NGO REPORT 2023
People living with HIV during humanitarian emergencies

Additional documents for this item: N/A

Action required at this meeting—the Programme Coordinating Board is invited to:

- *Recall* the Global AIDS Strategy 2021–2026, specifically its 95–95–95 treatment targets in all populations, regions, and countries affected by the HIV epidemic; its 95% combination prevention target for people at risk of HIV in humanitarian settings; its 90% target of people in humanitarian settings having access to sexual and reproductive health and rights, tuberculosis, HIV and gender-based violence services;

- *Recall* the report by the NGO Representative at the 43rd meeting of the UNAIDS PCB, decision point 4.4, on addressing the diverse needs of migrants and mobile populations as well as refugees and crisis-affected populations, and decision point 4.6, on promoting access to services; improving data about people on the move; adapting laws, policies and practices that prevent access; strengthening health systems; and enabling collaboration between health systems and communities;

- *Take note* of the report by the NGO Representative;

- *Call on* the Joint Programme to:
    a. Update the 2010 *Guidelines for Addressing HIV within Humanitarian Settings* (Inter-Agency Standing Committee Task Force on HIV), including specifically addressing the needs of people living with HIV;
    b. Provide the PCB annually with an update on HIV prevalence and incidence in countries experiencing humanitarian emergencies, as well as an update on the Joint Programme's response to HIV in humanitarian emergencies, with a specific focus on people living with HIV;
    c. Review and, where needed, update the division of labour between the Cosponsors of the Joint Programme on HIV services in humanitarian emergencies to ensure a stronger integration of HIV in the humanitarian response of all actors especially at the country level;
    d. Collaborate with national stakeholders to develop a targeted response for people living with HIV during humanitarian emergencies in national strategic and emergency plans;
    e. In conjunction with relevant stakeholders, agree on a common definition of humanitarian emergencies;
    f. Develop guidelines for service provision for people living with HIV during humanitarian emergencies, including identifying a minimum package of interventions and highlighting the role of communities;
    g. Coordinate the development of an investment strategy—including government, donor, and private funding streams—for building and sustaining the leadership of communities and people living with HIV during humanitarian emergencies; and
    h. Establish a collaboration with the International Organization for Migration and the United Nations Office for the Coordination of Humanitarian Affairs to improve the collective capacity of different UN agencies and other stakeholders to address HIV in humanitarian settings.

Cost implications for the implementation of the decisions: N/A

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Summary

1. This 2023 NGO Report builds on the 2018 NGO Report titled *People on the move*. It is intended to be a user-friendly document which, among other things, expands our understanding of humanitarian emergencies and contributes to the development of a minimum package of services for people living with HIV during humanitarian emergencies.

2. The report draws on a variety of sources, including: library research; a global community survey in English, French, Spanish and Russian; interviews with 28 key informants; six focus groups in English and French (55 participants); seven good practice case studies; and a peer review process.

3. Over the years, key concepts in the field of humanitarian emergencies have become less clear and the related funding models have weakened. At the same time, these emergencies continue to seriously disrupt services for people living with HIV, including for preventing and treating HIV and for providing mental health and other support.

4. Communities provide a range of services through local physical and mental health professionals, as well as trained and supervised peers and lay workers. That work requires partnerships with strong and well-prepared healthcare systems, speedier access to humanitarian aid, improved opportunities, and a strengthened capacity for leadership. It also requires that humanitarian responses be conducted in ways that build agency and resilience. Delaying support for communities until *after* a humanitarian phase misses huge opportunities, as shown in the seven good practice case studies below.

5. This report proposes an initial set of guiding principles towards developing a minimum package of HIV services for people living with HIV during humanitarian emergencies. It also provides an initial outline of what a minimum package of services would include: a three-month supply of antiretrovirals; enough food to meet the additional nutritional needs of adults and children living with HIV; HIV-related health-care priorities; capacity building of community workers and peers; and mechanisms for delivering cash transfers.

6. The report highlights six overarching recommendations:

   - promote a clear understanding of the term "humanitarian emergency";
   - recognize the special health and psychosocial needs of people living with HIV;
   - integrate humanitarian responses within HIV strategic plans;
   - collaborate with relevant partners to further clarify a minimum package of interventions;
   - recognize the critical role of communities; and
   - develop and implement interventions aimed at mitigating the negative impacts on the continuum of HIV services.

7. The report ends with a call to action which is directed to the UNAIDS Programme Coordinating Board. It highlights the need to:

   - promote a common understanding of humanitarian emergencies in terms of their impact on people living with HIV;
   - clarify where UNAIDS locates accountability within its own structures in relation to its response to the needs of people living with HIV during humanitarian emergencies;
   - update the 2010 Guidelines for Addressing HIV within Humanitarian Settings;
   - convene a process to further develop the guiding principles and contents of a minimum package of interventions;

- elaborate an investment strategy for building the leadership of communities and people living with HIV during humanitarian emergencies; and
- urgently enhance collaboration with the International Organization for Migration and the United Nations Office for the Coordination of Humanitarian Affairs.

Introduction

"With hunger, many sick people have stopped taking ARVs and, unfortunately, we lost four of our comrades. Most of the sick don't have money."

– Francophone African survey respondent

8. The 2023 NGO Report addresses the topic of people living with HIV during humanitarian emergencies. The report aims to:

- share a common understanding of humanitarian emergencies in terms of their impact on people living with HIV;
- highlight the effects of humanitarian emergencies on HIV prevention, testing, treatment and care specifically relative to people living with HIV;
- showcase the critical role of communities in responding to the needs of people living with HIV during humanitarian emergencies;
- share best practices on responses to humanitarian emergencies for and by people living with HIV; and
- identify the minimum package of interventions for people living with HIV during humanitarian emergencies.

9. Currently, there are acknowledged humanitarian emergencies in almost every UNAIDS region; a majority of them are occurring in sub-Saharan Africa and in the Middle East and North Africa.

10. This report builds on the 2018 NGO report, titled *People on the move*.[1] That report showed that HIV itself presented a humanitarian emergency but that not all people on the move were doing so because of a humanitarian situation they faced. The report followed the broad definition of "migrant" used by the International Organization for Migration (IOM) and discussed a wide range of key populations moving across international borders and within states, regardless of legal status, willingness, cause, or length of stay. For example, it discussed the experiences of people living with or affected by HIV who were refugees, experiencing forced displacement, or migrating across borders for economic reasons or due to legal environments, or who were regularly moving back and forth across frontiers for work purposes.

11. The 2018 report touched on a range of issues, including the effects of increased human mobility; obstacles affecting access to HIV-related services; mobile populations that are being left behind in the HIV response; and a range of innovative and scalable good practices. The subsequent decision points agreed to by the UNAIDS Programme Coordinating Board (PCB)[2] included calls for supporting migrant and mobile populations,

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[1] UNAIDS PCB NGO Delegation. Report by the NGO Representative: Agenda item 1.4. Geneva: UNAIDS Programme Coordinating Board; 11 December 2018
(https://www.unaids.org/en/resources/documents/2018/PCB43_18.20).

[2] *Ibid*

refugees and crisis-affected populations in accessing HIV-related services; improving the availability of data on HIV and migration; addressing legal, policy and practice barriers to HIV-related services; strengthening national health systems; and encouraging the creation of enabling environments for greater cooperation between national health systems, communities and civil society organizations.

Clarifying specific key concepts: literature review

> *"It is difficult to have a clear understanding of what we mean by 'humanitarian emergency'. Promoting human welfare through urgent action is central. However, not all emergencies are sudden, with a clear beginning. In MENA (the Middle East and North Africa), acute economic and other difficulties have been building for years."*
>
> – Maher Sleiman, Frontline AIDS–MENA, Lebanon

12. The literature review focused on three themes that pertain to people living with HIV during humanitarian emergencies:

   ▪ the concepts of "natural" versus "man-made" emergencies;
   ▪ the relationship of humanitarian relief to the development continuum; and
   ▪ clarification of what constitutes humanitarian emergencies.

"Natural" versus "man-made"

13. In the past, humanitarian emergencies were seen as having either "natural" or "man-made" causes. "Natural" causes include phenomena such as avalanches, cyclones, droughts, earthquakes, epidemics, floods, tsunamis and volcanic eruptions. "Man-made" causes tend to involve armed conflict, including terrorism and civil or inter-state war. It is important to note that emergencies increasingly result from a mix of "natural" and "man-made" causes, which has yielded a third category: the complex humanitarian emergency.[3] The number of complex humanitarian situations are also increasing. This is due partly to the global climate emergency, which itself results from both "natural" and "man-made" causes. These complex emergencies—potentially reaching all regions as the climate emergency intensifies —are stretching available humanitarian resources.

14. Whether "natural", "man-made" or complex, the conditions in which a humanitarian emergency occurs affect its impact, including on people living with HIV. For example, the effects of humanitarian emergencies are likely to be more severe in countries with weaker health systems, recurring seasonal disasters or climate emergency impacts, weak human rights-based legal frameworks, high levels of stigma, civil unrest or instability, significant economic disparity and poverty, and higher background prevalence of HIV. Humanitarian emergencies magnify the effects of those pre-existing conditions.

15. It is increasingly difficult to draw neat distinctions between "natural" and "man-made" emergencies. Humanitarian emergencies tend to emerge from a protracted series of shocks that result in steady societal degradation. Examples include the multiyear armed conflict alongside severe food insecurity in South Sudan, and regular flood/hurricane

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[3] Humanitarian Coalition. What is a humanitarian emergency? (https://www.humanitariancoalition.ca/what-is-a-humanitarian-emergency).

damage alongside gang violence in Haiti.[4] "Natural" events can be shaped by "man-made" factors, such as the lack of flood defenses or poor building construction.[5] Similarly, armed conflict can stem from intensified competition for natural resources, especially under the growing pressure of the climate emergency.

The disaster/relief-development continuum

16. Historically, humanitarian responses have been seen as intense and relatively short-term interventions that are aimed primarily at minimizing further loss of life. This early response phase is assumed, over time, to give way to a development phase where the focus shifts to rebuilding and preparing for future disasters and/or emergencies.

17. In the context of increasingly complex and longer-lasting humanitarian challenges, that simple paradigm is no longer appropriate. Increasingly, ongoing humanitarian, development and preparedness work is occurring simultaneously and is then interrupted by repeated, new emergencies which require relief responses. This is being seen, for example, in Burkina Faso and other Sahel countries; in Ethiopia, Somalia and other countries in the Horn of Africa; and in Mozambique, Pakistan, Syria and Venezuela.

