk oblasts. Certain quantity of ARV medicines for prisoners is already stored at the Network's logistics partner warehouse. However, the medicines for opportunistic infections and somatic conditions were centrally procured by the State Penitentiary Service at the expense of the state budget; the medicines necessary for urgent care of the prisoners in Donetsk and Luhansk oblast prisons have run out of stock already in January 2015. In oblasts the prisoners cannot obtain medical aid due to the impossibility of transfer. For example, the Charitable organization "Club "Svitanok" attends Donetsk pretrial detention facility to bring infant food and humanitarian aid to a HIV+ convicted mother. She was brought for court from Artemovsk pretrial detention facility being already pregnant and delivered the baby in Donetsk, as it was not possible to transfer her back due to the aggravated situation in the region. In October All-Ukrainian Network of PLWH appealed to the Ombudsman of Ukraine to solve the issue of evacuating 2 HIV-positive women with children from Donetsk detention facility, because there are no appropriate conditions for long-time stay of women with children in the detention facilities on the uncontrolled territory. The NGO providing women with ART, milk formula and other humanitarian aid was the only one who assisted them. Moreover, there is always a risk that NGO may be restricted to visit closed facilities, and these women will be left without help and supply. However, the Network finally received the reply from the Secretariat of the Verkhovna Rada Ombudsman stating that positive solution of this problem is impossible, thus, women with children are still kept in Donetsk facility.

Overcoming the problems with treatment for PLWH in Donetsk and Luhansk oblasts

During the negotiations between PRs and the Global Fund it was decided to continue funding the projects on the territories not controlled by Ukrainian Government; moreover, ARV medicines and medical goods will be supplied at the expense of GF. AUCO "All-Ukrainian Network of PLWH" as a Principal Recipient of the Global Fund grant, committed to ensure ARV medicines supply. Under the WHO coordination the working group on programmatic activities implementation in Donetsk and Luhansk oblasts was established. The implementation plan was prepared for the territories not controlled by the Ukrainian Government. During January 2015 All-Ukrainian Network of PLWH had collected the ART needs on the territory. The information was forwarded to Ukrainian Center of the Socially Dangerous Diseases Control of the MoH of Ukraine for verification. Thus, on February 19 ARV medicines and medical goods were supplied to the territory. MSF provided vehicles for transportation, and under the WHO coordination 3 tons of humanitarian cargo were supplied to the uncontrolled territory, thus securing the needs in ARV medicines for PLWH who remained on the uncontrolled territory up to July 2015.

AUCO "All-Ukrainian Network of PLWH" faces the following problems while delivering

the medicines in the ATO area: Warfare in the ATO area; Impossibility to insure the cargo to be transported in the ATO area; Lack of legal grounds for cooperation with the state facilities which are formally re-registered at the new legal addresses in the cities controlled by the Government of Ukraine; Lengthy process of state entities re-registration at the places where they were relocated; The relocated entities are not ready to accept and store medical goods with special storage requirements (cold chain, etc.);

Financing and management:

On July 21, 2014 AUCO “All-Ukrainian Network of PLWH” established a temporary working group on the issues of cooperating with ATO regions. As soon as by the second meeting the information was collected the actions to supply ARV medicines in the ATO area were developed. The data were presented in September 2014 at the roundtable chaired by the Verkhovna Rada Ombudsman and attended by the representatives of the Ministry of Health, State Penitentiary Service, Office of the Prosecutor General and other entities. All-Ukrainian Network of PLWH demonstrated its competency to collect operative information and solve the problems on medicines supply to the penitentiary facilities. With the support of East Europe and Central Asia Union of PLWH (ECUO) and upon the initiative of All-Ukrainian Network of PLWH the monitoring visits by the National Preventive Mechanism were carried out. Based on the outcomes of several visits to the PDFs in the ATO area Ombudsman Valeriya Lutkovskaya sent a letter to the Prime Minister of Ukraine setting forth the need to take urgent actions to solve the issues with pretrial detention facilities in the ATO area. The Prime Minister ordered the responsible Ministers to respond and report on the actions taken. Thus, the food and medicines supply was restored in the areas controlled by Ukrainian Government in Donetsk and Luhansk oblasts. The prisoners transfer was also restored. Thus, for example, the detainee transfer from Mariupol PDF is now provided 3 times per month by special vehicles. Under the WHO coordination the working group was established on implementing the GF grant on the territory of Donetsk and Luhansk oblasts.

Lessons learned and recommendations:

The key factor for successful overcoming of the problems was that AUCO “All-Ukrainian Network of PLWH” openly discussed the problems on all levels.

The number of media activities were carried out. On different sessions/working meetings the issues of ARV medicines supply to the ATO area were raised; thus, on February 25, 2015 Volodymyr Zhovtyak, Head of the All-Ukrainian Network of PLWH Coordination Council, presented the report «Role of the All-Ukrainian Network of PLWH in ensuring the right to medical care in the warfare situation» at the session of the National TB and HIV Council. The respective decisions were taken to facilitate the humanitarian medicines cargo supply on the territories of Donetsk and Luhansk oblasts. Our key partners in solving the ARV medicines supply issue were the World Health Organization, which coordinated all parties interested in supplying medicines to the patients on the uncontrolled territory, and MSF, which undertook to transport the humanitarian cargo. The Network tries to proceed from one-off solutions, when NGO staff themselves had to carry the medicines by intercity transport in plain bags, to the development of a systemic solution to ensure the supplies. All-Ukrainian Network of PLWH seeks new mechanisms to support patients’ lives.

Further actions regarding the medicines supply

- Continue lobbying for approval of the Resolution of the Cabinet of Ministers (CMU) “On certain matters of interim procedure of assistance to the population on temporarily uncontrolled territories of Donetsk and Luhansk oblasts».



- Continue and develop cooperation with the International Committee of the Red Cross, World Health Organization, MSF on humanitarian aid supply.
- Keep a reserve stock of the ARV medicines procured by the Network at the central warehouse to be able to promptly respond to the changing situation in the ATO area.
- Continue organizing the supply of ARV medicines procured at the expense of the GF on the uncontrolled territory according to the Procedure of providing humanitarian and other aid approved by the CMU. Further distribution of ARV medicines to HIV-positive prisoners and detainees will be ensured by NGO social workers.

As of today the political will of the Government is needed to provide medicines to PLWH who remained on the uncontrolled territory, especially prisoners, who are actually taken hostages of the situation. To set up a humanitarian cargo we, All-Ukrainian Network of PLWH, need all and every facilitation from Donetsk and Luhansk military and civil administrations in registering and handling the humanitarian cargo, which will save lives of more than 8,000 of HIV-positive people in Donetsk and Luhansk oblasts and prevent the humanitarian catastrophe in the East of Ukraine.

IV. Latin American and Caribbean States

34. Antigua and Barbuda

Title of the programme: Antigua & Barbuda HIV/AIDS Network (ABHAN) Peer Buddy Treatment Adherence Program (PBTAP)

CONTACT PERSON

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Programme is being implemented since: 2006

Implemented by: Civil Society

Scope of submission: Access to HIV prevention, care and treatment, Protection issues, equity and human rights, Community resilience

Has the programme been evaluated /assessed? No

Is the programme part of the national AIDS plan? Yes, It is part of the National AIDS plan as we are one of the main organizations that work with individuals infected and affected by HIV and AIDS in Antigua.

Is the programme part of a national emergency response plan? No

Background:

Antigua's & Barbuda's population is ~90,000 persons. Since 1985 to December 2014, 1,042 HIV positive cases were reported. However, the actual number may be 2-3 times greater. The reported cases is due to under reporting (only cases tested in government facilities are reported) Of the more than ~797 persons living with HIV (PLWH) i.e. 1,042 total reported infections - 245 HIV/AIDS related deaths, approximately 548 (797 -248 in treatment and care) ~ 68.7% of reported HIV positive individuals are not linked to treatment or care. ABHAN created PBTAP to link individuals to prevention services treatment, care and support especially newly diagnosed and displaced individuals in emergency conditions.

Antigua & Barbuda has a median age of ~29.5 years and less than 30% of the population are in the labour force, therefore many individuals are living below the poverty level. Many of these individuals are also HIV infected; encounter food insecurity, homelessness, stigma, gender inequity, decreased access to health care, decreased understanding of HIV, AIDS and general illiteracy. When this population become HIV infected they are less likely to know how to access or navigate services even if they are available. ABHAN created PBTAP to address the need for HIV services under all conditions.

Approach:

In 2009, ABHAN fully implemented PBTAP by partnering with the American University of Antigua Medical School (AUA). AUA students are Buddies, ABHAN members are Peers.

