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AIDS, Security and Humanitarian Response

Table of Contents

A. INTRODUCTION

1. Conflicts and natural disasters, especially when combined with displacement, food insecurity and poverty, can lead to humanitarian emergencies that have the potential of increasing the vulnerability to HIV infection among affected populations[1]. The recognition of this vulnerability was highlighted in the Declaration of Commitment adopted at the 2001 General Assembly Special Session on HIV/AIDS (UNGASS). The Declaration called for the development and implementation of national strategies that incorporate HIV awareness, prevention, care or treatment elements into programmes or actions that respond to emergency situations.

2. In 2000, AIDS became the first health issue ever to be discussed by the UN Security Council, due to its potential threat to the maintenance of peace and security. The adoption of Security Council Resolution 1308 and subsequently, Security Council Resolution 1325 on gender-based violence, led to a generation of specific programmes aiming to deal with AIDS and gender-based violence among uniformed services and peacekeeping operations. In 2004, the UN High-Level Panel on Threats and Challenges further defined a threat to international security as "any event or process that leads to large-scale death or lessening of life chances and undermines States as the basic unit of the international system".

3. Humanitarian emergencies (as a result of natural disasters and conflict), security, and HIV are interrelated. It has also been argued that AIDS itself, in the absence of conflict (or natural disaster), may result in a humanitarian emergency[2]. In some hyper endemic countries, especially in Southern Africa, AIDS is, indeed, increasingly being recognized as a humanitarian concern *per se*,[3] due to its wider impact on societies, such as increased food insecurity and reduced coping mechanisms and livelihoods, its adverse effects on the delivery and quality of basic services, and the nature of family, gender and intergenerational relations[4].

4. The objectives of this paper are: 1) to describe the linkages between AIDS, humanitarian emergencies and security as evident from the literature; 2) to examine the response by UNAIDS[5] to date; and 3) to present recommendations for action for the coming years.

B. AIDS in HUMANITARIAN EMERGENCIES

5. Humanitarian emergencies and the characteristics of emergency-affected populations vary greatly. Emergencies may be due to conflict, either of short duration or protracted, acute natural disasters like earthquakes and tsunamis, or recurring ones like hurricanes and droughts. Sometimes, emergencies may lead to widespread population displacement, either internal or across national borders, while others affect only certain parts of a country or region. Emergency-affected populations include: 1) populations that are directly affected by conflict or

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[1] Spiegel, P. (2004)HIV/AIDS among Conflict-affected and Displaced Populations: Dispelling the Myths and Taking Action. Disasters, 2004, 28 (3): 322-399.

[2] De Waal, A; Whiteside, A (2003) New variant famine: AIDS and food crisis in southern Africa. The Lancet, Vol 362, October 11, 2003

[3] Harvey, P. (2004) HIV/AIDS and humanitarian action. The Humanitarian Policy Group (HPG) at Overseas Development Institute, Research Briefing Number 14 April 2004

[4] Barnett, T. (2006) A long-wave event. HIV/AIDS, politics, governance and 'security': sundering the intergenerational bond? International Affairs 82, 2 (2006) 297-313.

[5] The Joint United Nations Programme on HIV/AIDS consisting of the UNAIDS Secretariat and 10 co-sponsoring UN Agencies

natural disasters, both displaced and non-displaced persons; 2) persons indirectly or previously affected, such as host populations, returnees, those in transition to recover, and humanitarian workers; and 3) armed or uniformed groups involved in the humanitarian emergency situations.

6. HIV transmission patterns in humanitarian emergencies are complex and depend upon many dynamic and countervailing factors:

   a. Vulnerability to HIV infection may be increased due to the loss of livelihoods and the disruption of supportive and protective family and social networks and institutions, forcing women and girls into transactional sex for money, food or protection. Conflict also tends to increase sexual violence against women and girls, and systematic rape may be used as a weapon of war. As a reaction to trauma, alcohol and other drug use may increase and, in general, perceptions of HIV risk and behaviors may change.

   b. Factors that have been identified that may act to reduce transmission of HIV include the isolation and inaccessibility of some emergency-affected populations, reduced mobility during both acute emergencies and protracted conflict, and, especially in some post-emergency settings, the availability of better protection and HIV-related services than in those populations not directly affected.