18. This complex reality creates particular challenges within the structures and funding mechanisms of humanitarian agencies. For example, limited and targeted humanitarian funds are being used for development purposes, while development funds are being used to meet the need urgent calls for humanitarian relief. A notable drain on international aid funding has been the so-called "war on drugs", which has absorbed billions of taxpayer dollars with very few positive results.[6]

19. In addition, as humanitarian needs increase, financial support to humanitarian agencies is decreasing, while inflation and currency fluctuations are adding further financial strain. Earlier in 2023, the International Committee of the Red Cross cut 1,800 staff globally (almost one-tenth of its entire staff) as it struggled with the most serious financial crisis of its 60-year history. United Nations (UN) agencies involved in humanitarian activities are facing similar challenges.[7] Current approaches to humanitarian funding and response are failing.

20. In the mid-1990s already, a new vision for humanitarian disaster responses was being discussed: the so-called relief-development or humanitarian-development continuum.[8] The aim was to link relief and development to avoid competition for funding: better relief work would contribute to development, and better development would reduce the need

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[4] Global humanitarian overview. Geneva: OCHA; 2022 (https://www.un-ilibrary.org/content/books/9789210012423).

[5] "Modelling based on temperature data and data from 400 000 individuals across 25 countries in sub-Saharan Africa in a "business as usual" scenario for carbon emissions, shows between 11.6 and 16.0 million additional cases of HIV by 2050, an increase in prevalence of 1.4–2.1 percentage points. An analysis of biomarker data on 200 000 individuals' serostatus across 19 African countries reveals an 11% increase in HIV infection rates after every drought in HIV-endemic rural areas." See Proposition paper: The climate crises and HIV. Brighton: Frontline AIDS; 2022, p. 15.

[6] Provost, C, et al. Aid for the war on drugs. London: Harm Reduction International; 2023 (https://hri.global/publications/aid-for-the-war-on-drugs/).

[7] "En 2022, les Nations unies ont enregistré un déficit record de leurs missions humanitaires avec seulement 24 milliards de dollars récoltés sur un montant nécessaire estimé à près de 52 milliards." Rich, D. France 24, 8 June 2023 (https://www.france24.com/fr/europe/20230608-ukraine-inflation-ins%C3%A9curit%C3%A9-la-crise-au-cicr-remet-en-cause-le-financement-des-ong).

[8] Bidder M. Linking relief and development—a conceptual outline. Addis Ababa: UNDP, Emergencies Unit for Ethiopia; 1994 (https://www.africa.upenn.edu/eue_web/ctinuum.htm).

for relief. That approach has evolved into an approach that seeks to maximize outcomes across three areas, resulting in a humanitarian-development-peace continuum.[9]

21. In this new approach, an improved humanitarian response would simultaneously lay the groundwork for future development and peace, with the prioritizing of local community agency and leadership a key element. Localization becomes an important mechanism for establishing improved and sustainable linkages between relief, on the one hand, and both development and peace, on the other. In the context of HIV, that would mean maximizing the leadership of people living with HIV and affected communities within humanitarian responses. This is discussed in greater detail in Chapter 6, below, particularly in relation to the 30–60–80 targets of the Global AIDS Strategy 2021–2026.[10]

What constitutes a humanitarian emergency?

22. Not all disasters are acknowledged as *humanitarian* disasters or linked to *humanitarian* crises or emergencies. National governments may declare a local, regional or countrywide disaster, crisis or emergency without it being considered a humanitarian situation. In addition, there is no globally shared understanding of the difference between humanitarian crises and emergencies. Often, these two concepts are used interchangeably or in overlapping, even circular, ways to refer to a sudden, damaging event that affects many people.[11] Crises may be more sudden than emergencies, but emergencies may need a more immediate or urgent response than crises.[12] In addition, each humanitarian emergency is unique. Similarly, not all humanitarian emergencies elicit the same responses: compare, for example, the resourcing responses to the Ukraine emergency situation and comparable situations in other regions.

23. Humanitarian emergencies should be distinguished also from serious human rights violations that affect certain populations in a country or across many countries. Some participants in this report's global community survey commented that there were key populations[13] who face significant challenges in situations they consider humanitarian emergencies even though those situations are not necessarily recognized as such by their governments or in current understandings of what constitutes a humanitarian emergency. Examples provided in the survey included people criminalized and victimized in the "war on drugs"; the thousands of victims of extra-judicial killings in the Philippines' "war on drugs"; the murders of gay people; and the maltreatment and violence directed at indigenous populations. These examples are usually considered to constitute human rights violations rather than humanitarian emergencies.

24. Pre-existing vulnerabilities or fragilities can lead to and/or aggravate a humanitarian emergency—for example, unstable government or health systems, prolonged economic crisis, high HIV prevalence, high levels of stigma and discrimination, criminalization of key populations, or an already ongoing national emergency. For example, while both COVID-19 and HIV present global and highly challenging pandemics or crises, they tend

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[9] Global humanitarian review. Geneva: OCHA; 2022 (https://2022.gho.unocha.org/delivering-better/operationalizing-humanitarian-development-peace-nexus-through-basic-social/?gclid=Cj0KCQjw4bipBhCyARIsAFsieCyKKUMT86kXyY7roF_6NblAmirv9jnwAz9VW_O5IvZp8vU7D3qGhhEaAn5wEALw_wcB).

[10] SEE below p. 15ff.

[11] Bloxham L. What is a humanitarian crisis? London: Concern Worldwide; 2022 (https://www.concern.org.uk/news/what-is-a-humanitarian-crisis).

[12] Al-Dahash HF, Thayaparan M, Kulatunga U. Understanding the terminologies: disaster, crisis and emergency. *In:* Chan and Neilson (Eds), Proceedings of the 32nd ARCOM Conference. Manchester, 5–7 September 2016 (https://openresearch.lsbu.ac.uk/item/872x5).

[13] Defined as sex workers, gay men and other men who have sex with men, people who inject drugs, transgender people, and prisoners and other people in closed settings.

to be referred to as humanitarian emergencies only when they exceed the response capacities of a country.

25.   The UN International Strategy for Disaster Reduction (UNISDR) defines a humanitarian emergency arising from a disaster as: "A serious disruption of the functioning of a community or a society involving widespread human, material, economic or environmental losses and impacts, which exceeds the ability of the affected community or society to cope using its own resources."[14]

26.   Meanwhile, the WHO describes a humanitarian emergency as a situation "impacting the lives and well-being of a large number of people or a significant percentage of a population and requiring substantial multi-sectoral assistance. For a WHO response, there must be clear public health consequences."[15] The WHO definition is similar to the UNISDR's definition in that it emphasizes impacts on a large[16] number of people or a significant percentage of the population. However, it is more specific in noting the need for substantial multisectoral assistance, including additional support from abroad. The WHO definition also requires the presence of public health consequences. It could be further adapted by UNAIDS to specifically focus on HIV, for example: "For a UNAIDS response, there must be clear HIV-related consequences".

27.   This report is intended to contribute to ongoing dialogue about the definition and declaration of humanitarian emergencies. As the UN body charged with leading the coordination of international humanitarian assistance, the UN Office for the Coordination of Humanitarian Affairs (OCHA) needs to be a priority stakeholder in the effort to develop a stronger consensus. Stronger links between UNAIDS and OCHA are needed if the needs of people living with HIV are to be effectively served during humanitarian emergencies.

Summary

28.   The current paradigm of humanitarian responses emerged after World War Two. In the 1990s, the paradigm was revised into a humanitarian-development continuum approach. More recently, especially during COVID-19 and the acute impacts of the climate emergency, our understanding of key humanitarian concepts has blurred further. In addition, the models for funding humanitarian responses are not appropriate for current realities. It is time for a serious rethink.

29.   The literature suggests that humanitarian emergencies tend to share three characteristics: (1) an event or series of events ("natural", "man-made" or both) that constitute an acute and/or ongoing threat to the health, safety, rights (including health rights), or physical and mental wellbeing of a large group of people; (2) an immediate need for action; which (3) includes multisectoral internal and, especially, external humanitarian relief. From the perspective of UNAIDS, the adoption of the WHO definition can provide a basis for a workable understanding of a "humanitarian emergency".

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[14] UNISDR Terminology on disaster risk reduction. New York: UN International Strategy for Disaster Reduction; 2009 (https://reliefweb.int/report/world/2009-unisdr-terminology-disaster-risk-reduction?gclid=CjwKCAjwp8OpBhAFEiwAG7NaEtSswYiMNUJfAfpnduiF2qRtvIipd400LwS4HMQz_YYxVUsWhIVodRoCAgEQAvD_BwE).

[15] Emergency response framework (2nd ed.). Geneva: WHO; 2017, p.3.

[16] It is worth noting that "a large number" is not defined by WHO; for example, it is not clear whether extrajudicial killings of alleged drug users (e.g., in the Philippines) or widespread murders of men who have sex with men, or attacks on indigenous populations would satisfy the criterion.

Methodology

30. This report draws on a variety of sources to explore the cross-cutting themes that are relevant for people living with HIV during humanitarian emergencies.

   ▪ **Library or desk research**. The report is based on a review of 146 written documents, including journal articles, conference reports, newspaper articles, organizational website statements, policy briefs, and other resources prepared by UN, academic and civil society bodies. The most relevant of those documents are listed in the Bibliography (Annex 1).

   ▪ **Global community survey**. This was an online qualitative survey to gather detailed and diverse feedback from community participants in their own words. It was conducted early in the preparation of the report to uncover issues and experiences that needed to be considered in the report. The survey was conducted in four languages: English, French, Spanish and Russian. Feedback was received from 322 individual respondents[17] from all UNAIDS regions.

Table 1: Regional responses to global community survey

UNAIDS regions	Number of responses
Eastern and southern Africa	39
Western and central Africa	20
Asia and the Pacific	33
Latin America	88
Caribbean	9
Middle East and North Africa	12
Eastern Europe and Central Asia	65
Western and central Europe and North America	54
Prefer not to say	13
TOTAL	333

   ▪ **Key informant interviews**. Twenty-eight key informants were interviewed online. The majority of them were in countries with current humanitarian emergencies, e.g., Afghanistan, Bangladesh, Haiti, India, Lebanon, Myanmar, Mozambique, Pakistan, South Sudan, Ukraine, and Venezuela (see Annex 2). The informants had direct experience with humanitarian emergencies and were proposed by stakeholders, including PCB Member States, Cosponsors, international and national AIDS organizations, and members of the PCB NGO Delegation. The informants included advisors to PCB Members, Geneva or country-based staff of Cosponsors, and representatives of international and national HIV service organizations. Their professional backgrounds included humanitarian response work, medical and social services, and human rights advocacy.

   ▪ **African focus groups.** Given the large number of humanitarian emergencies in sub-Saharan Africa and the high HIV prevalence in much of that region, six focus groups were held in English and French, with the participation of 55 people from Cameroon,

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[17] Eleven respondents indicated that they represented two regions. Thus, while the total number of responses came to 333, there were 322 individual participants in the global community survey.

the Democratic Republic of the Congo, Kenya, Mali, Mozambique, Nigeria and Zambia (see Annex 2). The participants were recruited with the help of the African NGO delegates to the PCB, as well as the Global Network of People Living with HIV (GNP+). Participants were staff, volunteers and members of local or regional African nongovernmental organizations (NGOs).