ABHAN trains ~45 students as Buddies each year. ABHAN has ~51 members (25 treatment



adherent peers) in addition to spouses, partners and children, age of members, 8-55 years; 55% female, 35% male, 10% LGBT. ABHAN conducted a structured intervention over six years to increase medication adherence, medical clinic attendance, counselling and psychosocial support. To investigate program outcomes, we collected baseline and post-intervention as well as continued surveys and monitoring of CD4 counts and Viral Loads when available. Services include:

- Prevention education interventions/positive prevention
- Prevention services for negatives
- Self-care information and Domestic violence information
- Acting as a liaison between the members and their healthcare providers
- Referrals: medical, social, housing, drug treatment/rehabilitation, food-pantry, cooked meals twice per week, employment, legal, housing etc.
- Navigating the healthcare system and Transportation
- Communication- member receives a cell phone with a closed-user network free of cost
- Connection with needed services and appointment reminders, text messages
- Legal consultation/immigration assistance & Pharmacy services/medication pickup

Reach of the intervention:

The focus of ABHAN's PBTAP is to promote prevention of HIV, adherence to HIV and AIDS treatment and delay disease progression. The model adopts a long-term sustainable approach, and includes:

- Recruitment of HIV positive individuals,
- Linkage of HIV positive individuals to treatment, care and support
- Retention in treatment and care
- Reengaging individuals lost to follow-up.
- Facilitating a comprehensive package of services including case-management
- Promoting medication adherence to delay disease progression resulting in viral suppression
- Providing psychosocial and emotional support in the form of the Peer Buddy Treatment Adherence Program. (PBTAP)
- Life skills training, literacy training, and home-based outreach

The resilience of our community is based on our ability to utilize available resources to respond to the situations we encounter each day; whether it is a single mother in need of food for her children, a recently released prisoner in need of medication, housing and food, someone displaced from their home or someone who is afraid to get their prescriptions. We lobby for the "Rights" of those infected and affected by HIV & AIDS to government officials at all levels, making presentations to the Cabinet and sensitizing the public through workshops, PSA's, outreach & walks.

Impact of the intervention:

Based on the ABHAN's intervention since 2009 our Peer Buddy Treatment Adherence Program has recorded:

- Increased CD4 counts
- Decreased Viral Load (Viral Suppression)
- Trained 50 Peers and 245 Buddies
- Weekly support group meetings and monthly counselling sessions
- 15 workshops

- Annual 5K AIDS Walk
- Lectures: Schools, Churches, Businesses, Media
- 200 Home-based care-kits
- 2,220 food packages
- 13,800 cooked meals
- 634 - 20lb cylinders of cooking gas
- 115 Cell phones
- Clothing
- 15,000 brochures
- 62,000 male/female condoms

Challenges faced:

Challenges faced included the willingness of the intended population to be seen. Also after receiving the available services most are reluctant to help others because of the stigma associated with being HIV positive. There are challenges with prisoners, migrant and LGBT populations. We overcame some of these challenges by normalizing HIV within the community using those who are now healthy as an example of what is possible.

Financing and management

The intervention is managed by skilled and highly qualified volunteers trained in public health, HIV and psychosocial support. The program is collaboration with ABHAN members, AUA medical school, faith based organizations that provide cooked meals, supermarkets, businesses, community organizations and individuals. There is financial sustainability because donors of the services continue to provide them even though no money is involved in many cases just the products or services. The major challenge we faced was there is not enough monetary donations.

Lessons learned and recommendations:

This High Impact Biomedical Prevention Intervention proved to be an effective tool for everyone. Results indicate that engagement of HIV-infected individuals in treatment and care is critical for individual health and the prevention of HIV transmission to others. Disengaged individuals especially during emergencies continue to contribute to the ongoing transmission of HIV infection. PBTAP works with individuals to tackle psychosocial HIV and AIDS issues such as ignorance about HIV and AIDS, stigma and discrimination. The program includes basic and ongoing training modules for Peer and Buddy volunteers. Having this program is a vital support for the HIV community in Antigua & Barbuda.

As mentioned by one member: The opportunity to meet and communicate in mutual support is one of the key elements to the success of the program. It provides the opportunity to learn from each other by sharing experiences. PBTAP improved access to ART, treatment, care, psychosocial support and HIV and Health literacy. PBTAP has important clinical implications for general health and immune system functioning resulting in viral suppression leading to decreased transmission of HIV. It also decreased morbidity and mortality among our members;



therefore, reducing treatment cost. Working with all members of the community especially government was very important in the success of the program- they provided housing for the organization as well as financial support and when we lobbied for an HIV strategic plan in 2009 our voices were heard and a plan developed in 2011.

35. Haiti

Title of the programme:

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Programme is being implemented since: 2009

Implemented by: Civil Society

Scope of submission: Access to HIV prevention, care and treatment, Protection issues, equity and human rights: Community resilience, Inter-agency coordination, Effects of emergencies on key populations, Early recovery and development, Situations of fragility, Urban contexts

Has the programme been evaluated /assessed? Yes

Is the programme part of the national AIDS plan? No

Is the programme part of a national emergency response plan? No

Background:

Prior to the earthquake in Port-au-Prince on January 12, 2010, an effective partnership was progressing to deliver appropriate health care with the harsh and inhospitable environments of Haitian prisons. The primary intervention focused on the Prison Civile of Port-au-Prince, the largest penitentiary in Haiti within the urban center. The prison held 4,215 adult male prisoners in a space initially originally intended for no more than 800. Health through Walls (HtW), an international nongovernmental organization dedicated to prisoner health, joined local health organization GHESKIO, the United Nations Department of Peace Keeping Operations (UNDPKO), and the Haitian Ministry of Health in a Memorandum of Understanding through the Office of Prime Minister to deliver HIV care, treatment and prevention for prisoners. In July 2009, a peer education program began in the prison with support from UNAIDS. This was followed by voluntary HIV testing, care and treatment for the first time in the history of the Haitian prison. With support from USAID, a comprehensive program of HIV services for HIV infected prisoners had begun.

It was within this context that the earthquake struck. Significant damage was caused, several fires erupted, and all of the prisoners fled. They took with them all of their health problems, including partially treated infectious diseases such as 50 with active tuberculosis and 84 newly identified HIV infections. HIV infection in the prison had been identified at rates 2-3 fold higher than the community, a common finding among prisoners throughout the world.

Approach:

Recovery for any nation following conflict or national disaster requires security and rule of law. This necessarily involves systems of law enforcement, the administration of justice, and detention facilities. Relief agencies poured into Haiti following the earthquake, but reticence existed with the knowledge that more than 4,000 prisoners were on the loose. Pressure mounted to rebuild and reopen the prison. A stable prison system also depends on respect for the human rights of the accused and the condemned, and this necessarily includes meeting their health needs. Support for prison reconstruction and resumption of health care activities came from multiple sources: NGO's, such as HtW; international agencies such as the International Committee of the Red Cross (ICRC), UNDPKO, UNAIDS, American Correctional Association and International Corrections and Prisons Association; and international donors such as USAID, Canadian Aid and US International Narcotics and Law Enforcement. Within one month of the earthquake, the prison doors were reopened and the prison population began to grow.

For HtW, the program design focused on re-establishing the comprehensive HIV prevention, care and treatment program. This also set the framework to address other infectious disease and medical needs. The key elements within the prison included:

- 1) Safe and secure work and living environment
- 2) Adequate nutrition and clean water
- 3) Sanitation and hygiene
- 4) Disease and prevention education, including reduction of stigma, utilizing prisoners as peer educators
- 5) Training of medical staff and correctional officers
- 6) Rebuild infrastructure including equipment and supplies
- 7) Medical records for prisoners
- 8) Pharmaceutical supply chain
- 9) Laboratory infrastructure
- 10) Systematic disease screening of all prisoners
- 11) Clinical visits
- 12) Case management
- 13) Discharge planning
- 14) Outreach to families and sexual partners of HIV infected prisoners

Reach of the intervention:

Through the varied interventions of multiple partners, relief efforts following the earthquake achieved:

- Access to HIV prevention, care and treatment for prisoners through programming
- Recognition that human rights of prisoners includes meeting health needs
- Dependence upon the resilience of the Haitian people to carry on
- Bringing together multiple partners
- Advocacy and focus on prisoners, while majority of attention and resources were

elsewhere

- Persistence despite a fragile and sometime insecure environment
- Concentration of needs and resources within the urban context

Impact of the intervention:

After the infrastructure was rebuilt and foundation re-established, the comprehensive program continued to identify and meet the needs of prisoners with HIV infection. In 2014, for example, four years after the earthquake, the program provided HIV testing to 9,030 Haitian prisoners across 18 prisons, newly identifying 571 (6.3%) with HIV infection, and connecting all to care and treatment. Whereas HIV (confirmed and suspected) was the leading cause of death for prisoners just 6 years earlier, mortality from HIV became nearly non-existent.

Challenges faced:

While finding and detaining former prisoners and new criminals was the priority of law enforcement, establishing a safe, humane environment respectful of human rights including health needs was not a priority. It was through the advocacy and action by groups such as HtW and ICRC that resources and actions came together. Support and funding from United Nations and donor countries and agencies, particularly USAID, made the critical difference. Recognition that health needs of prisoners, particularly control of infectious diseases, impacts the community health, convinced many agencies of the importance of attention to this vulnerable population.

Financing and management:

Presently, the intervention is overseen by the Haitian Prison Authority which provides guidance and authorizations for all partners. The primary steward of HIV prevention, care and treatment is the NGO, Health through Walls. Majority funding is provided from USAID, with additional support from the Gilead Foundation, Elton John AIDS Foundation, and AIDS Healthcare Foundation. There is a paucity of donors agreeable to fund prison-based interventions despite the higher prevalence of HIV infection and opportunities for success within the closed environment. Attention to human rights and infectious disease control for otherwise hard-to-reach or vulnerable population prompts some responsiveness to funding.

Lessons learned and recommendations: What factors helped success of the intervention, including institutional set-up, legislative and policy environment, coordination, political mobilisation and support, advocacy?

