UNAIDS PROGRAMME COORDINATING BOARD

UNAIDS/PCB (36)/15.13
Issue date: 12 June 2015

THIRTY-SIXTH MEETING

Date: 30 June-2 July 2015

Venue: Executive Board room, WHO, Geneva

Agenda item 9

HIV in emergency contexts

Background Note

INTRODUCTION

1. More people than ever before are affected by humanitarian emergencies across the world. Our newspapers and television screens are dominated by tragic realities of such emergencies every day. In 2013, the most recent year for which such figures are available, there were nearly 314.3 million people affected by humanitarian emergencies (natural disasters and conflicts), including 103.7 million children (0-14 years) and 6.8 million pregnant women[1]. Among all people affected by emergencies in 2013, 67 million (21%) were displaced, of whom 50 million (75%) were internally displaced people (IDPs) and 17 million (25%) were refugees.

2. During emergency situations, pre-existing and multiple forms of gender-based violence and sexual violence and abuse are exacerbated by risk factors like increased poverty, displacement, lack of security and the breakdown of rule of law. Conflict-related violence, such as militarized sexual violence and sexual exploitation and abuse, largely affects women and girls, but also men and boys. In Liberia, for example, 49% of women (15 to 70 years) reported having experienced at least one act of physical or sexual violence by a soldier or fighter during the five-year civil war.[2] In the Côte d'Ivoire armed conflict, 5.9% of males reported experiencing some form of sexual violence since age 15.[3] However, under-reporting of exposure to sexual violence in emergency situations means that the real number of cases are likely to be much higher. A systematic review of 19 studies found an overall prevalence of 21.4% of sexual violence in complex emergency settings.[4]

3. Against this complex background, we are at a historic moment in the response to AIDS – where there is global consensus that the tools now exist to end the AIDS epidemic as a public health threat by 2030. We now have evidence that accelerated investment and action in the next five years – a Fast Track approach[5] - will enable the achievement of the ambitious 2030 goal. Accordingly, the UNAIDS Programme Coordinating Board requested UNAIDS to update and extend its Strategy for the period 2016-2021.

4. At this opportune moment in the AIDS response, it is more critical than ever to ensure all people and communities in need are reached with evidence-informed and human rights based responses. Conservative estimates based on data for 2013 put the number of people living with HIV among all people affected by humanitarian

[1] These estimates are the outcome of research jointly conducted by UNICEF, UNHCR and WFP in 2015.
[2] Swiss, S., Jennings, P.J., Aryee, G.V., Brown, G. H., Jappah-Samukai, R.M., Kamara, M.S., Turay-Kanneh, R.S. (1998). Violence against women during the Liberian civil conflict. Journal of the American Medical Association, 279, 625-629.
[3] Hossain, M., Zimmerman, C., Kiss, L., Kone, D., Bakayoko-Topolska, M., Manan K A, D. Lehmann, H. Watts, C (2014). Men's and women's experiences of violence and traumatic events in rural Côte d'Ivoire before, during and after a period of armed conflict. BMJ Open, 4(2), e003644.
[4] Vu, A., Adam, A., Wirtz, A., Pham, K., Rubenstein, L., Glass, N., Singh, S. (2014). The Prevalence of Sexual Violence among Female Refugees in Complex Humanitarian Emergencies: a Systematic Review and Meta-analysis. PLoS Currents.
[5] http://www.unaids.org/en/resources/documents/2014/JC2686_WAD2014report

emergencies at 1.6 million[6]. Given the size and scale of impact of humanitarian emergencies, the number of people vulnerable to HIV in these contexts is estimated to be much higher. But the lack of priority given to HIV responses and considerations within emergency contexts means that that too often people affected by humanitarian emergencies are being left behind in HIV responses.

Definitions:

"Humanitarian Emergencies": For the purposes of this paper, "humanitarian emergencies" will include both man-made and natural disasters. A humanitarian emergency occurs when a critical event, such as the onset of armed conflict or a natural disaster, threatens the health, safety and/or wellbeing of a community or a large group of people, demanding decision and follow-up through an extra-ordinary response and exceptional measures[7]. Humanitarian emergencies are often characterized by extensive violence and/or loss of life, mass displacement of people, widespread damage to societies and economies and the need for large-scale, multi-faceted humanitarian assistance[8]. While it is noted that in the context of HIV, a number of other situations such as restrictive legislation and discriminatory policies may also impinge upon health and human rights, these situations are not considered in this paper.

"***People affected by humanitarian emergencies***" includes refugees and asylum seekers, internally displaced persons (IDPs) and all those who are affected by emergencies resulting from armed conflict, generalized violence, persecution, human rights violations and/or natural disasters- whether these events have caused them to be (forcibly) displaced from their homes or not. It also encompasses persons living in other fragile communities that may ultimately require emergency humanitarian responses, including a differentiated approach in responding to HIV.

"Conflict-related sexual violence" refers to incidents or patterns of sexual violence, that is rape, sexual slavery, forced prostitution, forced pregnancy, enforced sterilization, or any other form of sexual violence of comparable gravity, against women, men, girls or boys. Such incidents or patterns occur in conflict or post-conflict settings or other situations of concern (e.g. political strife). They also have a direct or indirect nexus with the conflict or political strife itself, that is, a temporal, geographical and/or causal link. (UN Analytical and Conceptual Framing of Conflict-related Sexual Violence, June 2011)

5. Historically, consideration of people affected by humanitarian emergencies in HIV programmes has not been well enough integrated or addressed in high HIV prevalence settings, and even less so in low prevalence settings or in concentrated epidemic settings. For those affected by humanitarian emergencies, access to HIV prevention and/or life-saving treatment is often not prioritized or is of limited and inadequate scope. Frequently, it is even non-existent. In countries where HIV

[6] These estimates are the outcome of research jointly conducted by UNICEF, UNHCR and WFP in 2015. They are considered conservative because overlaps between data sources were systematically discounted to avoid double counting while some overlaps were in fact different events.
[7] United Nations Department of Humanitarian Affairs (UN DHA) in: ReliefWeb Glossary of Humanitarian Terms, August 2008
[8] OCHA Orientation Handbook on Complex Emergencies, August 1999

services are available and accessible, the onset of violent conflict or disaster, possibly resulting in forced displacement and the collapse of health systems, may lead to increased vulnerability to HIV infection or interruption of treatment.

6. During humanitarian emergency situations there is a risk of increased vulnerability to HIV due to sexual violence, sexual coercion and other human rights violations. Studies have shown the results of women's vulnerabilities to HIV in the context of conflict and post conflict settings. In Ethiopia, for example, HIV prevalence in female sex workers increased from 20% in 1988 to 73% in 1998, corresponding to years of war and the displacement of the population.[9] In Nepal, HIV prevalence increased from 2.7% to 17% in the three years corresponding with the revolution.[10] A study of the differences in HIV-related behaviors at the Lugufu refugee camp in Tanzania showed that women, particularly widowed, divorced or never-married were at increased risk of HIV infection due to transactional sex in the camps.

7. Preparedness, contingency planning and situational risk analysis are equally critical to HIV programming and action. Ongoing HIV programmes that are currently being implemented in stable or fragile environments may experience major disruptions as a consequence of emergencies, causing the rapid erosion of achievements made over decades. As local communities are at the centre of any effective emergency response, concerted efforts to build and strengthen the resilience of communities affected by humanitarian emergencies are an essential component of preparedness planning.

8. The sheer enormity and scale of impact of humanitarian emergencies illustrates the importance of ensuring greater focus on populations affected by such emergency contexts within the ongoing AIDS strategy planning, target setting and implementation of action. As UNAIDS undertakes the updating and extending of the 2016-2021 Strategy,– which includes elaboration of targets for 2020 and 2030 towards ending AIDS as a public health threat by 2030-- it is critical that humanitarian emergencies are effectively included, as they present contexts of fragile communities, vulnerability and uncertainties that are fertile settings for HIV transmission. Guided by the fundamental principles of human rights and equity, it is imperative to address HIV-related needs and to ensure that appropriate HIV activities and services are routinely integrated in all humanitarian emergency response operations

9. This background paper examines key aspects of the relationship between the global response to HIV and humanitarian emergencies. It builds on two earlier reports submitted to the UNAIDS Programme Coordinating Board (PCB) entitled "AIDS, Security and Humanitarian Response"[11]. The paper brings together the experience and perspectives of professionals in the field of humanitarian operations and HIV programmes and is informed by the discussions and outcomes of a one-day meeting of experts held in Geneva in March 2015. This meeting generated specialist inputs

[9] Holt BY, Brady W, Friday J, Belay E, Parker K, Toole M, et al. Planning STI/HIV prevention among refugees and mobile populations: situation assessment of Sudanese refugees. Disasters 2003;27: 1–15
[10] Karkee R, Shresta DB. HIV and conflict in Nepal: Relation and strategy for response. Kathmandu Univ Med J 2006;4:363–4.
[11] UNAIDS/PCB(27)/10.22 discussed at the 27th PCB of December 2010 and UNAIDS/PCB(30)/12.11 discussed at the 30th PCB of June 2012. The second report provides an update on the implementation of the recommendations relating to this topic that were agreed at the PCB of December 2010.

and contributions from the Global Fund, the International Centre for Migration, Health and Development (ICMHD), the International Committee of the Red Cross (ICRC), the International HIV/AIDS Alliance, International Federation of Red Cross and Red Crescent Societies (IFRCS), the International Organization for Migration (IOM), Médecins Sans Frontières (MSF), thethe Overseas Development Institute (ODI), UNAIDS, the UN Children's Fund (UNICEF), the Office of the UN High Commissioner for Refugees (UNHCR),. the World Food Programme (WFP) and the World Health Organization (WHO).