   c. In low-level or concentrated HIV epidemic settings, the risk of significant increases in HIV prevalence due to an emergency may be small. However, outbreaks due to unsafe blood transfusions or multiple infections among the most-at risk populations such as drug users cannot be ruled out. In high–prevalence settings, the dynamics of the epidemic will depend on the level of prevalence of HIV among the different affected sub-populations (e.g. refugees, displaced people, host populations, armed forces etc.) and on the nature and type of interactions among them.

   d. In some prolonged conflicts in Africa, HIV prevalence has remained relatively low compared to other countries that have not been affected by emergencies. This is the case for Sierra Leone,[6,7] the Democratic Republic of Congo[8] and Angola[9]. HIV prevalence among internally displaced persons has been less well studied.

   e. HIV transmission may well be accelerated in post-emergency, recovery and reconstruction periods, as a result of improved accessibility and transport, and increased mobility, including between rural and urban areas. This seems to have been the case for Mozambique[10,11] and could possibly occur in Angola, Southern Sudan and other countries recovering from conflict, if adequate measures are not taken. [12]

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[6] Kaiser R, Spiegel P, Salama P, et al. HIV seroprevalence and behavioral risk factor survey in Sierra Leone. Atlanta: Centers for Disease Control and Prevention, 2002.

[7] National HIV/AIDS Secretariat, Ministry of Health and Sanitation. National population based HIV seroprevalence survey of Sierra Leone in 2004. Freetown, 2005

[8] Programme National de Lutte contra le VIH/SIDA et les ISTs. Rapport du passage de la surveillance sentinelle du VIH chez les femmes enceinte frequentant les services de CPN. Kinshasa, 2003-4

[9] Ministry of Health Angola. Preliminary report of the seroprevalence study of HIV, syphilis and hepatitis B among pregnant women attending antenatal clinics. Angola 2004. In: WHO, ed. Preliminary - unpublished, 2004.

[10] Macassa G, Ghilagaber G, Bernhardt E, Burstrom B. Trends in infant and child mortality in Mozambique during and after a period of conflict. *Public Health* 2003;**117**(4)**:**221-227.

[11] Barreto J, Liljestrand J, Palha de SC, et al. HIV-1 and HIV-2 antibodies in pregnant women in the City of Maputo, Mozambique. A comparative study between 1982/1983 and 1990. *Scand.J.Infect Dis* 1993;**25**(6)**:**685-688.

[12] Mock N, Duale S, Brown, B et al, Conflict and HIV: A framework for risk assessment to prevent HIV in conflict-affected settings in Africa. Emerging Themes in Epidemiology, 29 October 2004

7. The <u>humanitarian crises in Southern Africa</u>, characterized by a combination of high HIV prevalence, chronic food insecurity, and weakened government institutions, may not fully fit the typical description of a humanitarian emergency. Though the situation is urgent, the emergency has become chronic, leaving AIDS affected households food-insecure not only during droughts, but also during normal seasons, due to difficulties in meeting the demands of labor-intensive agricultural practices[13]. In such situations, food insufficiency is an important risk factor for increased vulnerability and sexual risk-taking as well as HIV transmission, as shown in Botswana and Swaziland[14].

Zimbabwe: Diverse emergency settings within the same country

Following the mass evictions of urban dwellers in Zimbabwe in 2005, at least four different humanitarian assistance settings existed, all likely to be associated with quite different HIV vulnerability. The mass evictions resulted in several thousand persons living in 'holding camps' (like refugee camps) run by government uniformed services; thousands of others sleeping in the open for several months; others crowding in with families and friends, and still others moving to rural areas or splitting up their families. Almost a third of the rural Zimbabwean population was dependent on food distributions at that time, with rural distribution points thus constituting a 5th type of "emergency setting". While sexual harassment and abuse, and sex in exchange for protection and favors by the police were found to be more frequent in the camps, single women and girls, and those separated from their families, especially those taking care of children, appeared vulnerable across settings. Rural food distribution not only had to consider the particular needs of women, children, the elderly and chronically sick, but also the important opportunity distribution points provided with regards to awareness raising and condom distribution during gatherings.