- 1) Community development and stability following natural disaster, post-conflict crisis or other emergencies cannot succeed with attention to the rule of law, which includes prisons.
- 2) A stable prison system requires attention to human rights and delivery of adequate health care.
- 3) Collaboration by both local and international agencies bring needed resources and results. These should be coordinated by the local authority.

4) Control of infectious disease, including HIV, cannot succeed without attention to the needs of prisoners.

36. Mexico

Title of the programme: Sexual Health Research: HIV, HPV and STI in lesbian, bisexual women and women who have sex with women.

CONTACT PERSON

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Programme is being implemented since: 2011

Implemented by: Civil Society

Scope of submission: Protection issues, equity and human rights, Urban contexts

Has the programme been evaluated /assessed? No

Is the programme part of the national AIDS plan? No

Is the programme part of a national emergency response plan? No

Background:

Today humanity faces a reality, sexual transmitted infections can hardly be eradicated from the body of a person, that's why prevention efforts have been fundamental to withstand the onslaught that has claimed lives for three decades and affected the quality of people's life. This project is an effort that becomes necessary, to strengthen policies already implemented to promote prevention and social structural changes required to reduce, not only the transmission, but the discrimination that many people have suffered as a result of the existing stigma toward this population.

One group that has faced this reality are women living discrimination based on sexual orientation in different areas, such as health field, in which they are invisible for services and, therefore, needs are not met specific to their sexuality derived.

Global statistics published by UNAIDS, updated until September 2013, indicate that of the total population living with HIV, 50% are women, this is closely related to violence, education, poverty and gender differences. In Mexico, the National Center for the Prevention and Control of HIV and AIDS (CENSIDA) has reported 166, 370 AIDS cases, of which 29,800 are women, i.e. 17.9%. The age groups most affected are: 25-29 and 30-34 years.



The work against discrimination based on sexual orientation of no heterosexual women, is our reason for existence. According to our experience the issue of HIV and AIDS; it is a situation that is not only related to sexual practices; but combines age, race, poverty, discrimination, violence, etc.

That is why, from our organization, we seek to make visible to bisexual women, lesbians and women who have sex with women, for them to be taken into account in the actions taken by government agencies responsible for prevention, diagnosis and treatment, required necessary to reduce the damage and prevent these women are out of the services offered to other populations.

Finally in 2014 the letter titled *Lesbian, Bisexual women and HIV: Reflections from young women*, developed by Ximena Elizabeth Batista Ordaz and Josefina Araceli Valencia Toledano, won the prize in "Best practices and innovative approaches on gender, young women and HIV in Latin America" narrative category, UNAIDS.

Approach:

For over 20 years, our organization, *Closet de Sor Juana AC*, has focused its efforts in promoting and defending the rights of lesbians. Mainly has directed its work to the visibility and strengthening lesbian leadership in Mexico and Latin America.

Our organization, considers that the issue of HIV should be approached from a broad view of sexuality, taking into account the variety of factors, looking contexts and situations that violate the rights of certain population groups, we consider there are a lot of issues that are not being addressed within the health spaces. That's the reason we have been developing, since 2011, a research on sexual health, HIV and sexual practices of lesbians, bisexual women and women who have sex with women. Between our findings are that: the risk perception on this population is very low in terms of STIs, also found that regardless of the route of HIV transmission-positive lesbians exist, and they are not taken into account in the policies of prevention, diagnosis and treatment of HIV. Another of findings was that, due to the lack of risk perception, this group of women has faced no specific prevention policies in relation to transmission of human papillomavirus (HPV) diseases as a transmission quiet but able to affect the lives of all sexual. This situation requires careful and specific look practices to prevent transmission due to ignorance and lack of information.

The intention to share our research experience is to point out how little information exists on this matter; point to studies that combine qualitative with quantitative; and rescue proven experience in these matters.

Position the subject, as an invitation for civil society organizations involved in research, making interdisciplinary studies, on and from young women, working with people with different experiences in the field and dissemination of results, in a language and context-appropriate media.

Reach of the intervention:

Crosscutting issues that accompany the design and analysis are the focus on sexuality,

feminism, gender and human rights approach.

From documentary research, in the year 2011, a pilot questionnaire to collect quantitative data was developed; after that, the questionnaire was evaluated, corrected and supplemented, in 2013, a second data collection took place in Mexico City between March and July with the new version. The geographic areas selected for recover data collection were "meeting places" whose characteristic is that spaces are attended by lesbian and bisexual women recreationally, these are areas of the city with bars and gay nightclubs, the main area is *Zona Rosa* which is located in the center of the City, besides these data were collected in demonstrations for sexual diversity as in the case of "Lesbian March" and "The Gay Pride Parade" and in the vicinity of a Lesbian Festival.

The references used for the design of this instrument are framed in women's issues, sexual and reproductive health, identity, lesbians and bisexuals in relation to HIV. From this review we found that the intersectionality of these axes gives us the opportunity to build an investigation that includes, for the analysis and processing of data, the following themes:

- Violence: Gender and partner.
- Discrimination: schools, family, work, health services, among others.
- Sexual life: history, sexual practices and couples.
- Sexual and reproductive health: access, use of health services and risk perception.
- Maternity and abortion.
- Health and drug use: blood transfusions, use of piercings, tattoos and levels of consumption of alcohol, tobacco and other drugs.

These themes were incorporated at instrument for the recovery of quantitative data in the following sections.

- General data.
- Discrimination.
- Social Organization.
- Violence.
- Couple relationships.
- Life and sexual practices.
- Health.
- Maternity and abortion.

The application and data collection took place in the Mexico City; with this we establish contact with 211 lesbians and bisexual women.

Regarding the population group addressed: lesbian and bisexual, mainly young women. It is noteworthy that the categories named sexual orientations are useful for identifying and delineating specific characteristics, it is important to note that this study is not limited to only explore sex practices between women, but tries to include counseling sexual as a feature which, along with other factors, combine to present a complex picture in which it is possible to identify risks and transmission routes regarding this population beyond contact and sexual practices.

Impact of the intervention:

We consider really important the story about our experience in the process of applying the



instrument for collecting quantitative data, and we think we can combine it with the analysis of some of the obtained results.

The sample obtained so far is 211 women from Mexico City and metropolitan area surveyed between March and July 2013 whose average age is 25 years. It is noteworthy that there is a difficulty in obtaining a representative sample because we have no figures on women who have sex with other women and / or who are assumed to be lesbian or bisexual.

Using the results we are able to re-emphasize the importance of demystifying these women have relationships with other women only.

We found that 66% of women interviewed considered their self as lesbian, 26% bisexual, heterosexual 4% and 4% with another identity. Some heterosexual women reported sexual activity with other women, while another over these contradictions, 57% of women surveyed report having had sex with a man or men. Of the entire sample, the average of male sexual partners was 4, when only 30% identified themselves as bisexual or heterosexual.

In relation to other explored factors, as health, we introduced during the process a reflection Group to talk about vaginal infections because we noticed a considerable number of women who didn't identify it. Now, to get the results we know that 41% say they have had a yeast infection at least once, which continues to surprise us and makes us suspect that the low risk perception and poor information leads to these women not identify infection on their medical history, but this is still a hypothesis that cannot be verified.

From the analysis of some of the recovered data with quantitative instrument and the expansion of the literature reviewed during 2014, the organization managed to launch a project to train and sensitize both, lesbian and bisexual women. These trainings were conducted in nine states (10 cities: León, Xalapa, Toluca, Cuernavaca, Querétaro, Puebla, Mexico City, San Miguel de Allende, Hidalgo and Naucalpan) from the center of the country. Participants replied the information in their localities. In each of the replicated entities were trained average groups of 10 lesbian and bisexual women. The content of workshops involving issues related to the transmission and prevention of HIV, HPV and other STIs among lesbians, bisexual women and women who have sex with women. This strategy was accompanied with promotional materials designed by the organization, materials for these women and materials aimed at health personnel for their awareness.

Challenges faced:

Because of the stigma and discrimination lesbians and bisexual women are not among the priorities of care and prevention driven by public policy of the country or regional and international agencies involved in the response. This is certainly the result of a complex system in which lesbians are in disadvantage.

There are structural aspects such as misogyny that encourages discrimination and violence against lesbians reflected in the lack of information available on lesbian, bisexual women and women who have sex with women in their relation with HIV and other STI's.

In our country, according to the latest registration which is displeasing transmission routes with information on women (2012) indicates that the main routes of transmission are: Perinatal 6%,



people who inject drugs 1%, blood transfusion 6% and 87% through sexual contact.

Within these statistics, lesbians and bisexual women have been left blurred, because it has reduced to the study of anal and vaginal transmission, with sex between women rarely studied also traditionally been considered that the sexual life of lesbians is reduced to interaction with other lesbians when the recovered data make it clear that the diversity of practices exist and do not necessarily define an identity.

Although in men has come to establish criteria for MSM as a category that identifies an important route of HIV transmission, the criterion of WSW in Mexico has been little considered, endangering women with these practices and is hardly, in 2013 the National Center for the Prevention and Control of HIV and AIDS (CENSIDA) included in its public call for implementation of strategies combination prevention to strengthen the response to HIV and AIDS 2013, the category of ML (Lesbians) and MB (Bisexual Women). However, in 2015 they closed this category.

The invisibility of a population is a factor that limits the knowledge about the real situation of risk and vulnerability, in this case, the health situation of lesbians and bisexual women, who are not covered within public policies that comprise the State's response Mexican against HIV, AIDS and other STI's.