10. This paper provides guidance for the UNAIDS Thematic Segment on "HIV in Emergency Contexts" scheduled on 2nd July 2015 during the 36th session of the UNAIDS PCB. The thematic discussion presents a unique opportunity to emphasize the critical need for increased focus on people affected by humanitarian emergencies within the updated UNAIDS Strategy (2016-2021), as part of the Fast Track efforts for accelerated action and investment towards the ultimate goal of ending of AIDS as a public health threat by 2030, and leaving no one behind.

BACKGROUND

11. To reach the visionary goal of ending the AIDS epidemic as a public health threat by 2030, evidence shows that accelerated action and investment over the next five years – a Fast Track approach - is a critical necessity for success. In contrast, modelling predicts that if HIV programming continues as usual and service coverage is kept at current levels, the epidemic will rebound by 2030, eroding much of the progress made during previous years.

12. In order to accelerate progress towards ending the AIDS epidemic, and reaching targets for 2020 and 2030 that have been developed as part of the Fast Track approach[12], urgent focus is required on locations and populations where risk and vulnerability are greatest and where, if the appropriate actions are taken, the most decisive gains can be made[13].

13. The findings of UNAIDS' Gap Report (2014) highlighted twelve key populations, including "displaced persons". However, the broader category of "persons affected by humanitarian emergencies" (as defined earlier in this Background Note) needs greater focus within ongoing AIDS strategic planning and action – including within the updating and extending of the UNAIDS strategy for 2016-2021. Given the size of populations and magnitude of impact generated by emergency contexts, a failure to give prominence to these populations and context represents a significant risk. It is essential to ensure that humanitarian emergencies are well integrated into ongoing HIV-related strategies, policies and programming if ending the AIDS epidemic as a public health threat by 2030 is to be achieved.

14. The development of a "new narrative" on HIV in humanitarian emergency contexts, including specific, focused actions for affected populations, is therefore of paramount importance to underpin the updating and extending of the UNAIDS Strategy 2016-2021, currently under development. This narrative must reflect the latest evidence and research findings as well as the most effective operational

[12] http://www.unaids.org/en/resources/documents/2014/JC2686_WAD2014report
[13] "Locations" refer to countries, but also to regions and areas within countries, including cities.

experiences and practices identified to date, to drive strategic action and investment in this area.

MAJOR TRENDS IN HUMANITARIAN EMERGENCIES

15. Of the 314.3 million people affected by humanitarian emergencies (natural disasters and conflicts), the largest numbers of people affected geographically were Asia Pacific (122.2 million/39%), followed by Middle East and North Africa (MENA; 78.2 million/25%) and then Sub-Saharan Africa (SSA; 69.3 million/22%)[14]. Among all people affected by emergencies in 2013, 67 million (21%) were displaced, of whom 50 million (75%) were IDPs and 17 million (25%) were refugees.

16. The number of people affected by natural disasters has increased exponentially in recent years: according to recent figures released by the UN Office for Coordination of Humanitarian Affairs (OCHA), the likelihood of being hit by a disaster is twice as high today as it was in the late 1970s[15]. During the years 2005-2015, overall more than 1.5 billion people were affected by disasters in various ways. Women, children and people in vulnerable situations were disproportionally affected. During the same decade, over 700,000 persons lost their lives due to disasters, over 1.4 million were injured and approximately 23 million were made homeless[16].

17. At the end of 2013 more than 51 million people worldwide were forcibly displaced due to persecution, armed conflict, generalized violence or human rights violations, the largest number since the end of the Second World War. The majority of them are women and children. Provisional figures released by UNHCR for the first half of 2014 reveal a continued upward trend[17]: during the first six months of 2014 the total number of persons of concern to UNHCR increased by 8%.

18. Not only the scale, also the character of displacement has changed significantly during recent years. This applies to displacement caused by a natural disaster as well as in the case of forced displacement. It is estimated that the average duration of major refugee situations, protracted or not, has increased from nine years in 1993 to 17 years in 2003[18]. Also, disaster-induced displacement, which historically was often short-term in nature, has increasingly become long-term, especially in areas where people were already highly vulnerable and which may also be facing the impact of conflict[19]. For the overwhelming majority of the displaced, whether by conflict or disaster, the prospect of eventually returning home and re-building their livelihoods remains an increasingly distant possibility. The numbers of refugees and other displaced persons who ultimately decide to return home has continued to drop. While in 2013 alone, an estimated 8 million were added to the global figures of conflict-induced displacement, only 1 million were able to return home[20].

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[14] Ibid.
[15] Factors include climate change and the increase in severe weather phenomena as well as increased population pressure on disaster-prone areas which until recently have remained uninhabited.
[16] Sendai Framework for Disaster Risk Reduction 2015-2030; adopted by the International Conference on Disaster Risk Reduction, Sendai, Japan, March 2015; A/conf. 224/CRP.1 of 18 March 2015.
[17] Mid-Year Trends 2014, UNHCR
[18] Protracted Refugee Situations, UNHCR Standing Committee document EC/54/SC/CRP.14, June 2004.
[19] The forgotten millions, Strohmeyer HJ, OCHA, 22 January 2015.
[20] Ibid.

19. The implications of these trends for the future are significant. If the numbers of newly displaced continue to outstrip the number of people returning by such enormous margins, the overall number of displaced people will continue to grow at the same fast pace as they have done during recent years. As these trends continue, particularly countries at the lower end of the income scale will carry a growing share of this burden.

20. Increasingly, displacement is concentrated in low-income countries that have few resources to dedicate to the complex needs of vulnerable displaced persons. Since the mid-1990s, the proportion of the world's refugees hosted by developing regions has steadily grown as they have received millions of new refugees and, during the past few years, in increasing numbers. At the end of 2013, developing regions hosted 10.1 million or 86% of the world's refugees[21], the highest proportion for the past 22 years. The Least Developed Countries alone provided asylum to 2.8 million refugees or 24% of the global total[22].

21. Forcibly displaced persons find themselves in different types of living situations. By the end of 2013, of the refugees[23] who lived in camps, the overwhelming majority (93%) resided in rural areas, most in sub-Saharan Africa and Asia. In sub-Saharan Africa, over the last three years the proportion of refugees residing in camps has consistently increased, from 60%in 2011 to 64% in 2013[24] [25]. Refugee camps in rural areas are often situated at great distance from the main urban centers in remote areas that are frequently under-resourced and marginalized and where insecurity often prevails.

22. Conversely, and of increasing importance, in regions outside of sub-Saharan Africa the majority of refugees are "self-settled" in urban areas where their numbers can cause significant pressure on existing local services. In fact, of the global total number of refugees, the majority (56%) reportedly now resides in urban areas[26], most in lower and middle-income countries.

23. Displacement is frequently seen as an important or even a defining aspect of humanitarian emergencies but many emergencies occur without involving or causing major movements of people. Often, physical or security barriers obstruct the departure of people from their area of habitual residence. People may be forced to remain because of fears of losing essential family assets such as a house, land, or livestock and the related prospect of a definitive loss of livelihood. These populations often remain inaccessible to relief efforts and their humanitarian needs may therefore be even more pronounced than those of the displaced. While it is difficult to estimate the global number of people involved in this category, a recent review of 24 countries affected by conflict estimated that up to 87% of persons in these situations never left

[21] Refugees under UNHCR's mandate.
[22] War's Human Cost, Global Trends 2013; UNHCR, June 2014 (page 16-17). Also quoted in the Chapter on Displaced Persons, Gap Report, 2014.
[23] The 11.7 million refugees under UNHCR's mandate at the end of 2013.
[24] War's Human Cost, Global Trends 2013; UNHCR, June 2014 (page 16-17). Also quoted in the Chapter on Displaced Persons, Gap Report, 2014.
[25] By comparison, 25 per cent of refugees reside in camps in Asia while the majority of refugees in the Americas (96%) and Middle East and North Africa (76%) reside in individual accommodation types, predominantly in urban areas.
[26] War's Human Cost, Global Trends 2013; UNHCR, June 2014. p 37.

their home areas. This equated with a total of 149 million people out of an estimated 172 million people affected by violent conflict in that year (2013). Because this figure only includes 24 countries for which comparable and validated data were available, the global total would be higher[27]. Nearly all armed conflicts today are civil rather than inter-state wars and civilians constitute the overwhelming majority of casualties.