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8. Emergencies not only have the potential to increase vulnerability to HIV, they also tend to lead to serious <u>disruptions of previously existing essential AIDS programs and services.</u> For instance, in Nepal, interruptions of antiretroviral supplies occurred, and in Zimbabwe, thousands of condom outlets were destroyed, and many displaced persons living with AIDS lost access to their care providers. Therefore, emergency responses to HIV not only require prevention and protection, but also the restoration and maintenance of all essential AIDS services.

C. RESPONSES TO AIDS IN EMERGENCIES

9. <u>The global response to AIDS in emergencies has expanded</u> in recent years, partially due to the increasing mobilization of different actors including, prominently, UNAIDS cosponsors, and partners (see Annex A). Since 2001, when the Task Force on HIV/AIDS in Emergency Settings was established, the United Nations Inter-Agency Standing Committee has been involved in AIDS work. In 2005, the Inter-Agency Standing Committee identified AIDS as a cross-cutting issue that must be adequately integrated into the cluster process (as part of the humanitarian reform process)[15].

10. In 2004, the Inter-Agency Standing Committee Task Force launched <u>Guidelines for HIV/AIDS Interventions in Emergency Settings</u>[16], covering a broad range of programming areas including prevention, basic care, protection of those affected, and workplace programmes for humanitarian workers, for the different response stages: emergency preparedness, minimum and

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[13] De Waal, A; Whiteside, A (2003) New variant famine: AIDS and food crisis in southern Africa. *The Lancet*, Vol 362, October 11, 2003

[14] Weiser S. Leiter K., Heisler M. et al, Food insufficiency predicts high-risk sexual behavior among women but not men in southern Africa, Oral presentation on behalf of the Centre of AIDS prevention, University of California, International AIDS Conference, Toronto, Canada, August 2006 .

[15] Outcome Statement, Ad Hoc Inter-Agency Standing Committee Principles Meeting, "Strengthening Humanitarian Response", September, New York, 2005.

[16] Inter-Agency Standing Committee Guidelines for HIV/AIDS interventions in emergency settings. Geneva: IASC Reference Group, 2003.

comprehensive response. Since then, a number of training workshops have been held (mainly in Africa), to introduce these guidelines to field staff and to train trainers. The Task Force is expected to reconvene in 2007, to update the guidelines and to establish a mechanism to monitor implementation.

11. Other, more specific tools addressing the AIDS needs of emergency affected populations to complement the Inter-Agency Standing Committee Guidelines are available or under development. In 2006, UNHCR released a note on HIV and the protection of refugees, internally displaced persons and other persons of concern. The new Inter-Agency Standing Committee Guidelines on Gender-Based Violence Interventions in Humanitarian Settings will be finalized by year-end and a handbook outlining specific programming tools for adolescents in emergencies is in the initial stages of development.

12. Nonetheless, certain gaps and weaknesses in existing guidelines have been noted. One identified constraint is the relative lack of advice, especially for field-level implementers, on how to monitor and evaluate their HIV mainstreaming activities. Other perceived gaps include the need to update HIV testing and counselling strategies and a lack of specific modules on antiretroviral therapy and HIV programming in the reintegration and recovery phase. Some of these issues are currently being addressed.

13. During the past few years, minimum, and in some instances comprehensive responses to HIV prevention and care needs of emergency affected populations have started to be implemented. The fact that a cross-cutting, multi-sectoral response to HIV is needed as early as possible in any emergency is now universally being recognized. Recent events, including the Asian tsunami, the Lebanon crisis and the Zimbabwe displacements saw some basic HIV elements included in the response from the onset.

Indonesia: Mainstreaming HIV into the early emergency response to the tsunami

Following the tsunami that hit the Western part of the Indonesian island of Sumatra (an area characterized by the strong religious beliefs and low HIV prevalence), initial emphasis was put on preventing HIV transmission through the consistent practice of universal precautions. Information materials on HIV prevention and gender-based violence as well as on professional codes of conduct were also distributed, and workshops held specifically for the 45,000 or so uniformed services involved in providing humanitarian assistance. These early measures strengthened the provincial AIDS commission and supported the development of an AIDS strategic plan in the post-emergency phase.