Another challenge we face frequently during the execution of projects within research on HIV and lesbian and bisexual women is the difficulty that many of these women have to assume their sexual orientation publicly, i.e., not all are willing to identified themselves as lesbian, or bisexual, or as women having sex with women, although in itself have related practices; this makes both data recovery and systematization and analysis thereof.

Financing and management:

The research project was conducted with national public funds, that is, in our country, the government invites civil society organizations to participate in calls for obtaining resources; we as an organization have obtained funding from some of these sources, the first instance that supported the initiative in 2013 was the General Directorate for Social Equality and Diversity, that instance is local (Mexico City) and supports organizations in Social Co-investment program, i.e. contributes part of financial resource while the organization provides another (financial resources, human and / or material). The amount approved for this project was \$ 8,000. Subsequently, in 2014 we were supported by the National Center for the Prevention and Control of HIV and AIDS (CENSIDA) in the amount of \$ 38,000.

The main challenges we have faced in the management of resources are diverse but most respond to lesbians, bisexual women and women who have sex with women; due to previously mentioned factors do not constitute a priority population for financing prevention and care. The targets for the treatment of HIV and other STIs derived from the recommendations made by international bodies do not necessarily provide for lesbians and bisexual women as a vulnerable population, this has to do with the prevalence rates and also with the manifest inequality between men and women.

Those involved in the design, coordination and implementation of project and resource management are young women collaborating organization, Josefina Araceli Valencia Toledano,



Erandi Serrano Avendaño and Ximena Elizabeth Batista Ordaz whose training is different social sciences area and with specializations in gender, sexuality and human rights.

Lessons learned and recommendations:

One element that has allowed the development of this research is the fact of having a public call by the National Center for the Prevention and Control of HIV and AIDS (CENSIDA) involving lesbians and bisexual women as one of its working population, now this specific area of work is closed and we are aware of what is going to happen with these efforts to include lesbian and bisexual women in the HIV response.

The research process has allowed us to reflect on the importance of the gender perspective and human rights of the youth, as in the statistics we can see that in the cases identified, there is a high prevalence of HIV and AIDS in women young, so, keep watching this from an intersectional approach gives us elements for the development of public policies to rights, so we consider vital that exist:

- Prevention programs for HIV and STIs and healthcare, primarily gynecological, lesbian and bisexual women, since so far no efforts by the Mexican government to alert the lesbian and bisexual people about the risks they face and the measures they can take to avoid any sexually transmitted diseases.
- Protocols gynecological care for lesbians and bisexual women within health services, because so far only from civil society have made efforts to promote the work on this line.
- Research on sexuality, sexual life, sexually transmitted infections and other relevant aspects of the lives of lesbian and bisexual women because we believe that the invisibility is paid to do so and, therefore, difficult coexistence through diversity, and the lack of information that contributes to the provision of specialized services.
- Laws protecting women's rights, specifically the rights of lesbians and bisexual women, and, among other rights, permit assisted human reproduction in women and lesbian and bisexual couples without discrimination; it is the desire of the other maternity aspects that relate to the risks of acquiring HIV.
- The elimination of all forms of violence and discrimination against women, because they hinder the exercise of their rights.

V. Multiple Countries

37. Argentina, Chile, Paraguay, Bolivia, Peru, Colombia, Panama, Costa Rica, Nicaragua, Dominican Republic, El Salvador, Guatemala, Honduras.

Title of the programme: Latin American And Caribbean Female Sex Workers, Working To Create Alternatives For Decreasing Their Vulnerability To HIV: A Regional Strategy To Achieve A Real Impact

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Programme is being implemented since: 2012

Implemented by: Civil Society

Scope of submission: Protection issues, equity and human rights, Situations of fragility, Innovative funding strategies

Has the programme been evaluated /assessed? No

Is the programme part of the national AIDS plan? No

Is the programme part of a national emergency response plan? No

Background:

Female Sex Workers belong to one of the groups most affected by HIV. At the same time, is an historically forgotten population by public policies for prevention and treatment. Female Sex Workers (FSW) have elements of high vulnerability towards HIV, as a result of their social and cultural conditions, their limited access to health services (related to the stigma and discrimination they suffer), and their labour conditions.

Our initiative is meant to generate improvements in the access to treatments, the definition of policies and the reduction of stigma and discrimination.

RedTraSex was founded in 1997 with the objective of strengthening National Organizations of



Female Sex Workers in order to defend and promote our Human rights. Present in 13 countries of Latin America and Hispanic Caribbean —Argentina, Bolivia, Chile, Colombia, Costa Rica, El Salvador, Guatemala, Honduras, Nicaragua, Panama, Paraguay, Peru and Dominican Republic— our proposal has a regional approach which impacts on the sex workers' organizations and leaders. Under the slogan "Sex workers are not the problem, but part of the solution" we contribute to the joint effort to fight the HIV pandemic, with a specific vision: we believe that having a comprehensive health outlook (physical plus mental) is the best way to stop the virus transmission and to consolidate the empowerment of our members. Prevention should not be reduced to handing out condoms in the scope of a campaign. We should demonstrate that we are human beings entitled to rights, which we must demand. For this reason, we encourage the training and strengthening of local and regional Organizations. We want our voice to be heard in spaces where public policies referred to our group are decided. This means that, at the end of the project, our sex workers will be trained regarding human rights, comprehensive health, gender, advocacy and organizational strengthening. Such work will be multiplied by other sex workers. Our contribution is to put Female Sex Workers and the defense of their rights on an outstanding position. Having implemented this for many years, at present we can rely on stronger organizations, with leaders who are in direct contact with the founders. From our place we add to the fight against HIV, renewing our efforts to continue.

Approach:

One of the goals of our regional strategy is: Raising awareness about the situation of sex work and HIV, and the fight against the social stigma and discrimination.

We address the problem of HIV/AIDS by proposing a comprehensive health care approach. We fight against HIV/AIDS, which affects the community of sex workers, as we understand the situations we go through and the role we play as an organization that protects and advocates for our rights. In that sense, we are leaders in our projects as we know about our needs better than anyone else and we can look then for more adequate responses. An example of this is our perception on HIV/AIDS, which affects us so closely. We work very hard on the symbolic dimension of this problem.

Our strategy aims to contribute to the reduction of HIV in the population of female sex workers in the region. For this reason, we have the intention of strengthening the abilities of the organizations within our network in order to implement programs, design policies and revise legal frameworks involving female sex workers, thus reducing our vulnerability to HIV nationally and regionally. In the countries where RedTraSex is present our partners join the national programs on HIV and they have an active participation on the initiatives and projects of those programs.

Another very strong strategy of RedTraSex is linked to the health system of Latin American countries. We work to change the perception that health professionals have on sex work as a way to ensure the access of sex workers to appropriate prevention strategies, tests and treatments.

The core of our strategy is the training of our members and the strengthening of their political capacities. During this proposal, we have conducted regional, sub regional and national training workshops, as well as a regional online training program on HIV and other organizational issues.

Reach of the intervention:

We encourage the training and strengthening of local organizations. RedTraSex has presence



in fifteen Latin American countries; thirteen of them are already working in this regional proposal. At the end of the regional project, sex workers leaders from all of our countries will be trained regarding human rights, comprehensive health, gender, advocacy and organizational strengthening. Such work will be multiplied by other sex workers. In 2013 RedTraSex reported more than 17000 FSW reached for the first time, and more than 8000 in 2014. Our contribution is to put Female Sex Workers and the defense of their rights in an outstanding position. In the health sector, we have reached more than 2500 professionals through sensitive activities conducted by our members. In 2014, our national organizations signed agreements with 22 health centres to work according to the good practices RedTraSex is disseminating. The aim of this material is to raise awareness among the interdisciplinary health care teams in order to guarantee an integral care and a response to our specific needs.

Impact of the intervention:

Having implemented our programme for many years, at present we can rely on stronger organizations, with leaders who are in direct contact with decision makers, founders and opinion formers. Our partners in fifteen countries in Latin America are empowered female sex workers who have been trained to reach more women in order to prevent AIDS through the sharing of knowledge and information.

Challenges faced:

At first, worked with small organizations with weak structures or even without any structure at all. Building technical teams and skills has been a strong challenge for RedTrasex. These difficulties were overcome with a big effort on training and by building handbooks, guides and other documents that constitute RedTraSex's background and even will remain as a reference after this intervention.

Financing and management:

Our intervention is financed by the Global Fund to fight AIDS, Tuberculosis and Malaria, since 2012. The management and coordination of activities and its planning belongs to RedTrasex.

Lessons learned and recommendations:

The reach of the interventions was favoured by the strong track records of RedTraSex in working with national and international organisms and governments on the needs of female sex workers. Undoubtedly, this experience set up the road to a regional strategy to fight AIDS from a comprehensive and integral approach.