24. In recent years, the phenomenon of international migrants caught in crises outside of their country of origin has become increasingly apparent. With more people than ever living outside of their home countries and growing international migration flows (regular and/or irregular), the presence of migrants among the populations affected by humanitarian emergencies has also increased[28]. Notwithstanding the growing visibility of this trend, migrants are often overlooked in humanitarian preparedness planning and responses. This is of particular concern because migrants are often especially vulnerable during a humanitarian emergency or crisis. When a country hosting migrants, whether it is a country of destination or merely of transit, experiences an emergency or a crisis, migrant populations often have few means to ensure their own safety. In some cases migrants may be unable to leave the crisis area; in other cases they may be unwilling to leave or unable to access humanitarian assistance. Those in an irregular situation[29] may be *de facto* excluded from humanitarian assistance. Given the growing number of migrants around the world, the consequences of these emergency situations for migrant populations need to be better factored into humanitarian response mechanisms.[30]

LINKS BETWEEN HIV AND HUMANITARIAN EMERGENCIES: CHALLENGES, OPPORTUNITIES AND KEY CONSIDERATIONS

25. How HIV transmission is affected by emergencies is complicated and includes an interconnected and context-specific mixture of factors that exacerbate vulnerability and risk factors, but also include other factors that may offer increased protection against these risks[31]. Factors that increase a displaced person's vulnerability to HIV include separation of families, the breakdown of community structures and social norms, food insecurity and malnutrition, the inability to meet basic needs, disrupted

[27] People Affected by Conflict, 2013, Humanitarian Needs in Numbers, page 13, Centre for Research on the Epidemiology of Disasters (CRED). The estimate is based on a sample of 24 countries in conflict.
[28] Protecting migrants during times of crisis: immediate responses and sustainable strategies; International Organization for Migration (IOM). Background paper for the International Dialogue on Migration: Managing Migration in Crisis Situations, September 2012.
[29] Irregular migration is migratory movement that takes place outside the regulatory norms of the sending, transit and receiving countries. There is no clear or internationally accepted definition of irregular migration. From the perspective of the receiving or transit countries it is illegal entry or stay, meaning that the migrant does not have the necessary authorization or documents required under immigration regulations to enter, reside or work in a given country. The term "illegal migration" is usually restricted to smuggling of migrants and trafficking of persons (Ref.: International Migration Law, Glossary on Migration; International Organization for Migration, IOM, 2004).
[30] Protecting migrants during times of crisis: immediate responses and sustainable strategies; International Organization for Migration (IOM). Background paper for the International Dialogue on Migration: Managing Migration in Crisis Situations, September 2012.The *de facto* exclusion of migrants in an irregular situation from humanitarian assistance may be caused by the fact that they have not been registered by their country of origin and/or by the country where they find themselves; they may also be reluctant to resort to the authorities for assistance for fear of discovery.
[31] Spiegel PB, Bennedsen AR, Claass J, Bruns L, Patterson N, Yiweza D, Schilperoord M. Prevalence of HIV infection in conflict-affected and displaced people in seven sub-Saharan countries: a systematic review. Lancet, 2007; 369(9580): 2187-95.

income, sexual violence and abuse, and destroyed health and education infrastructure. However, there are also factors that may reduce the risk of HIV in such situations: these include reduced mobility and accessibility as a result of destroyed infrastructure (reducing travel to high-prevalence urban areas) or displacement to remote and isolated locations[32]. In the case of people being accommodated in well-managed and resourced camps, they often enjoy improved protection, health education and social services as compared to before the crisis, particularly during the post-emergency phase of their displacement.

26. Conservative estimates based on data for 2013 put the number of people living with HIV among all people affected by humanitarian emergencies at 1.6 million, which represents 4.6% of the 35 million people living with HIV globally[33].

27. The largest number of people living with HIV affected by emergencies was in Sub-Saharan Africa (1.3 million / 81%), followed by Asia Pacific (135,409 persons / 8.6%) and in MENA (67,160 persons / 4.2%). In Sub-Saharan Africa, people living with HIV affected by emergencies constituted 5.3% of the 24.7 million people living with HIV in the region; in Asia and the Pacific this constitutes 2.8 % of the 4.8 million people living with HIV in the region while in MENA this constitutes 29% of the 230,000 people living with HIV in the region. Unfortunately, the existing databases capturing the linkages between HIV and emergencies are overlapping and often incompatible. Improving data gathering processes and methodologies to enable analyses at sub-national level and to accurately forecast the impact of emergencies on HIV is critical.

28. It is widely recognized that HIV, food insecurity and malnutrition are interlinked. People living with HIV need more calories and nutrients, have lower appetites and are less able to absorb nutrients. Food insecurity can make it more difficult for people living with HIV to adhere to treatment and can lead them to forgoing treatment, selling off assets or engaging in HIV risk behaviors. The link between emergencies and food insecurity is also well documented. Disasters and conflict cause crop damage, reduce agricultural outputs and impact the all-round affordability, availability, quality and safety of food. Initial research found that out of the 30 countries of focus in the UNAIDS *Fast-Track* report[34] (accounting for 89% of all new infections globally) at least 11[35] rank among the 25% most food insecure in the world.[36] Of these countries, at least four[37] among the 25% most food insecure globally are situated within at least one region where ongoing conflict is occurring. More quantitative study is needed to better understand the nexus between HIV, food insecurity, malnutrition and emergencies.

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[32] UNAIDS Gap Report, 2014. Displaced Persons Chapter, p 9. http://www.unaids.org/sites/default/files/en/media/unaids/contentassets/documents/unaidspublication/2014/UNAIDS_Gap_report_en.pdf

[33] These estimates are the outcome of research jointly conducted by UNICEF, UNHCR and WFP in 2015. They are considered conservative because overlaps between data sources were systematically discounted to avoid double counting while some overlaps were in fact different events.

[34] Joint United Nations Programme on HIV/AIDS (UNAIDS). Fast-Track Report: ending the AIDS epidemic by 2030. 2014. Geneva, Switzerland. http://www.unaids.org/sites/default/files/media_asset/JC2686_WAD2014report_en.pdf

[35] Cameroon, Nigeria, Ethiopia, Angola, Malawi, Zambia, Mozambique, Haiti, Tanzania, Chad and DRC

[36] The Economist Intelligence Unit, Global Food Security Index 2014. New York, United States. Accessed from: http://foodsecurityindex.eiu.com/

[37] Cameroon, Chad, DRC, Nigeria.

29. In addition to vulnerability to HIV that emergency conditions may exacerbate, there are various other areas where links between emergencies and HIV come to the fore. These include protection and human rights concerns, the interrelations between persons affected by humanitarian emergencies and some of the other key populations at higher risk of HIV infection and the disruption of essential HIV services, including care, treatment and support.

Case study Central African Republic, Cameroon and Chad: Incorporating Support to HIV-affected families within the humanitarian crisis.

When a violent crisis erupted in the Central African Republic (CAR; population 4.5 million) in 2012, there were an estimated 120,000 people living with HIV, the majority of whom were women and children. The crisis caused some 436,000 persons to become internally displaced. Humanitarian agencies had to scale-up and re-orient their existing HIV programmes. In response to the crisis, the World Food Programme's Food by Prescription programme (FbP) that provided enriched food rations to people living with and affected by HIV was extended to additional parts of CAR to care for the increasing number of newly malnourished people living with HIV arriving in these areas. UNICEF and their local partner "Association des Jeunes Femmes Actives pour la Solidarité (ANJFAS)" also extended their HIV treatment services and services to prevent new HIV infections among children, as well as a programme to identify survivors of sexual violence. However, the continuous movement of families in response to ongoing violence and security concerns complicated the identification of those who had been lost to follow-up.

The violence also produced a refugee outflow of some 340,000 persons to neighbouring Cameroon and Chad. Border areas in Cameroon reported a 35% increase in the number of people living with HIV due to the influx. In response, WFP extended its FbP programme across the border and UNICEF intensified services to prevent new HIV infections among children, and other HIV services in the refugee receiving areas. The extended FbP programme significantly improved access to HIV care and support, enhanced community resilience and increased adherence to antiretroviral therapy (ART). UNICEF and partners were able to actively identify children and pregnant women living with HIV and to set up peer support groups that resulted in increased access to treatment and continuity of care.

Source: WFP Regional Bureau for West Africa.

Protection and human rights concerns

30. Different types of emergencies have different impacts on people living with HIV, which require tailored responses and the integration of HIV-related concerns[38]. This applies to the entire spectrum of prevention, treatment, care and support activities. According to inter-agency guidelines[39], in the early stage of a humanitarian

[38] UNAIDS Gap Report, 2014. Displaced Persons Chapter.
[39] IASC Guidelines for Addressing HIV in Humanitarian Settings, March 2010.

emergency, priorities for the integration of HIV-related activities into the overall response comprise a standard set of minimum interventions that should be carried out regardless of the specific local and epidemiological context and that seek to ensure that HIV is not approached in isolation. During subsequent stages, the response should incorporate additional core HIV interventions, as it will become possible to take account of the local context and priorities, the epidemiological profile and the capacity of different sectors to deliver the interventions. In areas with high prevalence, for instance, programmes should focus on reducing the risk of infection and ensuring treatment continuity. In low prevalence settings, HIV should be considered within a protection framework along with, for example, gender-based violence, mandatory testing, detention and, in the case of refugees or asylum-seekers, *refoulement*. In concentrated epidemics services should address, as a matter of priority, the needs of key populations. However, in emergency contexts these standards are often not followed due to a lack of familiarity with them, lack of preparedness planning or lack of flexible funding to address them.

Case study Democratic Republic of Congo (DRC): HIV, sexual and reproductive health care and protection women and children in the humanitarian context of Masisi, North Kivu.

For over 20 years, the North-Kivu province in the DRC has been characterized by instability and violent conflict, which frequently produce large population displacements. In this context, gender-based violence and sexual abuse of children have been major protection concerns. A 2013 baseline survey among displaced women and girls showed that 37% of women and girls reported to have been sexually abused during the previous twelve months. It also revealed that a large proportion of displaced women and girls resorted to transactional sex to cover their basic socio-economic needs and those of their families (33% of minors and 48% of adult women reported to have had sex for money during the previous three months). However, HIV and reproductive health awareness is extremely poor. HIV services are limited and the few that exist are, in practice, not accessible to the general population. To address the medical and protection challenges associated with transactional sex and with the sexual exploitation of children among the displaced in the Masisi area, a multi-sectorial project was developed involving interventions in health, protection, peer education and HIV awareness raising, and livelihoods. The project is implemented with the participation of the women themselves. Recognizing that HIV prevention and treatment services remained largely non-existent in the area the project included advocacy and support for the decentralization of the national HIV programme to the Masisi area. As a result, essential HIV services have become available for the displaced as well as for the general population in the region. Since its inception, the level of HIV and reproductive health awareness has increased significantly.