▪ **Good practice case studies**. The NGO Delegation posted an open call for submissions of examples of good practices for meeting the needs of people living with HIV during humanitarian emergencies. Case studies were received from various humanitarian settings, from civil society and staff of a country-level Cosponsor office. Seven case studies were selected to illustrate how communities have effectively responded to the needs of people living with HIV during a humanitarian emergency and how collaboration with the UN and other humanitarian agencies supported those responses.

▪ **Peer review process**. Drafts of the report were reviewed by members of the NGO Delegation, an external civil society expert panel convened by the Delegation, and governance and technical experts from the UNAIDS Secretariat.

31. The report was not intended to produce quantitative data or statistical analysis. While written documents in the bibliography provide both quantitative and qualitative information, the research methods used in preparing the report were largely qualitative. As such, the report is limited to drawing on the literature and on community and other experts to acquire greater knowledge and understanding of the situation of people living with HIV during humanitarian emergencies and to propose feasible responses based on that understanding.

Summary

32. The report uses a variety of information and evidence to explore the needs and experiences of people living with HIV during emergencies, including a desk review, a global online community survey, key informant interviews, focus groups in sub-Saharan Africa, good practice case studies, and a peer review process. The report draws on those sources to better understand the situation of people living with HIV during humanitarian emergencies and to propose responses based on that understanding.

Effects of humanitarian emergencies

"For people living with HIV in Afghanistan, already in a very difficult economic situation, limited access to health-care services and high level of stigma and discrimination in the country have greatly affected their livelihood and access to HIV prevention, care, treatment and support services."

– Abdul Rasheed, Youth Health and Development Organization, Afghanistan

33. Humanitarian emergencies disrupt lives on a massive scale. Globally, some 110 million people are displaced each year. Humanitarian emergencies seriously disrupt existing systems and structures, including those related to providing HIV prevention, treatment and care to people living with HIV. Community feedback received in the preparation of this report identified several priority needs of people living with HIV which become even more urgent to address during humanitarian emergencies. Prime among them is access to antiretroviral therapy (ART), without both HIV prevention and treatment is badly undermined. Also often disrupted are access to food and drinking water, HIV-related and other health care (including for sexually transmitted infections), and shelter or housing. In addition, specific key populations of people living with HIV who already struggle to meet their key needs often find themselves in even more perilous circumstances during humanitarian emergencies. Humanitarian aid has to address these effects, including providing material goods and technical assistance.

Effects on prevention and testing

34. Despite the disruptions that humanitarian emergencies have on prevention and testing, these services continue to be essential and now extend to include people on the move who may be undiagnosed or may have acquired HIV during displacement. Specific to people living with HIV - the focus of this Report - particular combination prevention and testing services may be at risk for example for STIs, viral hepatitis and tuberculosis; for HIV-related non-communicable physical and mental health conditions; for CD4 viral load testing.

35. While continuing to emphasize interventions such as contact tracing, condom use, the provision of harm reduction services, promotion of behavior change and other prevention activities, the focus of these services relative to people already living with HIV may shift slightly to place *added* emphasis on interventions such as the provision of vaccines for HPV and viral hepatitis; prevention of HIV-related communicable and non-communicable conditions like tuberculosis, viral hepatitis, aging-related conditions, and mental health conditions; preventing vertical transmission; preventing gender-based violence (GBV) and accompanying survivors of violence; and especially ensuring treatment as prevention with the goal of achieving viral suppression and undetectability.

Effects on treatment and care

36. People living with HIV in humanitarian settings tend to experience at least three major access issues in relation to treatment and care: antiretroviral (ARV) supplies; food; and mental health services.

37. Treatment and care challenges were evident at the height of the COVID-19 pandemic when lockdowns affected people – including people living with HIV, who have particular, additional requirements – to meet their food needs, earn incomes, seek basic health care or receive specialized care, fill medicine prescriptions, etc., employment/income, medical tests, TB services, etc. In some places, delivery and follow-up treatment and care related to vertical transmission struggled. Access was particularly difficult for people who were not in their place of domicile or who lacked the required documentation to access local services.

38. Humanitarian emergencies disrupt access to essential treatments, such as ART and opioid agonist treatment. Supply lines may be disrupted, health-care workers may be scattered and unable to attend work, and health-care facilities may be damaged. People living with HIV may also be forcibly displaced and find themselves in unfamiliar territory, with limited ability or permission to travel and not knowing where to access their prescribed ARVs. Those who are asylum seekers or refugees may face additional restrictions in their access to treatment and care. Despite the requirements of Article 31 of the 1951 Refugee Convention, some countries may not have the necessary policy frameworks in place and/or lack the necessary health system resources to comply.[18] People may not have the required health insurance documentation or prescriptions to access their medications. Multimonth prescriptions and support for acquiring appropriate medical documentation were highly effective responses.

39. Humanitarian emergencies affect not only access to services and medicines but also people's health-seeking behaviors as they prioritize their immediate humanitarian needs over their health concerns. During times of crisis, individuals living with HIV often prioritize basic needs such as shelter and food. People living with HIV or belonging to key populations may not know where to seek humanitarian support or may be wary of doing so due to fear of stigma and discrimination. A survey in Ukraine, for example, found that 87% of respondents had not applied for humanitarian assistance.[19] However, rapid assessments carried out by Light of Hope in Ukraine in June 2023 indicate that people were more willing to access HIV-related care when trusted and HIV-oriented organizations provided humanitarian support using a "one-stop shop" model.[20]

40. UNAIDS has acknowledged the specific food security and nutrition needs of people living with HIV. Generally, adults living with HIV are estimated to have 10–30% higher energy requirements than healthy, HIV-negative adults, while the energy needs of children living with HIV can be 50–100% higher than those of their HIV-negative counterparts.[21] These additional requirements should guide the provision of food to people living with HIV in humanitarian settings. However, that is unlikely to occur unless strategies specific to the needs of people living with HIV are put in place by governments and humanitarian agencies as part of their humanitarian responses.

41. Humanitarian emergencies can worsen and generate mental health challenges. The psychological effects of the COVID-19 pandemic boosted awareness of the need for psychological first aid and for ongoing psychological and psychosocial support. Many people living with HIV (especially those from key populations) are likely to be contending

18 Global trends report 2022. Geneva: UNHCR; 2023 (https://www.unhcr.org/global-trends-report-2022).

19 Volgina A. P*ersonal communication*, 14 September 2023).

20 Results of the rapid assessment of communities and local NGOs – Ukraine. Amsterdam; GNP+; 2023 (https://gnpplus.net/wp-content/uploads/2023/08/Results-of-rapid-assessment-_2023.docx.pdf).

21 HIV, food security and nutrition. Policy brief. Geneva: UNAIDS; 2008.

already with stigma and discrimination, isolation/loneliness, and certain cognitive challenges. Humanitarian emergencies aggravate those travails. One of the key informants in this report, a long-time HIV activist, admitted being too afraid to access a crowded clinic to get their ARV supply for fear of revealing their HIV status.

Summary

42. Humanitarian emergencies can seriously interrupt prevention, treatment, and care services for people living with HIV. To mitigate these disruptions, it is crucial to prioritize access to these services. This includes a strong focus on prevention to stop the spread of HIV and associated infections, ensuring the availability of Treatment as Prevention (TasP), addressing mental health concerns, and providing support for harm reduction and substance use treatment. Efforts should also be directed towards ensuring access to multi-month supplies of ARVs, satisfying nutritional needs, and serving people's psychosocial needs.

Communities at the centre of an emergency response

"Communities and people living with HIV need to be capable of bringing their needs to the table. This is harder to do if they have not been included prior to a humanitarian emergency: if civil society representatives were not involved as a partner before, they will be less likely to be able to contribute once there is a humanitarian emergency."

– Eva Marly Steide, Housing Works, Haiti

43. The Global AIDS Strategy 2021–2026 requires that community-led organizations deliver 30% of testing and treatment services, 60% of programmes supporting the achievement of societal enablers (i.e., addressing stigma and discrimination, gender-based inequalities and violence, and punitive and discriminatory laws and policies), and 80% of HIV prevention services for key populations and women by 2025.[22]

44. As highlighted in the theme for World AIDS Day 2023, "Let communities lead", there is growing recognition that community leadership has to be at the core of HIV plans and should be well-resourced and unencumbered by barriers. This is in line with the long-standing commitment to the "Greater Involvement of People Living with AIDS" (or GIPA) principle and the insistence of "Nothing about us without us". The HIV response requires the meaningful participation of people living with HIV in policy-making and programme design, from inception to implementation, delivery, monitoring, and evaluation. Affected communities have to be at the center of the HIV response, including in preparation for and during humanitarian emergencies.

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[22] Global AIDS Strategy 2021–2026. End Inequalities. End AIDS. Geneva: UNAIDS; 2021, p. 141.

Key lessons from the AIDS pandemic about the role of communities

45. The AIDS pandemic continues to show that communities can effectively lead and deliver HIV services, including some clinical services such as testing for HIV and viral hepatitis, as well as provide access points for prescribed medications, mental health first aid and treatment adherence support. Through their stakeholder networks, community-led HIV organizations are able to advocate for improved service delivery, as well as for greater investment in health and pandemic preparedness and responses. The HIV movement is strong and well-respected in communities and it is experienced in working with marginalized people in difficult situations: it has a lot to offer to the humanitarian sector. The AIDS pandemic reminds us that community-led and -based services are essential components of an effective health-care systems, including—and perhaps especially—when those systems are under strain.

Community roles

46. The report's background research aimed to clarify the most pressing needs and the range of responsive services that communities provide to people living with HIV during humanitarian emergencies. This was important for defining a minimum package of interventions.

47. Community-led organizations and services are sources of information, especially during periods of disruption and confusion. They are more likely to know who needs specific services, products, and support during upheavals and can play crucial roles in serving those needs. They can conduct needs assessments, collect data to monitor service delivery quality and fairness and work in local languages. They can build capacity among lay and professional service providers to help counter stigma and discrimination by fostering greater awareness and sensitivity about people's human rights and their need for confidentiality and trust. Community-led organizations typically do all this despite being underfunded and lacking proper recognition from formal health systems.

48. In addition to assisting with the distribution of ARV medicines, condoms and harm reduction commodities, community-led organizations can provide information and support for preventing HIV infection and for sexual and reproductive health generally. They can support survivors of gender-based violence; operate drop-in centers/safe spaces; provide mental health and psychosocial assistance; and help with food provision. These organizations can play vital roles in bolstering struggling health systems in these and other ways.