38. Cameroon, Chad, DRC

Title of the programme: Incorporating support to HIV-affected families within the humanitarian crisis in the Central African Republic, Cameroun and Chad

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Programme is being implemented since: 2013

Implemented by: UN or other intergovernmental organisation

Scope of submission: Access to HIV prevention, care and treatment, Community resilience, Inter-agency coordination

Has the programme been evaluated /assessed? Yes

Is the programme part of the national AIDS plan? Yes

Is the programme part of a national emergency response plan? No

Background:

In 2013, an estimated 120,000 [110,000–130,000] people were living with HIV (PLHIV) in Central African Republic (C.A.R.), approximately 60,000 of whom are women (15 years of age and older) and 17,000 of whom are children (0–15 years of age). The HIV prevalence is estimated at 4.9 percent, with a higher prevalence among women (6.3 percent) and a mother-



to-child transmission rate of 12 percent. The latest crisis which began in 2012 disrupted the entire health-care system and basic services are completely absent in many locations. Thirty percent of the general population (1.4 million people) is experiencing moderate or severe food insecurity. Global acute malnutrition varies from 8.0 percent in Bamingi Bangoran to 3.3 percent in Mambere Kadei while in Bangui the rate is 5.7 percent (SMART 2014).

The crisis in C.A.R. caused 436,256 people to become internally displaced. Approximately 245,821 refugees crossed the border and are living in Cameroon, and another 94,024 in Chad. Between 2013 and 2014, treatment/health centres in the Eastern Region of Cameroon reported a 35 percent increase in HIV cases in the camps/host communities due to the influx of refugees from C.A.R.. The United Nations agencies under the lead of the JURTA are implementing HIV-specific programmes to respond to the needs of the most vulnerable in C.A.R. and surrounding countries. HIV prevention, treatment, care and support services are provided to refugees in camps as well as to host communities.

WFP's ongoing provision of enriched food rations to HIV-infected and affected populations in C.A.R. started in 2003. Similarly nutritional support to most vulnerable to HIV people has been distributed in Cameroon since 2013, in order to improve treatment adherence while food assistance to households and care providers reduces the burden of HIV as well as food and nutrition insecurity. In 2014, in Cameroon, approximately 33,200 food-insecure and HIV-affected internally displaced households in the Northern regions as well as refugees (including PLHIV) benefited from WFP's nutritional support.

In parallel to WFP's activities, UNICEF has been working on providing support to pregnant women living with HIV in Bangui's displaced camps using associations of women living with HIV, and on developing activities around testing for HIV children with severe acute malnutrition (SAM) particularly in returnee camps in Chad and Cameroon.

Approach:

C.A.R.: Efforts are being made to extend the Food by Prescription (FbP) project to 12 new prefectures in C.A.R. to respond to the increasing number of malnourished PLHIV. An additional 33 support providers were trained in order to expand the programme.

UNICEF has been actively providing support to pregnant women living with HIV and women living with HIV who had recently given birth in priority displaced sites in Bangui. The project was conducted from December 2013 to March 2014 by ANJFAS (*Association Nationale des Jeunes Femmes Actives pour la Solidarité, former Congrès National des Jeunes Femmes VIH+*). The objectives aimed to: identify and refer children living with HIV and pregnant women living with HIV for PMTCT, identify babies of HIV-positive women born during the crisis and provide treatment; identify young women who might have been victims of sexual violence and provide services, as well as provision of support to any PLHIV with accessing the right services.

Cameroon and Chad: In the four priority regions of Cameroon (East, Adamaoua, North and Far North), PMTCT activities were integrated into treatment of acute malnutrition and were supported by WFP and UNICEF. The HIV-sensitive initiative significantly contributed to increasing prenatal care and support services, and contributes to the elimination of new HIV infections among children by 2015 and keeping their mothers alive. Moreover, the food assistance provided in the period following general food distributions saved lives of the food-insecure refugees, female- and male-headed households, PLHIV and host communities in all C.A.R.+ countries. Despite the absence of an HIV-specific intervention in Chad, WFP assists the most vulnerable households as well as C.A.R. refugees through general food distribution or cash and voucher transfers, targeting areas with registered high HIV prevalence rates (Kanem, 3.5 percent and Logone oriental and occidental, 6.4 percent).



In returnee camps in Cameroon and Chad, UNICEF has been scaling up its interventions: PMTCT (integrated in Antenatal Care services of the camps), pediatric care and identification of PLHIV who were under treatment in C.A.R. in order to support their re-initiation on treatment. In Chad, the regions where most returnees settled down (South) are priority regions for UNICEF HIV activities, which meant that the response built upon existing drugs availability and health practices. In Cameroon, an HIV task force was set up at provincial level to address HIV-related coordination issues with support from UNICEF Côte d'Ivoire country office; health care providers were trained; children with SAM and pregnant women were systematically tested for HIV and cared for when found HIV-positive; peer-support groups were put in place. In both countries, there are efforts to address HIV within child-friendly spaces set up in the camps.

Reach of the intervention:

Access to HIV prevention, treatment and care: Food for clients and affected households improves access to HIV care and support, develops community resilience by sustaining livelihoods and increases ART adherence. Active identification of children and pregnant women living with HIV and the setting up of peer support groups increase prevention of HIV transmission, access to treatment and improved continuum of care.

Community Resilience: The assistance is mainly focusing on C.A.R. refugees, internally displaced persons (IDPs) and women who are particularly, especially female-headed households who generally have high dependency ratios and child rearing responsibilities. 11.4 percent of beneficiaries of the FbP project in Cameroon were directed to PMTCT services. In addition, WFP continue implementing HIV-sensitive maternal and child health nutrition (MCHN) activities for the treatment of MAM in four priority regions in Cameroon. More than 77,335 children under 5 and 44,200 pregnant and lactating women were assisted.

Inter-agency cooperation: Under the lead of the JURTA, a joint mission is planned for June 2015 to further increase the collaboration efforts among agencies.

Impact of the intervention:

In 2014, Cameroon reported a 76 percent ART adherence rate, assisted by nutritional support to PLHIV. Similarly, the FbP evaluation report noted an increase in the active file of clients living with HIV and nutritional rehabilitation of malnourished PLHIV. WFP contracted a community-based organization (*Association d'Assistance au Développement – ASAD*) to support the monitoring and evaluation of nutritional care interventions and used community volunteers for case finding and follow up of activities.

In C.A.R., the exact figures of identified pregnant women and children living with HIV are not yet available. However, the project aimed at identifying 150 pregnant women living with HIV in displaced camps, 200 children living with HIV previously on treatment and 500 newborns of women living with HIV. In addition to the work conducted in displaced camps, 81 PMTCT sites were reactivated (against the initial 106 health sites), 35,000 pregnant women were tested for HIV, and 510,000 adolescents were provided with HIV counselling and testing in Bangui and Bossangoa. Medical and nutritional support was provided in all the active PMTCT centers. The numbers of pregnant women and children supported in Chad and Cameroon are not yet available.

Challenges faced:

The FbP evaluation found that clients often share their food rations; they are difficult to reach; pipeline breaks occur frequently and field workers are lacking motivation to ensure a proper follow-up of activities. WFP plans to adopt a door-to-door strategy to avoid sharing practices. WFP will be monitoring the warehouses more regularly to prevent shortages. Another constraint is the inadequate operational capacity of partners at the onset of the emergency to handle a large influx of refugees. Aligning programming with contextual realities and to improve the understanding of possible sale of food assistance and non-food items need to be further researched in terms of inter-community social and economic relations. Other support needs include mobilization of additional resources and to look into the impact of high insecurity on the delivery of health, nutrition, protection services, etc. WFP will continue its advocacy among donors to promote the use of humanitarian convoys to support the supply-chain management of needs.

For UNICEF in C.A.R., the volatile situation and constant insecurity meant that access to displaced camps remained challenging. The constant movements of families complicated also the identification of those lost-to-follow up. Addressing pediatric care in Chad (especially with regards to testing children with SAM and babies born of HIV-positive women) remained difficult because of the limited existing interventions around HIV pediatric care. Gender and sexual related issues were also raised as key challenges to be addressed in community-based activities, especially since sexual violence had been widespread in C.A.R.. The same observation was made in returnee camps in Cameroon, where adolescent girls had been identified as being particularly vulnerable.

Financing and management:

The intervention in C.A.R. is mostly funded through the UBRAF allocation and CERF funding. WFP is negotiating with IFRC an extension to the sub-recipient agreement under the Global Fund.

Lessons learned and recommendations:

To address the operational and country-level coordination challenges and improve the lives of HIV-affected individuals, care providers, displaced people/refugees and host communities, the JURTA sub-group on HIV in emergencies agreed on conducting a joint advocacy mission to C.A.R. in June 2015. A coordinated change in current approaches followed by United Nations country teams, host States, donors and implementing partners is critical. In line with the above and based on field experiences, the sub-group included in its 2015–2016 work plan a consolidation of activities and HIV-related information. The objective is to establish which data needs to become available and those to be shared for joint programming. An analysis report and a fact-sheet for advocacy purposes will be disseminated by December 2016. The members also seek to reactivate the C.A.R. task force platform.

The FbP evaluation showed that the food assistance project contributed to the nutritional recuperation of patients under ART, increase the active file and reduce the defaulter rate. In 2015, WFP will continue the implementation of the projects in both C.A.R. and Cameroon leading to scale-up efforts in the future.