Source: UNHCR-DRC.

31. Refugees and asylum seekers may face significant burdens as many states still restrict the entry of people living with HIV, presenting the need for HIV-related interventions to have a solid human rights and protection oriented focus. Some countries harbor concerns that allowing HIV positive asylum seekers to enter would result in large-scale immigration for treatment or that an influx of HIV positive asylum seekers or refugees would pose a substantial public health threat. Both of these concerns are contrary to evidence and have no moral, legal or public health basis[40].

32. In the 2013 estimation of people living with HIV and affected by emergencies, refugees living with HIV were estimated using prevalence from their countries of origin and their countries of asylum and an average eventually taken. While there would be 20,424 refugees living with HIV if prevalence in their countries of origin are used, this number would almost go up three times to 56,642 if the prevalence in countries of asylum are used. This finding corroborates with other research that refugees often have lower or comparable HIV prevalence to host populations[41] and need access to comprehensive HIV services at all stages of their displacement to keep HIV levels low.

33. Fundamental principles of refugee protection and human rights are also violated when countries use HIV positive status as a basis to refuse asylum for people who would otherwise qualify for such status. For applicants who have credible fears of persecution in their home country, the strict application of policies prohibiting entry for people living with HIV is a breach of human rights. It is likely that people in this situation may not even seek asylum, instead opting to live illegally in another country than their own. This may have significant adverse effects on the person's health since they are unlikely to seek health care or to acknowledge HIV status.

34. Mandatory HIV testing of refugees and asylum seekers without pre and post-test counseling and without guarantees for privacy is also a reality in a number of countries. In some countries, this occurs even where national legislation clearly states that all HIV testing should be voluntary, conducted with informed consent and combined with counseling and strict confidentiality.

35. Denial of access to HIV treatment is a significant concern. A number of countries hosting people who are forcibly displaced fail to recognize that HIV programmes for displaced persons are not only a human rights issue; they are a public health priority for affected populations and host populations alike[42].

[40] From: UNAIDS Gap Report, 2014. Displaced Persons Chapter http://www.unaids.org/sites/default/files/en/media/unaids/contentassets/documents/unaidspublication/2014/UNAIDS_Gap_report_en.pdf
[41] Spiegel PB, Bennedsen AR, Claass J, Bruns L, Patterson N, Yiweza D, Schilperoord M. Prevalence of HIV infection in conflict-affected and displaced people in seven sub-Saharan countries: a systematic review. Lancet, 2007; 369(9580): 2187-95.
[42] Ibid.

Case study Russian Federation: Ensuring antiretroviral treatment in Russia for HIV positive forced migrants from Ukraine

Due to the armed conflict in Eastern Ukraine since April 2014, over half a million people from that region have sought safety and protection in the Russian Federation. The region (*Oblast*) of Rostov-on-Don in the Russian Federation hosts approximately 38,000 persons who have recently arrived from Eastern Ukraine. According to HIV prevalence figures, there are approximately 400 people living with HIV among this group of forced migrants. However, so far only 30 have sought access to HIV treatment. This gap is explained by the fear of deportation: to come forward to the authorities in order to obtain the formal status of "temporary forced migrant" an applicant must disclose their HIV status or undergo HIV testing; a positive HIV result may result in deportation. In this context where the Federal Migration Services issued only a limited number of "temporary forced migrant" statuses to HIV positive applicants, a non-governmental organization of people living with HIV, "Kovcheg-AntiAIDS", has successfully negotiated for higher than standard limits. Subsequent to their efforts, status was issued to all those in need of HIV related medical services, including antiretroviral treatment. Kovcheg-AntiAIDS then embarked on information campaigns to inform forced migrants of the possibility of accessing legal information, counseling, psycho-social assistance and treatment. However, their scope of work has been limited due to financial and human resources.
Overall, Kovcheg-AntiAIDS has been effective in obtaining appropriate assistance for people living with HIV as well as to negotiate and liaise with the authorities for the issuance of the required formal status. They have worked with the Federal Migration Service to establish that there is a need to increase the number of temporary statuses issued to deal with the influx. Currently, no people living with HIV are being deported. Meanwhile, the NGO has reached out to the larger group of people living with HIV among the forced migrants from Ukraine who have not yet come forward to promote their services and to help them obtain the necessary status as well as appropriate assistance and care.
This experience demonstrates that organizations of people living with HIV are an important link and effective moderator between affected community groups, government structures and service providers. In addition, such organizations are flexible and can quickly react to urgent HIV-related challenges even with limited resources.

Source: Kovcheg-AntiAIDS, Rostov-on-Don

36. Stigma and discrimination, including the criminalization of same sex relationships, drug use and sex work, weaken the ability of individuals and communities to protect themselves from HIV and to remain healthy when they are HIV-positive in emergency contexts. This is more pronounced for displaced persons, who are often discriminated against in service delivery. Displaced persons have often been falsely blamed for spreading HIV among host populations, although there is no evidence to support this accusation. On the contrary, a large study of paired sites of refugees in protracted camp-based refugee situations and surrounding populations showed no consistent difference in HIV indicators between these two populations[43].

[43] Spiegel PB, Schilperoord M, Dahab M. High-risk sex and displacement among refugees and surrounding populations in 10 countries: the need for integrating interventions. AIDS. 2013;28(5):761–771. doi:10.1097/QAD.0000000000000118. Quoted in the GAP Report, Displaced Persons Chapter.

37. Rape and other forms of sexual and gender-based violence committed by uniformed service and combatants against civilian populations during conflicts are documented. and increase the risk of HIV transmission. In recognition of the urgent need to address this issue, the UN Security Council has adopted two Resolutions[44] dealing with HIV in the context of armed conflict and peacekeeping operations. UNAIDS has played and continues to play a major role in advocating these Resolutions and in their implementation across all regions and countries where the issue is most relevant. This will continue to be an important priority within the UNAIDS 2016-2021 Strategy. The Security Council has lent its support to the cooperation between UNAIDS and the UN Department of Peacekeeping Operations (DPKO), which is a key stakeholder in addressing HIV in emergencies and has a special mandate for the protection of civilians in conflict. It is crucial that in programmes to address conflict-related gender-based violence, the category of accused populations (alleged perpetrators of sexual and other forms of violent crimes) among combatants and non-state actors is not overlooked.

Key populations and vulnerability

38. There are multiple overlaps and inter-relations between the category of people affected by humanitarian emergencies and some of the key populations identified in the UNAIDS *Gap report*[45]. Key populations have a higher vulnerability to HIV, in humanitarian emergencies and non-emergency settings alike. When they are affected by a humanitarian emergency existing barriers to access to services may be amplified.

39. Considering the high proportion of children and women among the forcibly displaced, as well as among other categories of people affected by humanitarian emergencies[46], the extended and updated UNAIDS Strategy 2016-2021 needs to integrate this dimension to a greater extent, in particular with regards to access to antiretroviral therapy for pregnant women and children. This will be critical for the achievements of targets within the Fast Track approach and towards the goal of ending AIDS as a public health threat by 2030.In addition, emergency situations may result in the separation of children from their carers, putting these children at risk of exploitation and abuse. There is a need for the development of specific policies and approaches for such situations.

40. Power imbalances, due to gender inequality, that make girls and women disproportionately vulnerable to HIV become more pronounced in emergency contexts. In armed conflicts around the world, the use of rape and other forms of sexual and gender-based violence, mainly perpetrated against women and girls (but also against men and boys), is widespread[47]. But also in situations following a natural disaster or in displacement contexts, sexual and gender-based violence often escalates as traditional protection systems are weakened. Given the high incidence of sexual and gender-based violence in emergencies, PEP should be an integral part

[44] S/RES/1308 of 17 July 2000 and S/RES/1983 of 7 June 2011.
[45] http://www.unaids.org/sites/default/files/en/media/unaids/contentassets/documents/unaidspublication/2014/UNAIDS_Gap_report_en.pdf
[46] See paragraph 15 and 16 of this paper.
[47] UN Action Against Sexual Violence in Conflict, Progress Report 2013-2014.

of HIV related services. There may also be increased pressure for people to engage in transactional sex and/or sex work to meet basic needs for themselves and their children[48].

41. HIV risk among sex workers and their clients may be increased in emergencies due to lower condom availability and use as well as increased violence. Sex workers are highly stigmatized in communities and often may not access HIV prevention and response services, thus increasing their risk of acquiring and transmitting HIV. In emergencies, sex workers may find it even more difficult to access these services.

42. In emergency contexts, people who inject drugs may face the interruption of access to safe needles and syringes and to Opioid Substitution Therapy (OST), especially if displaced to a country with major legal and policy barriers to accessing these services. Men who have sex with men, sex workers and people who inject drugs also face high levels of stigma that may further affect access to HIV prevention and treatment services[49].

43. In humanitarian emergencies there may also be migrants and other third country nationals[50] who often have the same or similar needs as displaced persons. Several recent conflicts, such as in Libya, have revealed the importance of these categories of affected persons who are not routinely included in the humanitarian emergency response. Particularly, migrants without a legal status recognized by the State may remain invisible to humanitarian and other service providers and, as a result, become extremely vulnerable.