49. These roles are especially relevant to the ongoing WHO initiative aimed at developing a pandemic preparedness treaty under international law. The proposed treaty is rooted in the WHO constitution and is intended to adopt an all-government and all-society approach to strengthening the capacities, resilience and responsiveness of health systems to future pandemics. In addition to government actors, WHO intends to include the participation of a wider range of stakeholders via public hearings, including international agencies, civil society organizations and other relevant actors. These consultations are important opportunities for community-led and other civil society organizations to share the experiences they have acquired during the AIDS and COVID-19 pandemics and during various humanitarian emergencies.[23]

50. Key demands have emerged from the background research done for this report: stronger and better-prepared health-care systems that include community-led services;

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[23] Pandemic prevention, preparedness and response accord. Geneva: World Health Organization; 28 June 2023 (https://www.who.int/news-room/questions-and-answers/item/pandemic-prevention--preparedness-and-response-accord).

speedier access to funding support for local NGOs which provide relief services; and strong engagement with, and leadership by communities.

51. Governments have the primary responsibility to protect and assist citizens who are affected by disasters. If health-care systems are already weak, disasters will very likely weaken them further. Key informants noted the lack and variability of health-care facilities, with limited integration of services. One of the ways to prepare for emergencies is to focus on health system strengthening that includes the entire continuum of health care, from hospital to community-led services. Some informants also identified how slow and complex it was for local community or civil society organizations to access funds to support their relief efforts; especially in the early phases of emergencies, when help is most needed.

52. For communities to achieve their potential as part of health-care delivery during humanitarian emergencies, governments and humanitarian responders have to make room for communities to participate and even lead certain aspects of the response. Research participants urged that community engagement in leading and delivering services be treated as a strategic priority. Such recognition can be measured by the extent to which governments and humanitarian agencies, including entities like OCHA and the UNHCR, invite and facilitate the participation and leadership of community groups and build their technical and operational capacities. Given current funding pressures for humanitarian activities, stronger engagement with and use of community-led services are a viable way forward. Community-led services should be acknowledged and integrated as a crucial element of health-care systems.

53. People living with HIV require holistic support, including during humanitarian emergencies, but this can be hampered by the distinct mandates that guide donors and humanitarian organizations. Therefore, community organizations and others on the frontline must engage across various donor and organization mandates to serve people's needs holistically. The same principle—and constraints–applies to endeavors related to addressing violence, facilitating employment and societal integration, or providing education programmes for children: people need comprehensive support. This underscores the need for more flexibility in delivering humanitarian aid and the value of a "one-stop shop" model, which is well-suited to community providers.

Summary

54. Communities have to be at the center of humanitarian emergency responses for people living with HIV. By 2025, community-led organizations should be delivering 30% of testing and treatment services, 60% of programmes supporting the achievement of societal enablers, and 80% of HIV prevention services. These organizations already provide a wide range of services. But they need partnerships with strong and well-prepared health systems; speedier access to humanitarian funding support; and improved opportunities for leadership.

55. Communities also need humanitarian responses to be conducted in ways that build both their agency and resilience and that of people living with HIV. Achieving more locally-led humanitarian responses should not wait until *after* a humanitarian emergency has passed; the process should start now. Traditional responses can perpetuate or encourage dependency, undermining eventual recovery and development processes. A response methodology that works with and through sustainably funded community-led services would be more effective and would pay long-term dividends. Examples of effective community-government-agency collaborations can then be collected and used to inspire and drive others in different humanitarian settings.

Showcasing the critical role of communities: best practice case studies[24]

56. In preparing this report, it was clear that there are many examples around the world of good practices for meeting the needs of people living with HIV in humanitarian settings. Those examples must be collated and shared, replicated elsewhere and scaled-up where appropriate. The next section shares seven such examples.

Collaborating with 100% Life—Ukraine[25]

57. With 16 000 members, 100% Life (formerly the Network of People Living with HIV) is the largest HIV patient organization in both Ukraine and Europe. The Network aims to ensure full access to treatment for people living with HIV, TB and/or hepatitis C across 25 regions of Ukraine, improve their quality of life, and promote their rights and freedoms. Operating since 2001, it is the main implementing partner of the Global Fund and United States Agency for International Development. Annually, the Network provides services to more than 190 000 patients, 90 000 of whom are people living with HIV.

58. Before the current war in Ukraine, just over 60% of the population lived below the poverty line; that situation has not improved. UNHCR reports that, by mid-2023, nearly 5.1 million people were internally displaced in Ukraine and more than 6.2 million had left the country as refugees. Approximately 17.6 million people needed humanitarian assistance in 2023.

59. This case study describes how 100% Life worked with humanitarian agencies to improve the lives of people living with HIV in Ukraine. The World Food Programme (WFP) initiated the collaboration, which approached the Network to act as a partner. Although the principle of UN or other humanitarian agencies working with and even taking the lead from local organizations was not new, this was the first time such a major humanitarian agency had approached the Network.

60. Many people living with HIV in Ukraine struggle to earn a regular income. During crises, they are also often among the first to lose their jobs, largely due to stigma and discrimination. Some may resort to exchanging sex for food, protection and other necessities. The collaboration between 100% Life and WFP brought food security for 900 000 people, about 300 000 of whom were people living with HIV or TB, and their families. The Network led on delivering monthly food packages, each of which included about 17 kilograms of non-perishable food supplies. The packages helped ensure that no-one would die of hunger and offered people some leeway to supplement their meals with fresh products when available. The food packages were delivered in many ways, including at shelters and in hospitals.

61. A powerful example of the benefits of this collaboration was the rescue of two Ukrainian women from an isolated rural community close to the frontline, one of whom was living with HIV while the other was living with hepatitis C. Their food packages were funded by the Global Fund and were provided via WFP which also helped link the women to other services, including for dental problems and severe stress. The Network, WFP, and Global Fund and other private donors eventually managed to evacuate the women from close to the frontline and ensure they had adequate food and shelter.

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[24] There were many more good practice case studies proposed than could be included in this short report. We thank all the civil society individuals and groups who worked on them.

[25] Since the beginning of the war in February 2022, millions of people have been forced to flee Ukraine. Approximately 17.6 million people, almost half the entire population, now need humanitarian assistance and protection (https://www.unocha.org/ukraine).

*Reported by Valeriia Rachynska, Director – Human Rights, Gender and Communities
Development*
100% Life (https://network.org.ua/en/)

Displaced Venezuelans living with HIV—Venezuela/Colombia[26]

62. Red Somos is a community-based organization in Colombia. Founded in 2007, it works
for the recognition of sexual and gender diversity and for sexual health and community
empowerment through the provision of community services and social research. Red
Somos collaborates with groups and populations in vulnerable contexts, particularly
LGBTIQ+ people, people living with HIV, refugees and migrants. Its work combines
community and technical expertise in the development of effective interventions that
prevent HIV and promote sexual health, comprehensive care, viral suppression,
reduction of HIV stigma and discrimination, and empowerment of people living with HIV.

63. The HIV situation in Colombia is intertwined with the presence of some 2.9 million
displaced Venezuelans. "Assuming a stable HIV prevalence among migrants and
refugees and a population size of 2,477,588 refugees and migrants in Colombia, based
on September 2022 migration estimates that include all states of migration, this would
equate to 22,298 migrants and refugees are living with HIV in Colombia and require
continued access to treatment, though only 4,500 Venezuelans are registered with the
national health system, according to the Colombian Ministry of Health.

64. Vulnerabilities experienced by the displaced Venezuelan population living with HIV
include lack of access to health services and treatment, gaps in the continuum of care,
lack of information, economic vulnerability, lack of documentation, discrimination and
stigmatization, and conditions that favour HIV transmission, such as survival sex, human
trafficking, gender-based violence, and xenophobia. The situation has been mitigated
somewhat by the entry into force of Colombia's Temporary Protection Permit for refugee
and migrant Venezuelans, which provides for protection and access to the health
system.

65. Red Somos established *Tu pana te cuida* ("*Your friend/peer takes care of you"*) as an
innovative model for developing community-based health interventions that meet the
needs of LGBTIQ+ refugees and migrants, as well as people living with HIV. The model
has been implemented in three cities: Barranquilla, Bogotá and Soacha. Services focus
on community and health attention and promotion; legal assistance; social protection;
and cultural change. Key services include HIV, syphilis and hepatitis C rapid testing;
delivery of ARVs; health advice; hormone therapy; mental health counseling and support
groups; and legal advice, for example, on discrimination and regularization issues.

66. *Tu pana te cuida* serves people who are particularly vulnerable to HIV infection, as well
as those living with HIV. Examples include an HIV-positive female sex worker who
needed help to access pre-exposure prophylaxis and now assists with HIV prevention
support and a 19-year-old Venezuelan who contracted HIV and was supported in being
regularized in Colombia so he could legally access HIV treatment.

67. Jose is a good example of the effectiveness of this project. After leaving Venezuela, he
arrived in Colombia without a support network and resorted to selling sex to have money
to eat and survive. He eventually took a rapid test at *Tu pana te cuida* and discovered he

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[26] Despite some signs of improvement, the most vulnerable Venezuelans still face limited access to essential
services and economic opportunities. The 2022 rainy season heavily affected tens of thousands of people due to
overflowing rivers and landslides, damaging small businesses and affecting small producers (see
https://www.unocha.org/venezuela). Colombia has made progress in development and peacebuilding over the
past decade, but internal armed conflict and violence, extreme weather-related events and the COVID-19
pandemic have left some 7.7 million people in need of humanitarian assistance. The influx of refugees and
migrants from Venezuela has increased the burden on host communities (see https://www.unocha.org/colombia).

had contracted HIV. The project accompanied him through the process of registering for treatment and other health services, provided psychosocial support, and helped him develop a stable support network. Jose is now a leader and community activist who shares his story openly and helps others take advantage of the project and its services. As Jose noted: "Red Somos and *Tu pana te cuida* are synonymous with opportunity, self-improvement, support and achievement. Once you recognize that migrants and refugees living with HIV have much more to offer than our diagnosis, you're able to create safe spaces for everyone, and that's what *Tu pana te cuida* does."

Reported by Miguel Angel Barriga Talero and David Marquez, Red Somos, Colombia

Peers supporting peers—Democratic Republic of the Congo[27]

68. This case study draws on the experience of two groups in the Democratic Republic of the Congo: the Congolese Union of Organizations of People Living with HIV (UCOP+) and the Community Distribution Post (PoDi) of Antiretrovirals, a community model of care developed by UCOP+.

69. UCOP+ is dedicated to defending the health and dignity of people living with HIV and raising their voices in the fight against HIV. It assists people living with HIV to organize into grassroots communities that promote the health rights of everyone in the country. For its part, PoDi provides decentralized HIV services, including psychosocial support and ARVs, facilitates viral load monitoring, and promotes positive living with HIV.