39. Cameroon, Chad, Congo, Democratic Republic of Congo (DRC)



Title of the programme: Ensuring and monitoring continuity of treatment of Central African Republic refugees in Cameroun, Chad, Democratic Republic of Congo and Congo

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Programme is being implemented since: December 2012 for the first refugees, and as soon as the others arrived after that date

Implemented by: Government, Civil Society

Scope of submission: Access to HIV prevention, care and treatment

Has the programme been evaluated /assessed? No

Is the programme part of the national AIDS plan? Yes, Access to ARV for refugees in part of the national policy in all countries

Is the programme part of a national emergency response plan? Yes, Access to ARV for refugees in part of the national policy in all countries

Background: Since December 2012 a military and political crisis in the Central African Republic (CAR) has caused a massive displacement of the population from which people living with HIV. Before the crisis, about 14 000 to 17 000 people living with HIV received antiretroviral therapy (ART). Due to the flaring conflict and continuous insecurity Central Africans left their home for more secured places within Central Africa and in neighbouring countries. By March 2015 there was 244'792 refugees in Cameroun; 94'306 in Chad; 90'851 in the Democratic Republic of Congo and 25'185 in Congo, one third of them leaving in 15 main camps.

Given the individual and public health impact of ART interruption, addressing continuity of treatment has been defined as a priority by too reference bodies, the Interagency Working group on Reproductive Health in Crisis (IAWG) and the Interagency Steering Committee (IASC). However fear of discrimination, lack of prioritisation by refugees and humanitarian worker, lack of ART pipelines in those remote areas and limited monitoring systems hamper continuity of treatment.

Approach:

- **Community awareness and passive case finding:** The purpose is to have people who were previously on ARVs to come forward. The community is informed during registration and gatherings (e.g.: distributions) about whom to contact if they have a known HIV positive status. They are reassured about confidentiality and reminded about the importance of treatment continuity.
- **Support to the national programme:** To ensure access to ART, the only possibility is to negotiate the decentralization of the national programme or support the extra needs linked to the additional caseload if it is already decentralised. ARVs need to be made available too rapidly to set up a comprehensive programme. The national programme is therefore supported to organise drug supply and dispensing as a first and immediate step. As a second step UNHCR supports the provision of the full package including the set-up of a sustainable supplies chain.

- **Monitoring:** Data is recorded in UNHCR HIS however it is not enough for decision making. A simple table is filled which highlights the proportions of pre-ART, first line, second line and PMTCE for women and infants. Data is also segregated by age and sex.
- **Cross border data analysis:** It is important for CAR to know if they have a major problem of lost in follow-up. This is possible through the identification of each PLHIV by CAR health zone through their code. Either they have kept the anonymous card that was issued by the MOH and UNHCR at the onset of the crisis in CAR, or a new one is issued. Data is then shared with CAR.

Reach of the intervention:

Access to HIV prevention, care and treatment: There can be a long delay between the time a refugee arrives in the country of asylum and his request for ART. The strategy builds knowledge, trust and confidence necessary for patients to get their treatment. The detailed monitoring helps to understand if the target has been reach while supporting the home country into their search as well.

Impact of the intervention: 918 people in 15 camps in 4 countries have been identified and followed up. 534 receive first line ARV and 17 receive second line. In March 61 women and 55 infants were also on treatment as part of the PMTCT programme. As a large number of refugees arrived recently in new sites, more people are informed and the national programme is supported to expend even more.

On the longer term the analysis of number will steer some strategies (e.g.: there are 3 times more women than men who identified as leaving with HIV).

It will also have a positive effect on the local population as those remote areas could have waited many more years before seeing an HIV programme in their area.

Challenges faced:

- There is a risk that refugees could be blamed for HIV transmission particularly if there was never any programme before the refugees arrival. Awareness on HIV was raised rapidly in the local community too, through community stake-holders in particular.
- It is difficult for the health system in most places to absorb the new caseload or the new programme. It was acknowledged and dedicated and trained staff were supported in many places
- Confidentiality is difficult in a camp structure and in a plastic sheeting clinic, however it is essential. Private spaces could be identified quite easily (e.g.: last room of the structure behind the storage room)
- Access to drugs in areas where the nationals have no services raises equity and programmatic issues. However it was one more argument to motivate the national programme to decentralise with UNHCR support. The refugee situation becomes an opportunity for progress in the fight against AIDS.
- Emergency monitoring system do not include ART continuity. While full flesh HIS is promoted a separate simple system is put in place to record the number of cases. It is also use to evaluate the need for more active case finding according to prevalence in the areas of origin.
- Difficult logistic access to some parts of the country. Fortunately the volume of supplies being very small, any transport can be used, even outside the health system.

- Both national and international health partners do not think that this is a priority. A lot of discussions are necessary to explain the rationale of continuity of HIV treatment. When health partners realise that it is actually not so much work, they tend to agree.

Financing and management:

The intervention is managed with the national HIV programme and to some extent with the Global Funds to Fight AIDS, TB and malaria (GF). Although it was not necessary, the GF had even agreed to facilitate funding or items transfer from one country to the other. In all those countries most of the funding comes from the GF and correspond to the country capacity, so the problem is much more structural than financial.

Lessons learned and recommendations: What factors helped success of the intervention, including institutional set-up, legislative and policy environment, coordination, political mobilisation and support, advocacy?

- Communication with all partners was essential to gain their support when needed
- Refugees are integrated into national HIV programmes, so we can make it a reality.
- Referral Pathway for HIV Patients need to be designed and communicated.
- Refugees can be empowered, and need to be empowered at the onset of an emergency as human resources are scarce. It is essential for refugees to be safe and feel safe. Confidentiality and respect are essential. If provided word to mouth function positively.
- An extremely simple monitoring system enables to understand if the mobilization worked (if the number of expected cases compared to the number of cases who came forward is close; to improve the programme once the situation stabilizes. It also helps to understand the extent of lost in follow-up problem

40. Liberia and Sierra Leone

Title of the programme: Engaging women living with HIV as responders to the Ebola crisis

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Programme is being implemented since: Not yet implemented.

Implemented by: Civil Society

Scope of submission: Access to HIV prevention, care and treatment, Protection issues, equity and human rights, Preparedness and contingency planning, Community resilience, Effects of emergencies on key populations:

Has the programme been evaluated /assessed? No

Is the programme part of the national AIDS plan? No

Is the programme part of a national emergency response plan? No

Background:

West African countries in partnership with UN agencies have been waging an extraordinary effort to fight the unprecedented outbreak of Ebola. However, well-intentioned public health measures coupled with the significant impact of the Ebola crisis had unanticipated and potentially deadly impacts for people living with HIV, particularly women living with HIV. Women living with HIV from the International Community of Women Living with HIV's (ICW) networks in countries hardest hit by the Ebola outbreak have reported that measures taken in the name of public health severely restricted their safe access to essential anti-retroviral medications (ARVs). The challenges faced by people living with HIV in the Ebola crisis and particularly, challenges in securing timely, effective, directed interventions can now serve as an opportunity to call for a new narrative on the needs of women living with HIV in emergency contexts.

A recent UNDP report stated that “women have been disproportionately affected by the Ebola virus because they serve as family caregivers and health workers, take part in traditional practices and rituals, and trade across borders where they come into contact with many people.”⁷ Further, “maternal deaths have increased because of reduced antenatal and neonatal care” and women’s risk of sexual violence also increased. For women living with HIV, the crisis has been compounded by lack of access to essential medicines, care, and support services.

ICW members reported that they are no longer able to access treatment due to quarantines and restrictions in movement, drug shortages, and challenges caused by the centralization of drug distribution during the crisis. Women living with HIV not under quarantine must overcome extreme fear to go to health facilities and hospitals to access their ARVs, and those who made it to health facilities have been frequently turned away because the facilities have closed or do not have capacity. The restructuring of HIV clinics into Ebola clinics created additional problems for consistent access to medicines, care, and support.

In addition to lack of access to essential medicines, food and water shortages among quarantined residents create the potential for further humanitarian crisis and are particularly dangerous for people living with HIV who require adequate nutrition to help manage side effects from medications and to strengthen their immune systems to fight off opportunistic infections. Baby formula, a commodity used for preventing transmission of both Ebola and HIV through breastmilk, was reportedly in short supply.⁸

Women living with HIV also face forced disclosure of their HIV status in multiple contexts, including to food aid workers in order to ask for assistance in obtaining their medications and to security personnel at checkpoints, and in order to gain access to health facilities. Forced disclosure of HIV status deters people from accessing services and places women at increased risk of stigma, discrimination, and violence in their homes and communities. ICW members have reported a high level of stigma related to HIV status and a doubled level of stigma for those having survived Ebola or who are living with family who also have been exposed to Ebola.

Approach:

⁷ UN Mission for Ebola Emergency Response (UNMEER) Internal Situation Report

⁸ *In Sierra Leone, quarantines without food threaten Ebola response*, Amy Maxman, February 19, 2015 Available at <http://america.aljazeera.com/articles/2015/2/19/in-sierra-leone-quarantined-ebola-survivors.html>



ICW West Africa and ICW Global have identified a key strategy to respond to the crisis and its ongoing longer-term impacts that utilizes the unique power of existing networks of directly impacted women to provide direct services (including food and medicine distribution), psycho-social and peer support, and community sensitization and anti-stigma campaigns. Supporting the capacity of existing networks to identify and respond to crisis impacts on people living with HIV could bolster emergency response infrastructure.

Emergency responses should leverage existing regional and country networks of women living with HIV to respond directly to the needs of women living with HIV in Liberia and Sierra Leone. Existing networks possess community trust and deep knowledge and expertise about the needs of their communities—as such they are uniquely positioned to strengthen the community support system for people living with HIV within this crisis. With the support of governments, international agencies, and global health workers, grassroots networks can provide key insights and support to assess and survey the needs of people living with HIV in the hardest hit areas and to help coordinate a safe and feasible response in order to maintain services and access to essential medications for these individuals. Networks can also serve as an early warning system to raise overlooked concerns of people living with HIV in emergency contexts.