44. Prisoners and detainees are key populations at higher risk of HIV infection but are often overlooked in humanitarian emergency preparedness and responses. These populations have lost freedom of movement and control of their daily lives and depend on agents of the State for their survival and health needs. In emergency contexts, the ability of the State to provide services to prisoners and detainees may be severely compromised. As part of the emergency response, humanitarian agencies may have to become involved in the provision of assistance, including health care and HIV services, to persons in detention.

[48] UNAIDS, Gap Report 2014, Displaced Persons: http://www.unaids.org/sites/default/files/en/media/unaids/contentassets/documents/unaidspublication/2014/UNAIDS_Gap_report_en.pdf
[49] Ibid.
[50] Third Country Nationals are non-nationals working in a country when it became affected by an emergency. They often number in the tens of thousands (e.g. Libya, Iraq, Syria), need urgent assistance to return to their country of origin and, pending return, are in need of emergency relief assistance. Migrants may not be in the country on a (semi-) permanent basis but in transit to other countries.

Case study Haiti: Treatment and care of prisoners with HIV in the context of an earthquake.

In 2009, Health through Walls, an international NGO dedicated to health of people in prison, had started comprehensive HIV services in the Prison Civile, the largest penitentiary in the capital Port-au-Prince, in partnership with the Government, the UN Department of Peacekeeping Operations (DPKO) and a local health organization GHESKIO. The programme marked the first time that voluntary HIV testing, care and treatment were made available in a prison in Haiti. At the time, the prison held over 4,200 adult males in a space designed for 800. In January 2010, an earthquake caused major damage to the prison and fires erupted. All prisoners fled, including 50 with active TB and 84 persons newly identified with HIV. Within the context of overwhelming humanitarian needs of the general population hit by the earthquake, finding support within the wider humanitarian relief operation for the rebuilding of the prison with respect for the human rights, including health rights, of prisoners and new detainees proved a challenge. However, strong advocacy supported by the International Committee of the Red Cross (ICRC) and donors (particularly USAID) made the difference. After the prison infrastructure had been rebuilt, the comprehensive HIV programme inside the prison resumed and identified and met the needs of prisoners with HIV. In 2014, four years after the earthquake, the programme 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) had been the leading cause of death for prisoners just six years earlier, mortality from HIV has become nearly non-existent.

Source: Health through Walls

45. A large proportion of people affected by humanitarian emergencies are not displaced but remain in their home areas, trying to survive under dramatically changed conditions. The choices they face are harsh: by moving out they risk losing the connections to their livelihoods, assets, family and community, and the traditions that tie them to their homes. Their continued presence is highly fragile; any deterioration of conditions may still force them to leave their areas of origin.

46. Communities that host refugees and forcibly displaced persons often become vulnerable as they share their economic and social resources with the often huge numbers of new arrivals; existing services may become severely overburdened.

47. The category of "*populations affected by humanitarian emergencies*" thus includes all those who were forcibly displaced including members of key populations, detainees, migrants and third country nationals, those who have been affected by disaster or violent conflict but who have not (yet) left their home areas, as well as any host population affected by the arrival of large numbers of forcibly displaced persons.

Case Study: Philippines: Project Sirak – Promoting sexual health, child protection and community building for young key affected populations in Haiyan-Yolanda affected areas.

Before the typhoon Haiyan/Yolanda struck the impoverished Tacloban area in the Philippines in November 2013, the situation for young key populations was already difficult. Awareness of HIV and STI prevention was low and HIV testing negligible. HIV services were limited and of poor quality and legal barriers prevented minors from accessing HIV services without parental consent. This meant that, in practice, these services were hardly being used, especially not by young men who have sex with men and transgender persons. The typhoon amplified the existing vulnerabilities. The devastation caused by the disaster exposed young key populations to human rights violations and further marginalization. There were indications that for many, the need to ensure immediate survival in the context of the emergency led to high-risk sexual behaviour.

Existing disaster preparedness and response plans did not include HIV services and the national AIDS programme did not consider the event of a humanitarian emergency. In partnership with a local group of men who have sex with men, and transgender people, Project Sirak filled these gaps by mobilizing and strengthening the communities of men who have sex with men, and transgender people, to support access to HIV services through peer-led prevention services and referrals. These activities also supported recovery by developing, for the first time, constructive relations between the community groups involved in the project and local authorities.

Source: TLF SHARE Collective Inc., Quezon City, Philippines.

Disruption of essential services, including antiretroviral treatment

48. Humanitarian emergencies often have serious negative effects on HIV programmes and access to health services. People who suddenly find themselves in extremely fragile conditions or who are forcibly displaced in large numbers from their homes face varied risks and vulnerabilities. While the emergency situation may cause a rapid and steep increase in the need for HIV services, delivery of such services may be severely hampered due to logistics and security challenges or the sudden absence of skilled personnel. The destruction of the electricity supply disrupts many key health services. Key populations for HIV interventions may be harder to reach or they may become entirely inaccessible. Likewise, key populations may find services more difficult to access. As a direct result of the consequences of emergency situations, strides in HIV programmes that may have taken decades to build may be eroded within a short time span, dramatically setting back national, regional and global levels of progress. This is particularly true in countries with already strained or fragile health systems and is compounded by the fact that humanitarian emergencies may arise anywhere in the world irrespective of a country's development situation. It

may be further aggravated by the fact that many humanitarian emergencies occur in areas where existing health and HIV indicators are poor.

49. For people living with HIV, emergencies may interrupt their care and antiretroviral treatment. There is a growing body of evidence on antiretroviral treatment and HIV-related risks and vulnerabilities among populations affected by humanitarian emergencies that emphasizes the critical importance of continuity of treatment[51]. Maintaining the provision of antiretroviral treatment for HIV and treatment for tuberculosis, sexually transmitted infections and opportunistic infections, as well as specific services for pregnant women[52] is critical. Similarly, the continuation of opioid substitution therapy (OST) should be ensured for people who inject drugs. It is therefore crucial that preparedness plans cover access to methadone or buprenorphine. Considering the security constraints associated with the transportation, stocking and dispensing of controlled medications (narcotic drugs for medical purpose) in the case of emergencies, alternative regulations should be established to avoid discontinuity of treatment.

50. In 2013, of the estimated 1.6 million people living with in emergencies, only 491,211 had access to antiretroviral treatment, leaving a treatment gap in 1,091,838 people. The treatment gap was particularly critical among children, adolescents and pregnant women living with HIV and affected by humanitarian emergencies, estimated at 161,233 children, 139,672 adolescents and 55,868 pregnant women. [53]

51. In Sub-Saharan Africa 894,172 people living with HIV affected by emergencies are estimated to be facing a treatment gap. In MENA this number is estimated to be 61,778 and in Asia and the Pacific, 88,475. The numbers are reflective of the sheer magnitude of the treatment challenges faced in emergencies.[54]

Case study West Africa: Patient tracing and continuation of HIV services in the context of the Ebola outbreak in West Africa.

In 2014, the Ebola crisis erupted in Sierra Leone, Liberia and Guinea. Very rapidly, the crisis severely disrupted health services. Many health staff died and the population became reluctant to seek care at health facilities for fear of contracting Ebola. Public health measures taken in response to the crisis such as quarantines and restrictions on movement hampered access to treatment, including antiretroviral treatment, for people living with HIV. Emerging shortages of food and water compounded the situation for people living with HIV.

[51] See evidence presented in: Guidelines for the delivery of antiretroviral therapy to migrants and crisis-affected persons in sub-Saharan Africa; September 2014. UNHCR, Southern African HIV Clinicians Society, Wits Reproductive Health and HIV Institute, et al.
[52] UNAIDS Gap Report, 2014. Displaced Persons. p 13. In emergencies, the priority should be to ensure access to safe delivery care (e.g. the Minimum Initial Service Package-MISP). When the emergency situation has been stabilized, the services should expand to comprehensive Reproductive Health services, including antenatal care, followed by PMTCT services.
[53] These estimates are the outcome of research jointly conducted by UNICEF, UNHCR, WFP and the UNAIDS Secretariat in 2015.
[54] Ibid

In Sierra Leone, HAPPY, an NGO with an existing programme on HIV prevention among young people in the capital Freetown, realized that the situation of people living with HIV was quickly becoming a health emergency of its own. In response, the agency launched a project aimed at reducing the number of persons defaulting on their HIV treatment and at preventing further loss to follow-up. When a rapid assessment of health facilities noted a significant decline in the uptake of HIV maternal and child services, improving access to HIV services for pregnant and lactating women as well as children was added to the project. Outreach teams were trained to trace and contact people who had interrupted their HIV treatment in order to dispense drugs and counsel patients within the constraints imposed by the risks and fears associated with Ebola. By the end of the year, 60% of children and 84% of pregnant women who had defaulted on treatment were back on treatment again.

In neighbouring Liberia, the Ebola outbreak had similar effects on HIV services and resulted in the closure of the three hospitals in the capital Monrovia for five months. In the midst of this unprecedented emergency situation, continuity of care for HIV positive patients was successfully ensured through an active collaboration between clinical staff, local patient associations such as “Positive Living with AIDS in Liberia” and the National AIDS Control Program.

In both Sierra Leone and Liberia, the active involvement of local organizations of people living with HIV proved crucial in restoring access to HIV services for many. Their involvement led to critical components of the response: knowledge and trust, as well as the ability to quickly adapt to emerging needs.

In Guinea, although health facilities remained open, the Médecins Sans Frontières (MSF) team also reported patients reduced access to HIV treatment. In response, the team introduced refilling treatment supplies for a period of six instead of the usual three months as a more feasible system to ensure treatment continuation.