70. Peers participate in various activities of the two organizations. They raise awareness about HIV, organize HIV testing among displaced people, and support those who test HIV-positive through referrals to care and treatment. They also help distribute ARVs and offer psychosocial support. They help put in place mechanisms to prevent vertical transmission of HIV among pregnant and breastfeeding women, raising awareness about the benefits of good nutrition and encouraging the eating of nutritious foods and dietary supplements.

71. Facilitators selected to be trained as peer educators must meet certain criteria; for example, they should be openly living with HIV, be literate, and be able to communicate in a local language. People who qualify undergo training, which focuses on HIV knowledge, testing, monitoring, and providing support for adherence and positive living with HIV. Participants receive cash payments for participating in training and to cover expenses. Peer educators' work includes conducting home visits, arranging appointments or reminding people of them, and organizing support group meetings to raise awareness, provide advice, and share experiences.

72. Some peers are trained to become mother mentors. They usually have to meet additional criteria, for example, be a mother with recent experience in childbirth and breastfeeding and be capable of raising awareness among HIV-positive pregnant or breastfeeding women. They also undergo training and receive cash payments to support their training and subsequent activities. They conduct HIV awareness sessions, support and monitor other mothers in maintaining adherence to ARV medications through home visits, phone calls, or text messages (SMS) to schedule appointments or reminders. They also organize self-help group meetings to raise awareness, advise and share experiences.

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[27] The Democratic Republic of the Congo has the largest number of internally displaced people in sub-Saharan Africa: years of violence and insecurity have forcibly displaced 5.7 million people. Violence has increased recently in some provinces, including against civilians living in displacement sites. See Democratic Republic of the Congo overview. Geneva: OCHA (https://www.unocha.org/democratic-republic-congo).

73. The peer-led work has numerous benefits. For example, UCOP+ reports that some 730 displaced people living with HIV have been identified at its seven sites and referred to care structures after follow-up and awareness visits. The peers also set up a monitoring system and support mechanism to ensure the continuum of care for displaced people living with HIV. "I talk about HIV without taboos, I understand my illness, and I am becoming my own doctor," said one of the recipients of peer-led services. "My peers are an outstanding support for my positive life with HIV," said another.

Reported by Angélique Machozi, Community Antiretroviral Distribution Post, Whiskey Kalume, Congolese Union of Organizations of People Living with HIV, Democratic Republic of the Congo

People living with HIV and using drugs—Afghanistan[28]

74. Bridge Hope Health Organization (BHHO) is a non-profit and non-political community-based organization in Afghanistan, established in May 2015 by people who use drugs. Its remit has since expanded to include people living with HIV and other key populations. It reinforces livelihoods, health, human rights, and harm reduction and strengthens emergency assistance. Currently, BHHO is implementing drug harm reduction projects with the financial support of the UN Office on Drugs and Crime (UNODC), the UN Development Programme (UNDP), and the Global Fund.

75. Afghanistan has very low HIV prevalence in the general population. Still, it is experiencing a concentrated HIV epidemic among people who inject drugs. According to WHO, in 2019, HIV prevalence among people who inject drugs was about 4.4% nationally,[29] A high prevalence of injecting drug use, weak surveillance system, insufficient HIV-related knowledge, stigma and discrimination against people living with HIV, and gender-based violence are contributing to the spread of HIV in the country.

76. The ruling Taliban have set their sights on stamping out drug addiction, including through force. The predominant drug treatment model involves long-term residential treatment services (45 days of in-patient treatment programmes for adults and 180 days for adolescents) with limited capacity for outpatient and outreach programmes. About 50 drug treatment centers are operating across the country. Those services are poorly integrated into the health system; patients have no access to ARVs, opioid agonist therapy, or psychosocial and peer support. Community-based treatment, shown to be one of the most efficient, is poorly developed. The recovery model and support, including tailored educational support, vocational training and employment support, and temporary livelihood provision for people in recovery, are almost non-existent, and most of the patients are discharged without any follow-up after these residential treatments. In addition to the treatment centers, the Taliban has been establishing large new "rehabilitation centers" to accommodate several thousand people who were rounded up from the streets by force.

77. Stigma and discrimination are common against people who use drugs or live with HIV, and there is a great deal of ignorance about HIV and hepatitis. People try to protect themselves by avoiding any contact with people living with HIV. Stigma is also high in healthcare settings, and fear of infection results in poor services. As a result, people may be denied procedures such as appendectomies or dental surgeries, or patients are required to provide disposable surgical kits at their own expense (around 70 euros per

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[28] Afghanistan is facing a major humanitarian crisis with serious risk of systemic collapse and human catastrophe. In addition to the human costs, the crisis is reversing many of the gains of the last 20 years, including on women's rights. The country is also highly prone to natural hazards, whose frequency and intensity are exacerbated by the effects of climate change. See Afghanistan overview. OCHA (https://www.unocha.org/afghanistan).

[29] WHO Afghanistan Country Office report 2019. Kabul: WHO; 2019 (http://www.emro.who.int/images/stories/afghanistan/who_at_a_glance_2019_feb.pdf?ua=1).

kit). HIV prevention services are available in only eight of the country's 34 provinces, while opioid agonist therapy is available in five provinces, and access to ARVs is limited in general.

78. BHHO and other local organizations, in collaboration with UNDP and UNODC, provide a range of services via a network of drop-in centers in eight provinces. There, people who use drugs or live with HIV can receive primary health care, including counseling, social support, HIV testing, needle and syringe exchange, condoms, and ARVs. BHHO also accompanies people living with HIV to clinic appointments in Kabul. Through its networks of people living with HIV in eight provinces, BHHO assists people to access their medicines and provides up to three months of ARVs to people living with HIV, which is especially important for pregnant women living with HIV. Earlier ARV shortages have been overcome through improved collaboration with ART providers and UNDP. BHHO and UNODC are also engaged in capacity building around, for example, harm reduction, good practices for drug use treatment, the specific needs of women, and HIV care among stimulants users. They also arrange training for health-care providers.

Message from Afghanistan

79. "There is a need for fundraising to scale up the services with a special focus on people living with HIV. Also, there is a need for interventions to reduce stigma and discrimination at the policy and service providers' levels."

Reported by Morgane BERNARD-HAREL & Dr Ziaurahman Zia, UNODC – Afghanistan, and
Ata Hamid & Abdur Raheem Rejae, Bridge Hope Health Organization

Stay on ART—International

80. "Stay on ART" (www.stayonart.com) is an international project that was set up by Life4me+, an NGO that works to prevent new cases of HIV and other STIs, hepatitis C, and tuberculosis by using software technologies, including apps for mobile phones. The Life4me+ system is available in 15 languages: Arabic, Armenian, Chinese, English, Estonian, French, Georgian, German, Italian, Portuguese, Romanian, Russian, Serbian, Spanish and Ukrainian.

81. "Stay on ART" began in 2020 when COVID-19 led to lockdowns and border closures, leaving many people without access to essential medicines such as ARV drugs. Stay on ART" created a simple Google form allowing people to request support in case of ART shortages. Applications came from everywhere, including tourists on islands, truck drivers, and sailors working on cargo liners. The initiative assisted more than 1,000 people to access ARVs, with the support of activists, doctors, and many caring people.

82. Each request presented its own challenges, but one is especially memorable. We received a request from a sailor, "Max" (not his real name), on a cargo ship in a port in Thailand. His six-month sailing period had been coming to an end when the lockdowns began. None of the crew could go ashore, and they were preparing to spend the next six months on the ship. Max managed to send us a request through a satellite phone network. We realized we had three days to provide him with his ARVs because the ship was about to set sail again. With assistance from Thai activists, we bought the right pills and arranged the transfer. Unfortunately, the ship was sent to a port in China ahead of schedule. So, the ARVs had to be sent to China, which was very difficult to do during the lockdown. But finding someone who could deliver the package to the ship was even more difficult. This time, activists in China stepped in. Max had already lost hope, but the parcel reached him! Max has stayed in touch with Life4me+ and continues to say: "I still can't believe that you managed to do it and do not understand how you did it".

83. The challenge of getting ART packages to people varies depending on the country involved. For example, when sending packages to countries where HIV is criminalized, we were forced to disguise pills by putting them in candy boxes or hiding them in personal items, like socks. During the war in Ukraine, a new wave of requests began arriving. One read: "Good afternoon, I am from Ukraine, I am in Poland. The therapy that I received in Ukraine is ending. Please tell me where I can get therapy here in Poland. I really look forward to your answer, as it is vitally important. Thank you in advance!" Another read: "Hello, my husband is a sailor. He is taking therapy for HIV. Now, he is heading to Spain, the port of Tarragona. Where can he get ARV therapy?"

84. Thanks to an improved referral system, we were able to help over 1,500 people as of July 2023. This number is likely much higher since we are only counting direct requests and not users who visit the special website of the "Stay on ART" project.

85. We have found that people living with HIV are still highly vulnerable to any kind of emergency. Stigma and discrimination at all levels force people to hide their status. However, we believe that our approach has proved its effectiveness and could be replicated in constrained conditions like natural disasters, war, and under discriminatory political regimes. "Stay on ART" was developed to reach a large number of people living with HIV and help them integrate into the healthcare system. The biggest reward for us is when people receive treatment and, of course, it is always nice to receive words of gratitude from them, like these: "Thank you very much for the answer. Now we know what to do. It's good that I found a resource where I can get all the answers and support! Thank you so much again!"

*Reported by Ten, Executive Director, and Alex Schneider, President Life4me+
(https://life4me.plus/en/)*

Working together—Bangladesh[30]

86. Based in Bangladesh, the Bandhu Social Welfare Society (Bandhu) focuses on the rights and well-being of gender-diverse and HIV-vulnerable communities, particularly people living with HIV. In the context of humanitarian emergencies, such as natural disasters or conflicts, Bandhu works to ensure that these marginalized groups are not left behind. It provides a range of services, including access to health care, psychosocial support, safe spaces, legal assistance, and awareness campaigns. It collaborates with other organizations, government agencies, and humanitarian actors to coordinate efforts. By advocating for people's rights and by providing essential services, Bandhu seeks to reduce the impact of emergencies on people's well-being and to facilitate their inclusion in relief and recovery efforts.

87. The Gender-Diverse Working Group, led by Bandhu in Cox's Baza, is a key collaborative effort that involves various stakeholders to address the specific needs and challenges faced by gender-diverse individuals and people living with HIV. The working group comprises representatives from UN and government agencies, NGOs, health-care providers, community advocates, and members of gender-diverse communities.