The key programmatic elements of engagement with networks would include:

- 1. Direct Services: Food and medicine distribution.**
 - a. Identification of gaps in services in their communities;
 - b. Provision of food and supplies to women living with HIV and their families under quarantine and where there is restricted movement;
 - c. Establish additional service delivery points and support for medicine collection and distribution.
- 2. Support Groups for women living with HIV:**
 - a. Strengthen support networks for women to address issues of access to ARVs and loss to follow-up;
 - b. Provide psycho-social support to members who are Ebola victims living with two diseases;
- 3. Community Sensitization:**
 - a. Hold community dialogues and other communication efforts including text message campaigns to sensitize community about Ebola and HIV stigma and reintegration in densely populated areas;
 - b. Media campaigns to address stigma of women living with HIV who are Ebola survivors, unite them with family members using mass media.

Reach of the intervention:

This project addresses in particular the disproportionate impact of the Ebola crisis on women living with HIV. The intervention aims to increase access to treatment, protect against human rights abuses and stigma and discrimination, increase preparedness, and strengthen community support networks among women, a key population within both the HIV and Ebola responses.

Impact of the intervention:

The overall objective of this programme sought to ensure the survival of people living with HIV, in light of the impacts of the Ebola crisis and benefit impacted communities and families by recognising the potential and building the capacity of networks of women living with HIV to meet



the needs of their network members and families within both the HIV and Ebola response in two countries, Liberia and Sierra Leone.

Engagement of networks of people living with HIV would result in an increase in targeted service delivery including food and medicine distribution and support groups. These activities will help to strengthen health systems by supporting the restoration and strengthening of HIV service delivery and positioning specific services critical to women living with HIV, including TB and PMTCT care, within recovery plans. Additionally engagement with networks will result in improved contact tracing for communities of people living with HIV who are exposed to Ebola, and engage women living with HIV as advocates reducing loss to follow-up and providing feedback into the community. This project will result in joint benefit for not only the HIV response, but also broader health gains within the Ebola response. The concept could serve as a model for preparedness for future such crises.

Challenges faced:

Given the unprecedented impact of the Ebola crisis within an already weak health infrastructure and under-resourced response, it was a challenge to gain recognition for the intersectional impacts being experienced by people living with HIV and to secure needed resources for specific and targeted interventions for women living with HIV. Efforts of women living with HIV on the ground to create awareness of the specific challenges faced by people living with HIV and to respond to the needs of their members were hampered by a lack of resources. Responses to our efforts on the ground have been understandably piecemeal and this intervention did not receive much traction until the peak of the crisis had passed.

The Ebola crisis, however, is not over and additional outbreaks are possible. The devastation wreaked by the outbreak will continue to have long-term impacts, particularly on marginalized communities. This intervention aims to continue to improve the on-going Ebola response for these marginalized communities while addressing potential continuing impacts, such as stigma and discrimination, and the inclusion of women living with HIV in efforts to rebuild health and community support structures.

The global and national level responses to the Ebola crisis have revealed key gaps and in particular, a deficit in preparedness for the intersectional impacts of crises on people living with HIV. The challenges in the response to the Ebola crisis provide a rich opportunity to explore the need to strengthen linkages between the HIV response and global emergency response mechanisms and key strategies to secure improved supports for people living with HIV in emergency contexts.

Financing and management:

This project is currently seeking funding to respond to the longer-term impacts of as of today this is a missed opportunity within the Ebola response. Key developers of this proposed intervention included: ICW West African Region (ICW WA) and its partner networks Women's Empowerment Network (WEN) in Liberia, which holds a membership of over 3500 women living with HIV, and Voice of Women (VOW) in Sierra Leone, which has a membership base of over 2200 women and young girls living with HIV and about 1600 children.

Lessons learned and recommendations:



The needs of people living with HIV must be anticipated in emergency responses including to serious health crises such as Ebola. Additionally, we recommend that particular attention be paid to increasing the capacity for existing infrastructure of support groups and other networks of people living with HIV who already engage deeply within communities and who are positioned to engage in emergency situations.

41. Afghanistan, Pakistan, Iran

Title of the programme: Provision of Comprehensive Harm Reduction Services to Afghan Refugees in Iran and Pakistan to Returnees in Afghanistan

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Programme is being implemented since: 2009 - ongoing

Implemented by: Government, Civil society, UN or other inter-governmental organisation

Scope of submission: Access to HIV prevention, care and treatment, Protection issues, equity and human rights

Community resilience, Inter-agency coordination, Urban contexts

Has the programme been evaluated /assessed? No



Is the programme part of the national AIDS plan? Yes, Included in the NAP of Afghanistan and Iran. In Pakistan refugees are included in the Provincial AIDS Strategy of Baluchistan only (no national strategy existed as of 2014 due to devolution).

Is the programme part of a national emergency response plan? No

Background:

Thirty years of protracted war and civil unrest made Afghanistan, a country of 29 million people, fall to 181, out of 182 countries, in terms of the Human Development Indicators and to be classified as among one of the poorest nations in the world⁹. Mass outward migration and displacement due to conflict as well as lack of income-generating opportunities resulted in high mobility of populations, including significant exodus to urban areas and long-term migration to Pakistan, Iran, and the countries of the Persian Gulf¹⁰. Consequently, today Afghanistan faces a variety of political, security, economic, social and human development challenges including drug dependence and HIV/AIDS epidemic posing emerging threats.

More than two decades of war, violence and poverty have also had an even more severe impact on Afghan women. Afghanistan ranks as fourth and second lowest in terms of standards of living and gender disparity related to the standard of living in the world¹¹.

The thirty years of war and the absence of a central government in the country forced more than 5.7 million Afghans to live as refugees in other countries, mostly in Pakistan and Iran. Many Afghans were internally displaced in various parts of the Afghanistan. The majority of returning refugees lived in countries with high prevalence of injection drug use and drug dependence and high HIV prevalence among people who inject drugs (PWID) and drug dependence (e.g. Pakistan and Iran).

Nearly one million Afghans aged between ages 15 and 64 are regular and / or problem drug users¹². The number of heroin users has increased from 50,000 to 120,000, since 2005 when a similar survey was conducted constituting a grand leap of 140 per cent. Prevalence of use of illicit drugs has increased across the country, dramatically so for opium, heroin and other opiates. In just four years, the number of regular opium users in Afghanistan grew from 150,000, to approximately 230,000 - an increase of 53 per cent. The numbers are even more alarming for heroin. In 2005, the estimate of regular heroin users in the country was 50,000, compared to approximately 120,000 users in 2009, with an increase of 140 per cent.

An assessment completed by UNODC, in partnership with UNHCR and IOM in 2010, estimated 30,000 recent heroin users among the returnee population, including some 8,000 PWID, of whom some 2,000 are likely to have shared injecting equipment. There may be as many as 1,800 regular injectors among the returnee population. The highest HIV prevalence was among PWID with an average of 4.4% in three cities (Herat, Kabul and Mazar) in 2012. No data is

⁹ Afghanistan at A Glance, World Bank, 2009; WHO, 2010; Human Development Report, 2009; Human Development Index (HDI) ranks countries based on income, life expectancy and literacy rates. In 2007, the Afghanistan National Human Development Report placed the country at 174 out of 178 countries.

¹⁰ UNHCR, Afghanistan Operational Update, 2007

¹¹ Women in Afghanistan. Fact Sheet UNIFEM. August 2006.

¹² Afghanistan Drug Use Survey, UNODC, Ministry of Counter Narcotics, Ministry of Public Health (2009)



available on the prevalence of HIV among refugees/ returnees. Little information is known about the size, distribution and characteristics of this sub-population.

Pakistan is a host to approximately 1.7 million registered Afghan refugees, one of the largest refugee population in the world. The refugees mostly live in village-like camps and urban areas in Khyber Pakhtunkhwa province and Baluchistan. Since March 2002, approximately 3.5 million Afghans have voluntarily repatriated from Pakistan to Afghanistan with UNHCR's assistance. No studies have been carried out on HIV prevalence among the refugees in Pakistan. Under the UNODC intervention, approximately 1,700 refugees who used drugs in the camps were tested for HIV, none was found HIV positive.

The Regional Programme for Afghanistan and Neighbouring Countries (hereafter referred to as the "Regional Programme") is a strategic framework for UNODC's engagement in the region and it is designed to provide a platform for better coordination and facilitation of counter-narcotics efforts across the region, bringing coherence to activities conducted by UNODC. Sub-Programme 3 of this Programme is designed to support ongoing UNODC initiatives aimed at reducing the demand for drugs, moreover, it supports drug related HIV prevention, treatment and rehabilitation services.

Under this Sub-programme UNODC is implementing a project providing harm reduction services to drug using Afghan refugees in Iran, Pakistan and returnees in Afghanistan. The prevalence of HIV among Afghan refugees and returnees is not clear yet the high rate of injection use among the right holders/target population (among the target groups of the project in Iran in 2015, 61%) confirms the need for this intervention.

Approach:

Since 2009, UNODC in partnership with UNHCR is implementing a sub-regional programme for Afghan refugee/returnees in Afghanistan, Iran and Pakistan. This programme aims to develop and sustain a sub regional initiative to strengthen and ensure continuity of comprehensive HIV prevention and care services to Afghan refugee in Iran and Pakistan and returnees in Afghanistan.