Source: Summary based on submissions from HAPPY in Freetown, Sierra Leone; the International Community of Women living with HIV, Médecins Sans Frontières (MSF) Guinea.

52. In humanitarian emergencies, service providers may fear that providing antiretroviral treatment is too complex due to the unstable nature of the situation. However, it has been demonstrated that providing HIV treatment in conflict zones is both feasible and effective and guidelines related to the process have been produced[55]. In fact, an analysis of 17 studies in 13 countries where treatment was available and accessible showed that 87-99.5% of people affected by conflicts adhered to treatment, which was similar to adherence rates among non-affected groups[56].

53. In fact, disruption to antiretroviral treatment service provision and adherence should be anticipated and included in preparedness planning. As treatment access increases globally, ever-larger numbers of people with HIV in currently stable areas

[55] Guidelines for the delivery of antiretroviral therapy to migrants and crisis-affected persons in sub-Saharan Africa; September 2014. UNHCR, Southern African HIV Clinicians Society, Wits Reproductive Health and HIV Institute, et al.
[56] O’Brien DP, Venis S, Greig, J, et al. Provision of antiretroviral treatment in conflict situations: the experience of Médecins Sans Frontières. Conf. Health; 2010, 4:12. Doi:10.1186/1752-1505-4-12. Quoted in the UNAIDS Gap Report, 2014. Displaced Persons Chapter, p. 8.

are at risk of treatment disruption should conflicts or other emergencies affect health services, or force their migration or displacement. Effective national and regional logistics strategies and supply chain management systems are fundamental to the stocking and delivery of antiretroviral medicines[57]. The development of simple, regionally harmonized standards of treatment should be a priority. This would improve the chances of patients on the move across or within international borders to remain on the same antiretroviral treatment regime. Monitoring and evaluation systems should also be strengthened to improve follow-up of patients that move between different treatment sites (e.g. through the use of unique patient identifiers)[58].

Case Study Mozambique. Flood response; lessons learned for HIV programming.

In January 2103, the Gaza Province experienced devastating floods. Many health facilities were damaged or destroyed and patient records and medicines lost. An estimated 150,000 people were directly affected, including some 13,000 people living with HIV who were at risk of antiretroviral treatment interruption. UNICEF responded with radio broadcasts and other community outreach activities to disseminate key information on HIV prevention and treatment. Community activists were mobilized to reach out to the affected population and distribute supplies such as condoms and water treatment kits. They identified people living with HIV and provided them with information about how to continue accessing services. Across the affected region, several tents were set up as temporary health clinics to provide treatment and care, including for HIV. In addition, nutritional support was offered to patients.

Source: UNICEF-Mozambique.

Emergency preparedness

54. Adequate preparedness at country-level is the key to an effective emergency response and this applies particularly to HIV programming. Interagency country-level preparedness planning sets the stage for an eventual response, identifies its likely future priorities and agrees an outline of its specific coordination arrangements. Within the context of many competing urgent needs of the overall population affected by the emergency, those of (smaller) groups with specific needs such as the elderly, persons with disabilities or the integration of an appropriate gender or HIV focus, often are overlooked during the critical first phase of the response. An appropriate HIV perspective must be integrated during the preparedness phase to ensure that HIV specific goals and activities are firmly embedded in initial emergency needs assessments (rapid assessments and those following).

Case Study Nepal: The Nepal earthquake exposes gaps in disaster preparedness.

[57] Ibid.
[58] Guidelines for the delivery of antiretroviral therapy to migrants and crisis-affected persons in sub-Saharan Africa; September 2014. UNHCR, Southern African HIV Clinicians Society, Wits Reproductive Health and HIV Institute, et al.

On 25 April 2015, an earthquake in Nepal caused widespread devastation. Hospitals were overcrowded and basic facilities such as water and electricity were disrupted. Many rural health centers had become dysfunctional. Some 75,000 people moved into rapidly erected tented relief camps. The immediate emergency response focused on the provision of food, water, shelter and medical help to the survivors. The latter mainly comprised trauma care for survivors injured by collapsing buildings. Another priority was the prevention of outbreaks of communicable diseases resulting from overcrowding in relief camps, contaminated water supply and poor sanitation. In the context of these sudden, urgent new priorities, it was a challenge to continue providing treatment to regular patients with chronic conditions, which will have included patients on ART. As recently as in March 2015, during the Third World Conference on Disaster Risk Reduction in Sendai, Japan, the Government of Nepal shared its concern about the hazard of an earthquake. They reported risk reduction plans that included the structural reinforcement of all health sector front-line buildings such as hospitals for the event of a natural disaster. Dramatically, the earthquake struck before these plans could be fully implemented, which underscored the critical importance of disaster preparedness.

Source: Sharma D. Nepal earthquake exposes gaps in disaster preparedness. Lancet: 9 May 2015 (Vol. 385, Number 9980).

55. Preparedness planning as a component of HIV programmes must always include contingency plans for the provision of antiretroviral treatment and, where appropriate, OST for people who inject drugs, especially in emergency-prone settings. Plans may include the use of 'health travel cards', which is an innovative approach to ensure the correct treatment for mobile populations without further HIV testing or clinical staging requirements[59].

56. Another critical component of preparedness planning is the systematic gathering of strategic information. This information is crucial to support planning, programming, and decision-making in order to improve the design and delivery of appropriate HIV interventions as well as for making adjustments in response to changed conditions and new challenges. Information should be gathered on potential hazards and risks as well as on the populations and ongoing HIV programmes likely to be affected.

57. Within the collective efforts to end the AIDS epidemic as a public health threat by 2030, including accelerated response and investment over the next five years, proper risk assessments as well as preparedness planning for potential crisis scenarios with the aim of ensuring the uninterrupted provision of services to the affected populations in the event of a humanitarian emergency will be critical. The development of contingency supply chain management systems and alternative logistical arrangements is a key element in these planning efforts. Strong supply chains and logistics mechanisms are essential to ensure that medicines and medical supplies remain available to populations affected by emergencies. Therefore, in all preparedness planning adequate attention should be given to supply chain risk management to prevent stock-outs and treatment interruption and to ensure that life-saving commodities remain available to those who depend on them. In addition, the feasibility of deploying mobile clinics in emergencies should be considered.

[59] Ibid.

Case Study Ukraine: Ensuring continued access to HIV prevention, treatment and care during the humanitarian emergency in Eastern Ukraine

Since the beginning of the armed conflict in April 2014, infrastructure in many parts of Eastern Ukraine has been destroyed and the supply of food, drinking water and medicines to the civilian population severely affected. As of May 2015, over 7,000 people have lost their lives, 15,000 were severely injured and 1.2 million were forcibly displaced. Risk factors associated with HIV, tuberculosis and hepatitis infection have substantially increased, including reported increases in sex work, unsafe drug use and drug overdose.

Prior to the start of the conflict, existing harm reduction programmes in two Eastern Ukrainian regions (Donetsk and Lugansk) were reaching almost 45000 people from key populations per year. The programmes comprised distribution of prevention commodities through outreach, community centres, pharmacies and mobile clinics; testing for HIV and STIs; and medical referrals, including antiretroviral treatment. At this time in the Donetsk and Lugansk regions 33,305 people living with HIV were receiving medical services (approximately 25% of all people living with HIV receiving medical services in Ukraine) and 13,422 were on treatment (20% of the total number of people receiving HIV treatment in Ukraine). When the violence began, the supply of opioid substitution therapy (OST) drugs was interrupted and hundreds of patients were internally displaced and forced to search for treatment elsewhere. The conflict also disrupted the state supply of antiretroviral medicines and medical goods to the non-government controlled territories. Under these emergency conditions, the harm reduction programme was redesigned and expanded to respond to new needs: basic food packages, paramedical and psychological services were added. Faced with the threat of treatment interruption, the All-Ukrainian Network of people living with HIV (AUCO), as the principal recipient of the Global Fund grant, has supplied antiretroviral medicines through its sub-recipients in hospitals and prisons in the non-government controlled territory. Despite security problems, repeated interruptions in supply of commodities, inaccessibility and new administrative obstacles, harm reduction programmes have been able to maintain almost the same level of coverage as prior to the violence in these two regions: 43,500 people were reached over the past year, 60% of which were reached in non-government controlled territories.
The World Health Organization (WHO), Médecins sans Frontières (MSF) and the Government of Ukraine provided critical support.

Source: International HIV/AIDS Alliance-Ukraine and the All-Ukrainian Network of PLHIV (AUCO).

Coordination

58. Experience has demonstrated that preparedness, response and recovery efforts need to first be informed by involving community structures, a review of local capacity and an understanding of community coping mechanisms and resilience—as local communities are usually the first responders to emergencies.

59. Whether or not a humanitarian emergency situation prompts the active involvement of international agencies depends largely on its scale, complexity, and urgency/gravity, as well as on the capacity of local or national services to ensure a rapid and effective response. In most situations, a large-scale sudden-onset humanitarian emergency caused by a natural disaster, conflict or mass displacement and exceeding (or threatening to exceed) the national response capacity triggers a coordinated complementary response by a variety of United Nations (UN) agencies, international organizations, non-governmental organizations (NGOs) and governments. As each humanitarian emergency is the outcome of different factors, each demands a unique response aimed towards the specific sectors affected.