88. Cox's Bazar is a region hosting a large number of refugees, including some 1100 people who are living with HIV. Through the joint efforts of the working group and Bandhu, we were able to serve their needs in meaningful ways through a number of activities. Bandhu set up networking connections with government stakeholders, particularly at

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[30] About one million Rohingya refugees live in the largest refugee camp in the world in Cox's Bazar. Rohingya refugees rely entirely on humanitarian assistance for protection, food, water, shelter and health. They live in temporary shelters in a highly congested camp setting. Bangladesh ranks third in the world among states most affected by natural disasters and Rohingya refugees are highly exposed to weather-related hazards, such as cyclones, flooding and landslides. See https://www.unhcr.org/countries/bangladesh.

Sadar Hospital, where ART services were available. This enabled people living with HIV to gain access to treatment. Once the networking was established, the individuals were supervised and provided with referral linkages to the government hospital. This helped ensure that their follow-up care was consistent and well-coordinated. In addition, the individuals were included in Bandhu's SPORSHO network, which offered a platform for sharing their experiences, exchanging information, and receiving emotional and mental health support.

89. The collaboration between the working group and Bandhu in Cox's Bazar led to a focused and effective support system for people living with HIV in a difficult environment through advocacy, networking, referral linkages, supervision, and inclusion in a support network. The work addressed both their medical and psychosocial needs, showing that a holistic and compassionate approach is possible in a humanitarian setting.

Reported by Shohel Rana, Team Leader, Bandhu (https://www.bandhu-bd.org/)

Youth empowerment—Nigeria

90. Today for Tomorrow Foundation (TFTF) is a youth-led and -serving NGO based in northeast Nigeria, which has experienced armed conflict since 2009, when the jihadist insurgent group Boko Haram announced its intention to set up a province of Islamic State there. TFTF was founded in 2016 to help everyone in the community attain their rights and fulfill their full potential, prioritizing adolescents and youth. To achieve this, TFTF works to address problems and improve people's well-being, especially through training, mentoring, and empowerment.

91. A key element of the work involves developing safe spaces where women and girls can receive sexual and reproductive health and rights (SRHR) information and services in two camps housing internally displaced persons. Camp leaders, women residents and community health workers were educated about the need for safe spaces and stigma-free ways of accessing SRHR materials, including sanitary pads, contraceptives, and HIV testing kits. The work also involved educating adolescents and young people about risky sexual behaviors.

92. TFTF also focuses on building capacity among young people living with HIV to address stigma and discrimination, and it supports them to protect their health, understand the benefits of ART and adhere to treatment, and recognize that people who stigmatize them are driven by ignorance and misperception. TFTF trains youth to advocate for themselves, including for supplies and resources related to their basic hygiene needs or for malaria and other health threats. Training is provided in a stigma-free environment where young people feel safe and can ask any questions they want.

Reported by Adek Bassey, Today for Tomorrow Foundation, Nigeria

Minimum package of interventions

> *"Ensuring a reliable and continued supply of ART is crucial. Ensuring access to regular check-ups, laboratory tests, and specialized care for HIV-related complications is important. Addressing the holistic needs of individual persons living with is crucial to prevention of AIDS."*
>
> – William Mabior Achuil, Executive Director, Food and Agriculture Development Agency, Republic of South Sudan

93. A key aim of this report is to identify a minimum package of interventions for people living with HIV in humanitarian emergencies. While the background research provided

many insights into such a minimum package, it also showed that wider stakeholder discussion and further research were needed to ensure a strong evidence base for defining, pilot testing, and implementing such a package. Therefore, The report took an evidence-informed approach to describe a minimum package, hoping that further, more collaborative research can quickly yield clear guidelines.

94. The concept of a minimum package is not new. The 2018 NGO Report, for example, specifically called for the development and promotion of: "a basic package of non-judgmental, confidential, and culturally and linguistically competent primary health-care services that will be made available to people on the move as part of UHC and in recognition of their right to the highest attainable standard of health, regardless of migration status, free of charge, and including speedy access to quality and culturally competent HIV, TB and hepatitis diagnostics, treatment and care services, mental health services as needed, sexual and reproductive health services for women and girls, and ensuring continuity of care".[31]

95. In 2010, the Inter-Agency Standing Committee Task Force on HIV created guidelines intended to "assist humanitarian and AIDS organizations in planning the delivery of a minimum set of HIV prevention, treatment, care, and support services to people affected by humanitarian crises".[32] Other examples exist of essential or minimum packages for humanitarian emergencies, including for education[33] and sexual and reproductive health.[34]

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[31] UNAIDS PCB NGO Delegation. Report by the NGO Representative: Agenda item 1.4. Geneva: UNAIDS Programme Coordinating Board; 11 December 2018, para 132 (https://www.unaids.org/en/resources/documents/2018/PCB43_18.20).

[32] Inter-Agency Standing Committee. Guidelines for addressing HIV in humanitarian settings. Geneva: UNAIDS; 2010, p. 6 (https://www.unaids.org/sites/default/files/media_asset/jc1767_iasc_doc_en_3.pdf).

[33] INEE Minimum standards for education: Preparedness, response and recovery. New York: Inter-Agency Network for Education in Emergencies; 2010 (https://inee.org/resources/inee-minimum-standards).

[34] Minimum initial services package for sexual and reproductive health in crisis situations: Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings. Inter-Agency Working Group; 2020.

Guiding principles

96. The global community survey, key informant interviews, and focus group discussions provided insights into the central needs of people living with HIV during humanitarian emergencies. Based on this information, it is possible to begin developing the outlines of a minimum package of appropriate interventions.

97. The first step is to clarify the principles for determining such a minimum package. The package should:

   ▪ deliver services that are especially needed in the earlier stages of a humanitarian emergency;
   ▪ minimize death and disease among people living with HIV; and
   ▪ build resilience.

98. The focus on "earlier stages" leaves room for the subsequent and progressive addition of more comprehensive physical and mental health services and detailed strengthening of community and social and government systems. However, given the growth in complex and ongoing emergencies, it is very likely that new humanitarian emergencies will emerge from time to time amid an existing emergency. The minimum package would, therefore, also be relevant for these new "emergencies within emergencies", for example, when a natural disaster occurs during an ongoing conflict situation or vice versa.

99. Services to protect lives would be a priority for the minimum package: for example, stable access to ARVs, food, drinkable water, and shelter, regardless of a person's nationality or immigration/citizenship status. Services supporting ARV adherence would need to reflect the diversity of people living with HIV. A minimum package of humanitarian interventions would be human rights-based and would emphasize the leadership and involvement of communities and people living with HIV.

Possible elements of the minimum package

100. Based on inputs received during the research for this report, five elements are proposed for the minimum package.

101. **A minimum three-month supply of ARVs**. Access to ARVs was commonly seen as the most pressing need of people living with HIV during humanitarian emergencies, especially people living far from locations where ARVs are distributed. The provision of a three-month supply of ARVs appears to be a widespread practice in humanitarian settings. An associated problem is that displaced people may not have with them the documentation that is needed to access ARVs (e.g., a prescription). Mechanisms are needed to assist people living with HIV to acquire the necessary documentation to access the available essential medications (which may be different from the ones they were previously using).

102. **Adequate food, water, and shelter**. The minimum package must reflect UNAIDS recommendations about the additional nutritional needs of children and adults living with HIV (i.e., adults have 10–30% higher energy requirements than a healthy adult without HIV, and children have 50–100% higher than normal requirements).[35] Providing for these needs in humanitarian settings may also require support for transport or evacuation to safer locations.

103. **HIV-related health care**. This would include testing and treatment for hepatitis, tuberculosis, and sexually transmitted infections; viral load testing; harm reduction

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[35] HIV, food security and nutrition. Policy brief. Geneva: UNAIDS; 2008.

materials and substance use treatment, specifically access to opioid agonist therapy; prevention of vertical transmission; treatment and care for people exposed to sexual violence, including rape; and psychological first aid and psychosocial support. Robust referral systems need to be implemented to ensure that people's other urgent health needs are addressed.

104. **Capacity-building for community health and social workers**. If communities and people living with HIV are to *lead* and *deliver* services in humanitarian settings, they need additional capacity building, training, supervision, and other support. That would include addressing HIV stigma and discrimination and adopting a human rights-based approach, as well as providing targeted information on delivering first aid during humanitarian emergencies and ensuring the safety of staff and service users.

105. **Cash transfers/employment/income**. There is a fundamental need during a humanitarian emergency for cash to purchase food, pay for transport, and buy data for mobile phones, etc., since many people will have lost their usual sources of income. The provision of uninterrupted access to income is a crucial component of a minimum package during humanitarian emergencies.[36] UNHCR, WFP, and other partners already provide cash interventions in emergencies worldwide.[37]

Summary

106. Clarifying a minimum package of interventions for humanitarian emergencies requires spelling out the guiding principles for those interventions and then elaborating on the service details. Three principles are proposed: focus on services that are needed in the initial stages of an emergency, that minimize death and morbidity, and that build resilience.

107. The minimum package for people living with HIV would include a three-month supply of ARVs; food and water that takes into account the added nutritional needs of adults and children living with HIV; HIV-related health care, including prevention and testing (including viral load testing); capacity building of community workers and peers; and mechanisms for acquiring cash.

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[36] This report is specifically about people living with HIV. However, cash transfers and access to income are also very important ways to minimize HIV vulnerability and risk.

[37] 2022 Annual report on cash assistance. Geneva: UNHCR, 2022 (https://www.unhcr.org/media/2022-annual-report-cash-assistance).

Conclusion: recommendations and proposed decision points

> *"UNAIDS could focus on educating its UN family people internally about prioritizing HIV, supporting collaboration and building bridges between communities and policymakers and governments, and backing leadership and advocacy by communities and people living with HIV."*
>
> – Daxa Patel, National Coalition of People living with HIV, India

108. The 2023 NGO report builds on the of 2018 NGO report. One of the recommendations of the 2018 report was for an improved working relationship with IOM; this was taken forward in the approved decision points of the PCB. However, a key recommendation for developing and promoting a minimum package of services for people on the move was not included in those final, approved decision points.

109. Improved collaboration with relevant stakeholders, including IOM and OCHA, as well as working towards a minimum package of interventions for people living with HIV during humanitarian emergencies, are priorities in this current report. This will require significant stakeholder engagement from Member States, UN agencies, civil society, people living with HIV, and donors such as the Global Fund and the United States President's Emergency Fund for AIDS Relief.

Overarching recommendations

110. Before detailing the specific decision points arising from this report, the following six overarching recommendations are presented to all stakeholders involved in providing services to people living with HIV during humanitarian emergencies.

111. **Promote a clear understanding of the term "humanitarian emergency"**. A shared understanding could emphasize three core features of an emergency as an event or series of events ("man-made", "natural" or both) which

   ▪ represent an acute and/or ongoing threat to the health, safety, rights (including health rights), or physical and mental wellbeing of a large group of people (acknowledging that large is a term open to interpretation);
   ▪ demand immediate action; and
   ▪ require multisectoral internal as well as external humanitarian relief, the latter under the coordination of OCHA.