Main objectives are:

1. Strengthening the availability, access, uptake and quality of HIV prevention and care services for Afghan injecting and non-injecting drug users who are registered refugees in Iran and considered as persons of concern to UNHCR in Pakistan as well as those returning voluntarily or having returned to Afghanistan.
2. Creating an enabling environment that supports a regional network of HIV prevention and care services across borders thereby guaranteeing continuation of services after voluntary repatriation of Afghan refugee drug users.

Provision of the comprehensive harm reduction services to Afghan refugees and returnees is fulfilled through service delivery by Drop-in-Centres (DIC) located in high populated refugee areas and boarder cities in Afghanistan. Comprehensive package of HIV prevention and care services are provided in the two bordering provinces of Afghanistan with Iran and Pakistan (Herat and Nangarhar, respectively).



In Afghanistan, the services include, Voluntary Counselling and Testing (VCT), primary health care, diagnosis , treatment and prevention of STI, distribution and collection of the disposable syringes, condom distribution, vaccination for hepatitis B, Social services (hygiene kits, basic clothing), health education , TB case diagnosis, referral for anti-retroviral (ART) and TB treatments and organizing community-based awareness raising campaigns among Afghan returnees.

The Regional Programme also supports three DICs in Iran, located in the provinces of Khorasan Razavi (Golshar and Nodeh DICs in the city of Mashhad) and Tehran (Payam Avaran DIC in Varamin) and one in Kot Chandna Mianwali, Pakistan. The service delivery package includes methadone maintenance treatment, distribution of sterile needles and syringes, condom promotion and distribution, short term residential centres services, first-aid, wound dressing and care, provision of food and tea, basic counselling, education about HIV and drugs, referral for HIV VCT and other needed services like psychiatric counselling, dentistry and hospitals.

In Pakistan, the same project is being implemented at two sites in refugee camps in Khyber Pakhtunkhwa and Punjab. The harm reduction services are provided through Drop-in-Centres (DIC) established near the refugee camps. The DIC, staffed with a medical doctor, psychologist and two outreach workers provide the same services mentioned above. In addition, linkages have been established with government hospitals in the area and the clients/patients are referred to these hospitals. The project also facilitates referral for drug dependence treatment. HIV positive refugees are referred to the existing ART centres in the provinces.

Reach of the intervention:

The project increases access of one of the most vulnerable groups, refugees and returnees, to HIV prevention, treatment and care through service provision at the centres which are located in populated refugee areas and boarder cities also through outreach groups. This activity promotes equality and human rights by providing high quality and free of charge harm reduction services to refugees and returnees including oral substitution treatment where it is available (in Iran). It also strengthens the community resilience by sheltering the most stigmatized groups and offer assistance. The activity was initiated through an agreement with the drug control agencies at country level and UNODC. Also there is a well-established referral system at the field level regarding service provision between UNODC and UNHCR in the named cities. Last but not least provision of harm reduction services in the border cities and high populated refugee areas contributes has an urban context.

Impact of the intervention:

In 2014, in Herat and Nangarhar cities, 444 males who inject drugs, 2,000 males who use drugs and approximately 500 women who use drugs received the above mentioned services. Around 47,000 syringes and 40,000 condoms were distributed and some 500 returnees were tested for HIV, Hepatitis B and C, syphilis and TB.



Moreover, 201 Afghanistan refugees receive services in Iran, including 180 refugees who received methadone maintenance treatment. Also 13,959 sterile syringes and needles and 1,442 condoms were distributed. Additionally the outreach teams reached 133 Afghans and distributed 13,811 needles and syringes, and 9,542 condoms in Mashhad and Tehran cities.

During the project life cycle in Pakistan drug dependence treatment was provided to 180 refugees, primary health care was provided to around 3,000 and 1700 refugees received HIV testing and counselling services. Also six HIV awareness raising campaigns were held and information, education and communication material (brochures, posters etc. in Pushto language with appropriate pictures) were distributed. UNODC collects data regarding the target population and provided services through field offices on monthly basis.

Challenges faced:

Lack of baseline data due to high sensitivity of the governments regarding the target group. Advocacy meetings are still ongoing at the field level to receive approval for conducting a need assessment, gap analysis and evaluation.

Insecurity, instability, armed conflicts, poor infrastructure, lack of technical capacity, stigma and discrimination, difficult access to the target population, high level of illiteracy particularly among women, limited health care services and weak coordination among key stakeholders are major challenges for the implementation of activities.

Due to the social and economic marginalization of women who use drugs there is a potential risk of failing to reach a significant number of female refugees.

Whereas in Pakistan, due to the security reasons, the project implementing organization require permission/NOC from the Ministry of States and Frontier Regions(SAFRON) to work in the refugee camps. The NGOs, intended to bid for services have to obtain the No Objection Certification (NOC), which is a lengthy process. The requirement for the NOC delayed initiation of service delivery.

Financing and management:

The project has been funded by EU, Japan, Italy and Sweden since 2012 with contribution by the Governments of Afghanistan, Iran and Pakistan. The Project is coordinated by UNODC Regional Programme with close collaboration with the drug control agencies in Afghanistan, Iran and Pakistan.

Regarding the sustainability, training is provided for the service providers and managers of the DICs for capacity building by UNODC. At field level the DICs are now more able to fund raise independently than being solely reliant on the funds raised by the UNODC.

In Pakistan, the project implementing organizations are required to submit regular progress reports and financial reports. The technical reports include monthly data and a narrative quarterly report along with the cumulative data. The instalments of funds are released upon submitting a satisfactory report. The implementing partners are required to report on specific indicators. The reports are evaluated by the technical and finance staff of UNODC. Regular monitoring visits are

carried out to the project sites. At the completion of the project, the implementing organization is required to submit an audit report of the project budget from an audit firm.

Lessons learned and recommendations:

Community-based approach of the project helped with the acceptance of the centres at field level. Organizing community-based awareness raising campaigns contributed to achievements of the project in being welcomed by the community and manages to gain trust.

In Pakistan, the refugee camps are located outside the cities, at a distance. Community-based approach has been supportive and providing the services at the nearest point to the refugees is an important factor. Advocacy with the relevant government departments and involvement of community has been helpful in smooth implementation of the project.

42. CAR and Yemen

Ensuring continuation of ART during acute instability, challenges and dilemmas: the experience of MSF OCBA in Central African Republic and Yemen

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Ethics statement: OCBA Medical Director confirms that this abstract meets MSF ethics criteria for studies involving the analysis of routinely-collected program data.

Introduction: Complex emergencies present significant challenges to ensure continuation of antiretroviral treatment (ART) in settings like Yemen and Central African Republic (CAR), countries where regular picks of violence arise. Differences among rural and urban contexts and access to mobile phones seem to make a difference on the response during acute crisis. Through this descriptive study we illustrate the experience and results of implementing contingency plans for HIV during the recent violent situation in CAR during 2013 and the acute instability in Yemen during 2011.

Projects:

Central African Republic: In 2008 MSF introduced HIV care in 3 medical programmes located in a conflict area. This resulted in 1.567 patients diagnosed with HIV and enrolled into care, 1128 (72%) commenced ART. In 2010 a contingency plan was set in order to respond to the volatile security situation of the area. By September 2013 when the context became unstable 683 patients were under ART.



Yemen: In 2010 MSF started supporting the ART centre at Al-Gumhuri Hospital, the only health facility providing HIV care in Sana'a. In January 2011 waves of clashes against the government began and continued for several months. By April 2011 medical activities couldn't continue further and a contingency plan was implemented.

Outcomes: In both settings, throughout the most acute phase of violence, HIV activities were frozen except for PMTCT services in CAR. "Emergency bags" containing 2 months ART buffer stock plus 1 week tail protection with TDF/3TC were distributed to the patients who reached the MSF facility in both settings, and an "extra ART point" allocated in Yemen in case patients could not reach the Hospital. Important messages regarding counselling and "what to do in the case of violence arising" was given to the patients all along the year as part of the regular counselling activities.

In CAR at January 2014, 594 (86%) patients received emergency bags to ensure continuation of treatment; by February 2014 313(52%) of those patients returned for consultation; we estimate that due to the pattern of the conflict patients may have crossed to Chad. Whereas in Yemen between April to November 2011 363 (100%) patients received emergency bags and by February 2012 354 (97%) patients returned or consultation. At the end of the emergency no patients coming to the ART centre complained of drugs shortages.

Main differences: due to the rural situation and lack of mobile phones in CAR, we believe that the implementation phase was more challenging than in Yemen where patients also received a "health card" including a phone number to call in case they run out of drugs or have any questions. Education level and health structures may also be an important factor although we don't have enough data to evidence it.

Conclusions: for both projects the implementation of the plan was effective being able to provide continuation of treatment to the majority of patients on ART. However we observe an important difference between the two settings in patients returning for follow up, this might be attributable to the different geographical settings, educational level and violence patterns. Patients living in rural areas have fewer options to scape during acute conflict and are forced to flee to more remote areas; while urban fixed spots of violence as in Yemen leave patients the option to move to safer areas until situation improves.

We are continually adapting our contingency plans in order to better respond to violence in the places we work. Information on what to do is integrated in the counselling package and pharmacy orders include stocks for emergency bags. Number of patients receiving continuation of ART is the success indicator in these settings, being aware that retention in care cannot be granted, hence quality indicator of the programs in these settings have been adapted according to the context difficulties.