60. With the typical involvement of multiple humanitarian organizations, the coordination of humanitarian emergency operations can be a challenge. This is compounded by the need to provide an effective response across a wide range of sectors (e.g. food security, shelter, water and sanitation, health, education, nutrition, protection, logistics, community services). In addition, there is a need to ensure continuous exchanges, in the context of a rapidly changing environment, with critical partners such as donors and development actors.

61. The foundations for the current international humanitarian coordination architecture were laid by the General Assembly Resolution 46/182 of December 1991. The Humanitarian Reform process, launched in 2005 introduced a number of new elements to enhance predictability, accountability and partnership. An important element is the cluster approach[60]. Within the cluster approach, HIV is recognized as a “cross-cutting issue”: the Humanitarian Coordinator of an emergency operation may establish a thematic group from among the partner organizations and task it to provide coordination on all HIV related issues across the different clusters. Despite this opportunity to consider HIV services appropriately, donors and humanitarian actors often do not adequately prioritize HIV in humanitarian response operations or utilize the cluster approach to integrate HIV. Response to refugee crises are

[60] Clusters, led and coordinated by Clusters Lead Agencies, are IASC-designated groupings of humanitarian organizations (both UN and non-UN) in each of the main sectors of humanitarian action. They operate at both global and country level. At the global level they are responsible for strengthening system-wide preparedness and coordinating technical capacity to respond to humanitarian emergencies in their respective sector. At the country level clusters ensure that activities of humanitarian organizations are coordinated, serve as a first point of call for the Government and the RC or HC, and as a provider of last resort in their respective sector (Handbook for Resident Coordinators and Humanitarian Coordinators on Emergency Preparedness and Response; IASC, 2010).

coordinated under the Refugee Coordination Model[61], in which UNHCR, per its statutory obligations leads and coordinates the delivery of protection, assistance and solutions through a partner inclusive multi-sector approach. While life-threatening situations are rightly given focus in emergencies, the goal of ending the AIDS epidemic as a public health threat by 2030 necessitates a stronger focus on HIV in emergency contexts.

62. Over the past 20 years, a series of guidelines have been produced by UN agencies, international organizations and NGOs to provide operational guidance on the appropriate integration of HIV services in emergency settings. Despite the comprehensive nature of these guidelines, they are not used on the scale intended[62]. Research and compilation of lessons learned is required to understand why this is the case as the most recent guidelines offer a reasoned approach that enables the development of appropriate programmes in light of the specificity of each emergency situation, including prevailing HIV prevalence levels and critical HIV related services. Yet, humanitarian agencies continue to almost exclusively focus on outbreak-prone diseases and malnutrition, both during the preparedness as well as the response phase of an emergency[63].

63. There have also been a number of strategies launched to enhance the delivery of HIV services to populations of humanitarian concern—for example, the "Joint UN System-wide Work Program on Scaling-up HIV Services for Populations of Humanitarian Concern" (2006-2008), an initiative to combine the efforts of ten UN agencies to integrate HIV into humanitarian mechanisms and to strengthen the prevention and mitigation efforts around gender-based violence, with particular focus on providing comprehensive HIV services to populations of humanitarian concern that had hitherto not been reached with these services[64]. However, despite an independent evaluation noting the programme's strong catalytic function in this area of work[65],so far neither this, or any other similar initiatives have led to the standard integration of people affected by humanitarian emergencies into both HIV and humanitarian planning and programming.

Case study Djibouti: Stop HIV in the refugee camps in Djibouti.

The two refugee camps in Djibouti accommodate mainly refugees from Somalia: Ali Addeh hosts almost 25,000 persons while Holl Holl has a population of some 2,300. In 2013, the HIV prevalence in the camps was similar to that of the general population of Djibouti. However, there were indications that numerous refugee women were engaging

[61] Refugee Coordination Model: http://www.unhcr.org/pages/538dd3da6.html
[62] In 1996, WHO, UNAIDS and UNHCR issued the "Guidelines on HIV/AIDS in Emergencies". In later years, the Inter-Agency Standing Committee (IASC) produced a series of new and updated guidelines on the subject. In 2003, the IASC Reference Group on HIV/AIDS issued a "Plan of Action for 2002-2003". The IASC issued the "Guidelines for HIV/AIDS Interventions in Emergency Settings" in November 2003. The most recent guidelines are the "IASC Guidelines for Addressing HIV in Humanitarian Settings" of September 2010. Each of the more recent documents contained the promise that lessons learnt exercises would be conducted; no evidence of this has so far been found.
[63] UNAIDS GAP Report 2014. P 11.
[64] The programme involved ten UN agencies: FAO, OCHA, IRIN, UNDP, UNFPA, UNHCR, UNICEF, WFP, WHO and UNAIDS.
[65] UNAIDS/PCB(27)/10.22 Page 4/12.

in sex work due to the extreme poverty faced in the absence of husbands and/or other providers. Whilst the refugee population has usually been included in the national AIDS plans, they have been generally overlooked when it came to implementation of these plans. UNAIDS and UNHCR found further indications that an urgent response was required: the refugees in Ali Addeh had little interest in HIV counseling and testing while refugees in Holl Holl had no access at all to HIV testing and counselling services; young refugees had extremely low HIV prevention awareness; and there was a high incidence of STIs. Following a participatory needs assessment and planning process in which the refugees were closely involved, a comprehensive HIV prevention programme was rolled out in January 2014. There was a clear division of duties: UNHCR assumed responsibility for technical coordination at camp-level, whilst UNAIDS was accountable for inter-agency coordination. The objective was to ensure access to HIV prevention services for all refugees in the camps as well as all members of the surrounding local communities. A voluntary HIV testing and counselling center was opened in Holl Holl and the center in Ali-Addeh was equipped. An intensive information campaign was undertaken with the support of a local NGO partner and the network of people living with HIV; the National AIDS Programme ensured the training of service providers on HIV counselling as well as on the use of the national guidelines on antiretroviral treatment. After one year, the project could be considered a success: the incidence of STIs was halved; HIV testing and counselling increased more than threefold from 522 to 2322 persons tested and also testing of pregnant women saw a significant increase. The project has contributed to a reduction in HIV prevalence in the camps: from 2.7% in 2012, 2.1% in 2013 and 0.89% in 2014. The main factors in the success of the project were: joint assessment, participatory planning and priority setting, and clarity in the allocation of responsibilities to each of the collaborating agencies. Implementation of the programme was made possible by the critical participation the “Association pour l’Épanouissement de la Famille” (APEF). UNICEF and UNDP provided technical contributions on supply management.

Source: Ministry of Health and UNHCR/UNAIDS in Djibouti.

Linkages with sustainable development

64. Whether they result from natural or man-made disasters or violent conflict, humanitarian emergencies typically have severely disruptive consequences for a country’s development. These negative effects are compounded by the long time it takes before reconstruction and rehabilitation that follow the initial emergency response take effect. Linking the short and mid-term humanitarian responses to a country’s longer-term development strategies are essential to mitigate the negative impacts that disasters, armed conflict and forced displacement have on sustainable development goals.

65. In particular, by strengthening local communities to prepare for and respond to emergencies, their capacity to absorb and withstand shocks can be significantly enhanced and the impact of disasters and emergencies reduced. Sustainable development programmes should therefore prioritize the building of community resilience. Conversely, humanitarian programmes can contribute to Sustainable Development Goals by closely involving local community structures in all aspects of emergency preparedness and response activities. Priority should be given to building national and local capacities in emergency preparedness and response plans in

order to prevent a gap that may occur when humanitarian agencies begin to depart after the emergency stabilizes. To be effective, the linkages between humanitarian agencies and development actors must already be established in the preparedness phase and maintained throughout the subsequent phases of response, early recovery and reconstruction.

66. Recently, participants at the Third World Conference on Disaster Risk Reduction (Sendai, Japan, March 2015) discussed multiple aspects of the links between humanitarian emergency management and development. The Conference recognized that key sustainable development goals, including HIV goals, cannot be achieved if humanitarian emergencies continue to erode progress. The Conference lent strong support to the notion that disaster risk reduction is essential to achieve sustainable development. One of its priority goals should be to strengthen the resilience of national health systems, including by integrating disaster risk management into primary, secondary and tertiary health care, especially at the local level. The Conference highlighted the importance of mobilizing vulnerable communities, putting them at the center of disaster prevention, preparedness, recovery and rehabilitation efforts, along with the need to foster effective shared accountability. It encouraged the adoption of policies and programmes that address disaster-induced displacement and strengthen the resilience of affected people as well as of host communities. The Conference recommended that health interventions, with a particular mention of pandemics and epidemics, should be mainstreamed across all risk management programmes[66]. More specifically, the Conference recommended that people with life-threatening and chronic disease, due to their particular needs, should be included in the design of policies and plans to manage their risks before, during and after disasters, including having continued, uninterrupted access to life-saving services.

Case Study Afghanistan, Pakistan and Iran: Provision of comprehensive harm reduction services to Afghan refugees in Iran and Pakistan and to returnees in Afghanistan.

Over thirty years of war have driven millions of Afghans into neighbouring Pakistan and Iran as refugees. Millions have since returned home, but several million Afghan refugees remain in their asylum countries. Iran and Pakistan both have a high prevalence of injection drug use and a high HIV prevalence among people who inject drugs. Over the past few years, Afghanistan has witnessed a steep increase in the numbers of people who inject drugs, including among returnees. In 2009, a UNODC survey showed that the number of Afghans between the ages of 15 and 64 who regularly used illicit drugs had increased dramatically since a preceding survey, only four years earlier: opium by 53% and heroin use by 140%. The HIV prevalence amongst Afghan refugees and returnees is not known. However, as the rates of injection use among Afghan refugees in the two asylum countries are high, the assumption can be made that as returns from Pakistan and Iran continue, the implementation of HIV prevention, treatment and care programmes targeting returnees and their communities are essential.