   UNAIDS could consider adopting the WHO definition of the term "humanitarian emergency".

112. **Recognize special health and psychosocial needs**. During emergencies, governments and humanitarian actors must urgently ensure access to appropriate prevention, medication, treatment and care specific to the physical and mental health needs of people living with HIV.

113. **Integrate humanitarian response within HIV strategic plans**. Governments and the humanitarian community need to work together to improve the integration of humanitarian concerns in HIV strategic plans and the integration of HIV in emergency preparedness, needs assessments and humanitarian responses. Strengthening the joint capacity to collect, analyze and use evidence and data related to HIV in humanitarian settings and among populations affected by emergencies is crucial to improve advocacy and programming in this area of work.

114. Collaborate with relevant stakeholders to further clarify a minimum package of interventions. A working description of such a package would include:

   ▪ a minimum three-month supply of ARVs;
   ▪ food and water supplies that take into account the added nutritional needs of adults and children living with HIV;
   ▪ HIV-related health care that is sensitive to the diverse, intersectional needs of key populations of people living with HIV, and that includes prevention and testing;
   ▪ capacity building for community workers; and
   ▪ mechanisms for acquiring cash.
   ▪ In practice, such a package would also need to address the needs of people at risk of HIV, and key stakeholders should pilot it before being implemented. Clarifying and ensuring such a minimum package is essential for emergency preparedness.

115. **Recognize the critical roles of communities**. It is time for communities to lead in the HIV response, as spelled out in the Global AIDS Strategy. UNAIDS and OCHA could lead in promoting a humanitarian emergency response that builds on existing local HIV-related capacities to more effectively meet the needs of people living with and vulnerable to HIV. As the world increasingly faces complex emergencies, climate breakdown, and dwindling humanitarian funds, humanitarian methodologies should emphasize and build on community leadership.

116. **Develop and implement interventions to minimize disruptions along the continuum of HIV services**. Governments and humanitarian actors need to prioritize the development and implementation of prevention, testing, treatment, and holistic care interventions that are targeted at minimizing the negative impacts of humanitarian emergencies on the continuum of HIV services for people living with HIV. Doing so requires ensuring the effective use of development funding and investments in health system strengthening. Having specific strategies to provide services for people living with HIV during humanitarian emergencies should be a priority for governments and humanitarian responders.

Proposed decision points

117. The 2023 NGO Report proposes decision points that avoid repeating commitments that have been made previously by the UN or UNAIDS PCB meetings. The proposed decision points are SMART[38] to address the urgency of ongoing and increasingly complex humanitarian emergencies, as well as the global goal of ending AIDS as a public health threat by 2030, a deadline that is only seven years away.

118. The following decision points are proposed to the 53rd meeting of the UNAIDS PCB, 12–14 December 2023:

   ▪ *Recall* the Global AIDS Strategy 2021–2026, specifically its 95–95–95 treatment targets in all populations, regions, and countries affected by the HIV epidemic; its 95% combination prevention target for people at risk of HIV in humanitarian settings; its 90% target of people in humanitarian settings having access to sexual and reproductive health and rights, tuberculosis, HIV and gender-based violence services;
   ▪ *Recall* the report by the NGO Representative at the 43rd meeting of the UNAIDS PCB, decision point 4.4, on addressing the diverse needs of migrants and mobile populations as well as refugees and crisis-affected populations, and decision point 4.6, on promoting access to services; improving data about people on the move; adapting

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[38] "Specific, Measurable, Achievable, Relevant, Time-bound".

laws, policies and practices that prevent access; strengthening health systems; and enabling collaboration between health systems and communities;

▪ *Take note* of the report by the NGO Representative;

▪ *Call on* the Joint Programme to:

a. Update the 2010 *Guidelines for Addressing HIV within Humanitarian Settings* (Inter-Agency Standing Committee Task Force on HIV), including specifically addressing the needs of people living with HIV;

b. Provide the PCB annually with an update on HIV prevalence and incidence in countries experiencing humanitarian emergencies, as well as an update on the Joint Programme's response to HIV in humanitarian emergencies, with a specific focus on people living with HIV;

c. Review and, where needed, update the division of labour between the Cosponsors of the Joint Programme on HIV services in humanitarian emergencies to ensure a stronger integration of HIV in the humanitarian response of all actors especially at the country level;

d. Collaborate with national stakeholders to develop a targeted response for people living with HIV during humanitarian emergencies in national strategic and emergency plans;

e. In conjunction with relevant stakeholders, agree on a common definition of humanitarian emergencies;

f. Develop guidelines for service provision for people living with HIV during humanitarian emergencies, including identifying a minimum package of interventions and highlighting the role of communities;

g. Coordinate the development of an investment strategy—including government, donor, and private funding streams—for building and sustaining the leadership of communities and people living with HIV during humanitarian emergencies; and

h. Establish a collaboration with the International Organization for Migration and the United Nations Office for the Coordination of Humanitarian Affairs to improve the collective capacity of different UN agencies and other stakeholders to address HIV in humanitarian settings.

[Annexes follow]

Annex 1. Bibliography

The worsening HIV crisis in eastern Europe and central Asia. Aidspan, issue 430, March 2023 (https://aidspan.org/the-worsening-hiv-crisis-in-eastern-europe-and-central-asia/).

Al-Dahash HF, Thayaparan M, Kulatunga U. Understanding the terminologies: disaster, crisis and emergency. *In:* Chan and Neilson (Eds), Proceedings of the 32nd ARCOM Conference, 5-7 September 2016, Manchester, United Kingdom.

Ayala G, Sprague L, van der Merwe LL-A, Thomas RM, Chang J, Arreola S, et al. Peer- and community-led responses to HIV: A scoping review. PLoS ONE. 2021;16(12):e0260555 (https://doi.org/10.1371/journal.pone.0260555).

Bennett, R. Estimation of people living with HIV affected by humanitarian disasters in 2016. Geneva: UNHCR; 2018.

Bidder M. Linking relief and development—a conceptual outline. Addis Ababa: UNDP, Emergencies Unit for Ethiopia; 1994 (https://www.africa.upenn.edu/eue_web/ctinuum.htm).

Byanyima W and Marmot M. Close inequalities to end AIDS & prepare for future pandemics. Inter-Press Service, 5 June 2023 (https://www.ipsnews.net/2023/06/close-inequalities-end-aids-prepare-future-pandemics/).

Bloxham L. What is a humanitarian crisis? London: Concern Worldwide; 2022 https://www.concern.org.uk/news/what-is-a-humanitarian-crisis

What is an emergency? Copenhagen: Danish Refugee Council (https://emergency.drc.ngo/home-page/policy-and-principles/).

Ferreyra C, O'Brien D, Alonso B, Al Zomour A, Ford, N. Provision and continuation of antiretroviral therapy during acute conflict: the experience of MSF in Central African Republic and Yemen. Conflict and Health. 2018;12:30 (https://doi.org/10.1186/s13031-018-0161-1).

Food Security Information Network. *Global report on food crises: Joint analysis for better decisions.* Rome: World Food Programme; 2023 (https://www.wfp.org/publications/global-report-food-crises-2023).

Improving the agency and equity of marginalised communities in the COVID-19 crisis: Advocacy brief for organizations working across the humanitarian-development nexus. Brighton: Frontline AIDS; 2021 (https://frontlineaids.org/resources/improving-agency-and-equity/).

Proposition paper: The climate crises and HIV. Brighton: Frontline AIDS; 2022.

Gilks C. Role of communities in AIDS response. Indian J Med Res. 2019;150:515–517.

Gkotsis P, Henriques S, Koukournesis E, Leleki E, Melachrinos C, Papaioannou M, et al. Challenges and opportunities in rapid situational awareness of Ukrainian displacement to the European Union: Some methodological insights. Migration Research Series, No. 75. Geneva: International Organization for Migration; 2023.

Results of the rapid assessment of communities and local NGOs—Ukraine. Amsterdam: GNP+; 2023 (https://gnpplus.net/wp-content/uploads/2023/08/Results-of-rapid-assessment-_2023.docx.pdf).

Gómez OA, Kawaguchi C. The continuum of humanitarian crisis management: Multiple approaches and the challenge of convergence. Working paper no. 136. Tokyo: Japan International Cooperation Agency Research Institute; May, 2016 (https://www.jica.go.jp/english/jica_ri/publication/workingpaper/wp_136.html).

Guinto RR, Cahatol JJF Lazaro K, Cruz Salazar A. Pathways linking climate change and HIV/AIDS: An updated conceptual framework and implications for the Philippines. J of Clim Change & Health. 2022;6.

Provost, C, Daniels, C, Gurung, G, Cook, C. Aid for the war on drugs. London: Harm Reduction International; 2023 (https://hri.global/publications/aid-for-the-war-on-drugs/).

What is a Humanitarian Emergency? Ottawa: Humanitarian Coalition (https://www.humanitariancoalition.ca/what-is-a-humanitarian-emergency).

Humanitarian Policy Group. HIV/AIDS and humanitarian action. London: Overseas Development Institute; 2004.

Inter-Agency Standing Committee Reference Group for Mental Health and Psychosocial Support in Emergency Settings. Mental health and psychosocial support in humanitarian emergencies: what should humanitarian health actors know? Geneva: OCHA; 2010.

Dealing with crises arising from conflicts and disasters – ILO training manual for workers' organizations. Geneva: ILO; 2022.

Regional Refugee and Migrant Response Plan (RMRP) 2023–2024. Inter-Agency Coordination Platform for Refugees and Migrants from Venezuela; 2023 (https://rmrp.r4v.info/#:~:text=To%20respond%20to%20these%20mounting,protection%20and%20socio %2Deconomic%20integration).

Inter-Agency Network for Education in Emergencies. (2010). *INEE Minimum standards for education: Preparedness, response and recovery*. https://www.right-to-education.org/resource/inee-minimum-standards-education-preparedness-response-recovery

Inter-Agency Standing Committee. Guidelines on mental health and psychosocial support in emergency settings. Geneva: OCHA; 2007 (https://interagencystandingcommittee.org/iasc-task-force-mental-health-and-psychosocial-support-emergency-settings/iasc-guidelines-mental-health-and-psychosocial-support-emergency-settings-2007).

Inter-Agency Standing Committee. Guidelines for addressing HIV in humanitarian settings. Geneva: UNAIDS; 2010 (https://www.unaids.org/sites/default/files/media_asset/jc1767_iasc_doc_en_3.pdf).

Inter-Agency Task Team on addressing HIV in humanitarian emergencies. COVID-19 and HIV in Humanitarian Situations: Considerations for preparedness and response. Geneva: UNAIDS; 2020.