Against this background, in 2014, UNODC in partnership with UNHCR developed a sub-regional programme comprising comprehensive HIV prevention and harm reduction activities as well as HIV testing and counselling and HIV treatment for Afghan refugees

[66]. http://www.wcdrr.org/uploads/Sendai_Framework_for_Disaster_Risk_Reduction_2015-2030.pdf

in Iran and Pakistan and returnees in Afghanistan. The prevention interventions include distribution of condoms and syringes. The programme's regional character supports HIV services across borders thus promoting continuation of services after a refugee's return. In Afghanistan, the programme has reached approximately 3,000 people who inject drugs, including some 500 women. In addition to providing HIV services, 500 returnees were tested for STIs. Approximately 5000 Afghan refugees have benefitted from various HIV services in Pakistan while in Iran several hundred Afghan refugees have accessed the programme. However, impact has been difficult to measure, mainly due to the lack of baseline data.

Source: UN Office on Drugs and Crime (UNODC), Vienna.

Resource mobilization

67. For inter-agency responses in humanitarian emergencies, there is a need to better utilize not only the cluster approach and the related Consolidated Appeal Process (CAP) or Humanitarian Programme Cycle[67] but also the available links between HIV and other inter-agency mechanisms such as the refugee coordination model and the refugee response plan. Likewise, it is important to coordinate with other programmes in the health sector such as tuberculosis (TB), sexual and reproductive health, nutrition and antenatal care (ANC) and with other sectors such as food, water/sanitation, education and protection.

Case study Horn of Africa: Important HIV issues overlooked in the emergency funding appeals and response to a regional drought.

In 2011, Djibouti, Ethiopia, Kenya and Somalia experienced two consecutive seasons of poor rainfall: approximately 12.4 million people were affected by drought. In the appeal documents detailing the humanitarian requirements for this situation, HIV was referred to in only three insignificant places, with no reference to data on the magnitude of the problem and no mention of existing gaps in HIV-related services. An analysis of the drought-related humanitarian appeals revealed that no HIV-specific projects were included in the country appeals despite both Ethiopia and Kenya being high-burden HIV countries and Djibouti experiencing a concentrated epidemic.

Source: UNAIDS Gap Report[68].

68. Within funding for HIV programmes there is an equally noticeable neglect of emergency contexts and the various categories of populations affected by humanitarian emergencies. In a large proportion of national HIV strategic plans as well as in grants awarded by the Global Fund in rounds 1-8 in sub-Saharan Africa, displaced persons (57% of countries) and refugees (52% of countries) were not mentioned. Only a minority of plans included activities for refugees and internally

[67] The Consolidated Appeal Process (CAP) is being phased out and being replaced by the Humanitarian Programme Cycle (HPC) in line with the IASC Transformative Agenda (OCHA-Consolidated Appeal website, accessed April 2015).
[68] UNAIDS GAP Report, Displaced Persons, p 11.

displaced persons. Between 61% and 83% of countries with more than 10,000 refugees and internally displaced persons did not include these groups in their approved proposals[69]. These figures emanate from a region with high overall HIV prevalence. It is also a region characterized by large-scale and protracted emergencies, particularly forced displacement. It is unlikely that other regions would perform better as far as the integration of humanitarian emergencies into HIV programming are concerned.

69. When confronted with a humanitarian emergency in their area of operation, stakeholders of the global AIDS response are frequently forced to revisit their priorities and to redirect already strained human and financial resources to respond to the consequences of the emergency. This applies to governments, UN agencies and other multilateral partners, civil society, donors (including private sector donors), and peacekeeping operations alike. The existing health systems are invariably severely burdened by the demands put on them by an emergency as well as by the sudden significant changes in the environment in which they operate (affecting human resources, procurement, security, logistics, etc.). These circumstances and challenges underscore the critical importance of timely preparedness planning to facilitate rapid decision-making and the appropriate re-prioritization of programme activities. Innovative funding mechanisms such as maintaining an internal, earmarked contingency fund to allow for a rapid response to address HIV in emergency settings have been introduced by donors. Such new funding mechanisms, as well as flexible donor regulations to allow for re-directing resources towards emerging HIV related needs in an emergency, should be expanded and further explored.

Case Study Sudan: Need for alternative multilateral funding procedures for HIV services under conditions of violent civil conflict.

Until 2011, the Sudanese National AIDS Programme, together with several international NGOs, had been supporting comprehensive HIV services at a dozen health facilities across the Sudanese province of South Kordofan. The Sudanese Secretariat of Health provided medical supplies and staff salaries. While the standard of health was basic, services functioned. However, when hostilities between the Sudanese military and the SPLM-North rebel movement resumed in 2011, this changed. Humanitarian actors were expelled and the support from the Secretariat of Health was suspended. HIV medicines as well as medicines for tuberculosis had been provided through the National AIDS Programme; however due to the conflict, this support was discontinued. Despite the violence, several partners continued to provide support to communities in rebel-controlled areas. The Diocese of El Obeid operates the only functional hospital in the area, the Mother of Mercy Hospital (MMH). In 2013 alone, the hospital provided health services, including HIV services, to over 40,000 people.

While there are no HIV prevalence figures available for Kordofan Province, in 2014 the MMH recorded an increase of 6.5% in the HIV infection rate among its patients. In

[69] Spiegel PB, Hering H, Paik E, Schilperoord M. Conflict-affected displaced people need to benefit more from HIV and malaria national strategic plans and Global Fund grants. Confl Health 2010;4:2. Quoted in the GAP Report, Displaced Persons, 2014.

response, the Diocese scaled up its HIV programme which now includes provider-initiated HIV testing and counselling, services for the prevention of new HIV infections among children and the full spectrum of care and treatment in addition to HIV awareness activities within the communities. However, ensuring a sufficient supply of HIV tests has proven a challenge. Also the critical ongoing supply of antiretroviral medicines for people on treatment cannot be ensured. As the local health authorities do not have the resources available, these needs can only be met through donor funding which is highly precarious since most international, particularly multilateral, aid is channeled through governments. This is complicated in areas of South Kordofan where the Sudanese government is not in control. Thus, attempts to access medicines through UN and other multilateral channels have been unsuccessful. As a stopgap measure, Caritas found support within its own global faith-based network after it launched an emergency appeal.

Source: Caritas Internationalis.

CONCLUSIONS AND THE WAY FORWARD

70. To reach the ambitious goal of ending the AIDS epidemic as a public health threat by 2030, including through accelerated action and investment over the next five years, the UNAIDS Strategy (2016-2021) and collective efforts should give greater prominence to the category of people affected by humanitarian emergencies to help ensure that no one is left behind.

71. Following the fundamental principles of **human rights, equity and protection**, it is imperative to address the HIV-related needs of all of those affected by humanitarian emergencies, regardless if they have been displaced. It should also be recognized that members of **key populations** are present in communities affected by humanitarian emergencies and may require special attention and tailored interventions.

72. Millions of people who currently live in stable or fragile environments may experience major disruptions as a consequence of emergencies. **Preparedness** is key, including contingency planning and risk analysis.

73. **Priority setting within an HIV response** in an emergency should be appropriate to the situation. In *low prevalence* settings, HIV issues should be addressed through existing entry points and efforts for protection, such as gender-based violence, mandatory testing, expulsion (refoulement) and other protection issues. In areas with *high prevalence*, programmes should focus on all elements of reducing the risk of infection and ensuring treatment continuity. Innovative approaches such as travel health cards and longer refills of antiretroviral treatment should be explored. In *concentrated epidemics*, the focus should prioritize the relevant key populations for continuity of prevention and treatment, including OST.[70]

74. The involvement of **community structures** and an understanding of community coping mechanisms and **resilience** should inform preparedness, response and recovery efforts as communities are the first responders to emergencies. From the

[70] http://www.unicef.org/aids/files/ART2014-189014B-LOWRES_(1).pdf

outset, therefore, a key focus of all preparedness and response activities should be to support and strengthen local community structures to assume an appropriate and central level of responsibility in the emergency response and early recovery phase. People living with HIV and key populations most affected by HIV should be included in the design of policies and plans to manage their risks, including the prevention of treatment interruption and ensuring continued access to all HIV services.

75. Cooperation with **development actors** is critical. The links with on-going development programmes as well as between those involved in the first response and those responsible for the post-emergency phases of recovery and development must be established in the preparedness stage and maintained throughout. Disaster risk reduction is essential to sustainable development.

76. In many field operations, **coordination** is a major challenge. Intersections between HIV programmes and inter-agency approaches such as the cluster mechanisms, refugee coordination model as well as the Consolidated Appeals Process (CAP) and Refugee Response Plan (RRP) planning should be better utilized. It is important to coordinate with other programmes in the health sector such as tuberculosis (TB), sexual and reproductive health, nutrition and antenatal care (ANC) and also with sectors such as food security, logistics and supply chain management, education and protection.

77. More robust **evidence** is needed. Existing databases capturing the linkages between HIV and emergencies are overlapping and often incompatible; metrics must be harmonized. Data gathering should be improved, should include sub-national analyses and be optimized to accurately forecast the impact of emergencies on HIV.

78. New approaches to **funding** should be explored, including seeking flexible funding and allocating internal seed funding, as well as focusing on an investment approach to ensure that the substantial funding invested to date, and the resultant gains, are not lost through neglecting populations affected by humanitarian emergencies.

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