Inter-Agency Task Team on HIV and Young People. Guidance Brief: HIV Interventions for young people in humanitarian emergencies. New York: UNFPA; 2007 (https://inee.org/sites/default/files/resources/iatt_hivandyoungpeople_emergencies.pdf).

Inter-Agency Task Team to Address HIV in Humanitarian Emergencies. Assessment of HIV in internally displaced situations. Geneva: UNHCR; 2014 (https://www.unhcr.org/sites/default/files/legacy-pdf/53cfafb99.pdf).

Inter-Agency Working Group. Minimum initial services package (MISP) for sexual and reproductive health (SRH) in crisis situations—Inter-Agency field manual on reproductive health in humanitarian settings. New York: UNFPA; 2020 (https://www.unfpa.org/sites/default/files/resource-pdf/MISP-Reference-English.pdf).

HIV in emergencies. Geneva: International Organization for Migration; 2014.

Jennings L, George AS, Jacobs T, Blanchet K, Singh NS. A forgotten group during humanitarian crises: a systematic review of sexual and reproductive health interventions for young people including adolescents in humanitarian settings. Conflict and Health. 2019;13:57 (https://doi.org/10.1186/s13031-019-0240-y).

Khoshnood K. "HIV/AIDS in humanitarian crises". Newsletter issue 3. New Haven: Center for Interdisciplinary Research on AIDS, Yale University: November 2022.

Kickbusch I, Liu A. Global health diplomacy—reconstructing power and governance. Lancet. 2022;399: 2156–2166 (https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(22)00583-9/fulltext).

Lieber M, Chin-Hong P, Whittle HJ, Hogg R, Weiser SD. The synergistic relationship between climate change and the HIV/AIDS epidemic: a conceptual framework. AIDS and Behavior. 2021;25:2266–2277 (https://doi.org/10.1007/s10461-020-03155-y).

Lilly D. Humanitarian action is the answer to fewer and fewer of today's humanitarian crises. London: Humanitarian Practice Network; 2023 (https://odihpn.org/publication/humanitarian-action-is-the-answer-to-fewer-and-fewer-of-todays-humanitarian-crises/).

Maurer P. Humanitarian crises are on the rise. By 2030, this is how we'll respond. Geneva: World Economic Forum; November 2016 (https://www.weforum.org/agenda/2016/11/humanitarian-crisis-are-on-the-rise-by-2030-this-is-how-well-respond/).

Community engagement at the centre of disaster response. Geneva: OCHA; 2016 https://www.unocha.org/publications/report/world/community-engagement-centre-disaster-response

Global humanitarian overview. Geneva: OCHA; 2022 (https://www.un-ilibrary.org/content/books/9789210012423).

ODI Humanitarian Policy Group. HIV/AIDS, food security and humanitarian action: a resource guide. London: Overseas Development Institute; 2019 (https://www.oxfam.org/en/power-local-leadership-emergencies).

The power of local leadership in emergencies. London: OXFAM (https://www.oxfam.org/en/power-local-leadership-emergencies).

Platform LAC and the Global Fund. A case study: response to HIV and TB in the framework of the migration phenomenon in the Andean region countries prioritized by the Global Fund to Fight AIDS, Tuberculosis and Malaria. Lima, Peru. Geneva: The Global Fund; 2022.

"Uganda's anti-gay law: how restricted are LGBTQ rights in Africa". Reuter's news agency, May 29, 2023 (https://www.reuters.com/world/africa/africas-restrictions-lgbtq-rights-2023-05-29/).

Rich D. "Ukraine, inflation, insécurité: la crise du CICR révélatrice des difficultés financières des ONG". France 24. 8 June 2023 (https://www.france24.com/fr/europe/20230608-ukraine-inflation-ins%C3%A9curit%C3%A9-la-crise-au-cicr-remet-en-cause-le-financement-des-ong).

Saberi P, Ming K, Arnold EA, Leddy AM, Weiser SD. Extreme weather events and HIV: development of a conceptual framework through qualitative interviews with people with HIV impacted by the California wildfires and their clinicians. BMC Public Health. 2023;23:950 (https://doi.org/10.1186/s12889-023-15957-5).

SáCouto S, Ford Ouoba, SA, Martin C. Good practice on accountability for conflict-related sexual violence: the Sepur Zarco case. New York; UN Women; 2022 (https://reliefweb.int/attachments/d077ed7b-ecd0-4991-94bc-c8b396bbaa40/Research-paper-Documenting-good-practice-on-accountability-for-conflict-related-sexual-violence-Sepur-Zarco-en_1.pdf).

Spiegel P. HIV/AIDS among conflict-affected and displaced populations: dispelling myths and taking action. Disasters. 2004;28(3):322–339 (https://doi.org/10.1111/j.0361-3666.2004.00261.x).

Stamnes E. Rethinking the humanitarian-development nexus. Policy brief. Oslo: Norwegian Institute of International Affairs; 2016 (https://nupi.brage.unit.no/nupi-xmlui/handle/11250/2405657).

Sturridge C. Living with climate change, conflict and displacement: recognising agency, voice, mobility, language and linkages. Policy brief. London: Overseas Development Institute; 2023 (https://odi.org/en/publications/living-with-climate-change-conflict-and-displacement-recognising-agency-voice-mobility-language-and-linkages).

Conflicts, crises and displaced people: how the Global Fund works in challenging operating environments. Geneva: The Global Fund; 2022.

The Sphere Project. Humanitarian charter and minimum standards in disaster response. London: Oxfam GB; 2004.

UNAIDS PCB NGO Delegation. Report by the NGO Representative: Agenda item 1.4. Geneva: UNAIDS Programme Coordinating Board; 11 December 2018, para 132 (https://www.unaids.org/en/resources/documents/2018/PCB43_18.20).

HIV, food security and nutrition. Policy brief. Geneva: UNAIDS; 2008.

Global AIDS Strategy 2021–2026: End Inequalities. End AIDS. Geneva: UNAIDS; 2021.

HIV prevention 2025 Road Map: Getting on track to end AIDS as a public health threat by 2030. Geneva: UNAIDS; 2022.

The path that ends AIDS: Global AIDS update 2023. Geneva: UNAIDS; 2023 (https://www.unaids.org/en/resources/documents/2023/global-aids-update-2023).

Manual: Inter-Agency reproductive health kits for use in humanitarian settings. New York: UNPFA; 2019.

UNHCR and WFP. Information note: HIV in humanitarian contexts. Geneva: UNHCR; 2019.

UNHCR and WFP. Humanitarian fact sheet. High-Level Meeting on HI/AIDS. Geneva: UNHCR; 2021.

Essential medicines and medical supplies guidance 2023. Geneva: UNHCR; 2023.

Global trends report 2022. Geneva: UNHCR; 2023 (https://www.unhcr.org/global-trends-report-2022).

UNHCR. International guidelines on HIV/AIDS and human rights. Geneva: UNAIDS; 2006.

UNICEF Canada. HIV/AIDS, conflict and displacement. Ottawa: UNICEF; 2006.

WHO, UNODC, INPUD. Recommended package of interventions for HIV, viral hepatitis and STI prevention, diagnosis, treatment and care for people in prisons and other closed settings. Policy brief. Geneva: World Health Organization; 2023 (https://iris.who.int/bitstream/handle/10665/366820/9789240071858-eng.pdf?sequence=1).

Emergency response framework (2nd ed.). Geneva: World Health Organization; 2017.

Serving the needs of key populations: case examples of innovation and good practice in HIV prevention, diagnosis, treatment and care. Geneva: World Health Organization; 2017.

Wirtz AL, Guillén JR, Stevenson M, Ortiz J, Barriga Talero MA, Page KR, et al. HIV infection and engagement in the care continuum among migrants and refugees from Venezuela in Colombia: a cross-sectional, biobehavioural survey. Lancet HIV 2023;10:e461–471. (https://www.thelancet.com/journals/lanhiv/article/PIIS2352-3018(23)00085-1/fulltext).

Annex 2. Key informants and focus groups

1. **Individuals** *(24)*

Emergency setting	Key informant
International	Frédéric Boyer, Global Health Advisor at the Permanent Representation of France to the UN
	Binod Mahanty, Advisor to the Ministry of Health, Germany
	Allen Maina, Chief of Public Health Section, UNHCR
	Michael Smith, HIV Adviser and UNAIDS Focal Point, WFP
Afghanistan	Morgane BERNARD-HAREL and Dr Ziaurahman Zia, *UNODC – Afghanistan*
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Bangladesh	Shale Ahmed, Nazmul Haque, Shohel Rana, *Bandhu Social Welfare Society*
Haiti	Eva Marly Steide, Housing Works (Haiti)
India	Daxa Patel, National Coalition of People living with HIV in India
Lebanon/MENA	Maher Sleiman, Frontline AIDS (Lebanon)
Myanmar	Pyae Phyo Kyaw (Victor)
	Anonymous key informant
Mozambique	Julio Mutemba, Regional Psychosocial Support Initiatives (REPSSI) - Mozambique
	Teles Nhanombe, Pediatric-Adolescent Treatment Africa (Mozambique)
Pakistan	Shahzadi Rai, Gender Interactive Alliance
South Sudan	William Mabior Achuil, Food and Agriculture Development Agency
Ukraine	Anton Basenko, *INPUD*
	Andrii Chernyshev, *Alliance Global*
	Ioannis Mameletzis, *WHO - Ukraine*
	Valeriia Rachynska, *100% Life*
	Maryna Varban, Alliance for Public Health
Venezuela	Mary Ann Torres, International Council of AIDS Service Organizations

2. **African focus group participants** *(55)*

Country	Focus group participants
Cameroon	Landom Shey, Gildas Ndzome, Virginie Zangue, Ndongo Jimenez, Nigel, Endeley Paul, Cathy Aba, Felico, Bruno Baha, Alice Wouedjie, André Tsogo, Benoit Bissohong
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Madagascar	Karancha Lydia, Marion Njorogo, Tasline Otieno, Michael Owino
Mali	Mariam TOURE, Dramane KONE, Amadou I. SANGHO, Amey GUE Mathurin, Ali DJERMA, Abdoulaye BANOU, Cheick H. SIDIBE, Madani Diarra, Djeneba COUMARE, Amadou TRAORE, Ibrahim S. TOURE
Mozambique	Roberto Paulo
Nigeria	Joseph I Anosike, Layidi Abraham Johnson, Nkechi Okoro, Blessing Omebiro, Ayomide Faith Jaiyeola, Adeyemi Bilikis Apeke, Bukola Okaraga Eneye, Hajara Aliyu, Kareem Samsudeen Adebola, Haruna Aaron Sunday, Stephanie Ajuma Okoriko, Amaka Enemo, Adek Bassey,
Zambia	Mable Zibuku

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