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14. Prevention and protection programmes implemented during the stabilization phase have included AIDS information campaigns, the supply of male and female condoms to affected populations, and addressing gender-based violence. Prevention campaigns, for instance, have been organized in camps and at food distribution points in Guinea Bissau and Zimbabwe. UNFPA has supplied condoms to emergency-affected populations in at least 22 conflict countries. Common failures to protect women from gender-based violence, particularly the impunity for perpetrators, have been identified and are starting to be addressed. Post-exposure prophylaxis is now recommended as a minimum response to HIV in emergency settings.

15. The implementation of voluntary counseling and testing, preventing mother-to-child-transmission, anti-retroviral therapy, and community-based care have also started in emergency settings. Community-based care, counseling and testing and, to a lesser extent, anti-retroviral therapy have been provided, for instance, in selected camps in North Uganda. Similarly, anti-retroviral for post-exposure prophylaxis and treatment have been provided in the eastern part of the Democratic Republic of Congo, and in post-conflict Somaliland. The Zambian and South

African Governments were among the first to include refugee populations in their national AIDS treatment policy.

16. In high HIV-prevalence countries in Southern Africa, such as Lesotho and Swaziland, affected by recurrent droughts and chronic food insecurity, WFP is providing <u>nutritional support</u> to people living with HIV on anti-retroviral therapy and AIDS affected households with chronically sick members or orphans. New, less labor-intensive agricultural practices have been introduced to facilitate rehabilitation and improve the livelihoods of women and child-headed households.

17. The <u>documentation of lessons learnt</u> remains relatively scarce. Experiences with delivering service components such as post-exposure prophylaxis have been documented. A UNAIDS/UNHCR best practice publication, "Strategies to support the AIDS related needs of refugees and host populations", describes principles and best practices, including the benefits of integrating refugee AIDS services into host policies, and combining humanitarian and development funding streams.[17] Similarly, a UNAIDS/WFP/UNHCR best practice collection on, "The development of programme strategies for integration of HIV, food and nutrition activities in refugee settings" has also been published.[18] Additionally, a few other field experiences have also been documented.

18. Despite these achievements, there are indications that many <u>responses remain far less comprehensive than recommended</u>. Irregular condom provision has been reported from some settings and data collected from 30 countries indicate that refugees in Asia and southern Africa have higher access to voluntary counseling and testing in or outside camp sites than refugees in other parts of the world. Similarly, access to anti-retroviral treatment services varied widely between refugee populations in different countries[19]. Emergency-affected populations other than refugees are believed to have less access to basic AIDS services than refugees.

19. Of particular concern are the <u>gaps identified in AIDS programming during post-emergency and recovery periods</u> that provide important opportunities for preventing the further spread of the epidemic. The mainstreaming of AIDS into all recovery and reintegration assistance has yet to occur in a systematic manner.

20. The <u>monitoring and evaluation</u> of AIDS mainstreaming into humanitarian assistance has barely started. Epidemiological and behavioral research has been conducted among refugees, and a methodology is currently being developed to estimate infection rates and the burden of AIDS among other emergency-affected populations. Indicators to monitor the implementation of the United Nations Inter-Agency Standing Committee Guidelines on HIV/AIDS in emergency settings are being developed.

21. The HIV needs of emergency-affected populations are increasingly being considered within <u>national AIDS strategic plans</u> and other development frameworks. Seventeen of the 25 national

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[17] UNAIDS/UNHCR. 2005. Best Practice Collection. Strategies to Support the HIV-related Needs of Refugees and Host Populations, Geneva

[18] UNAIDS/WFP/UNHCR.2006. Best Practice Collection. The Development of Programme Strategies for Intergration of HIV, Food and Nutrition Activities in Refugee Settings, Geneva

[19] UNHCR, 2006, Refugees, HIV and AIDS: Fighting HIV and AIDS together with refugees: report on UNHCR's HIV and AIDS Policies and Programmes for 2005

AIDS strategic plans[20] (of countries with significant emergency-affected populations) reviewed, mentioned refugees or internally displaced persons. A similar analysis of the extent to which HIV has been mainstreamed into humanitarian and poverty alleviation strategies and plans is planned.

22. <u>UN planning, coordination and leadership</u> on AIDS in humanitarian emergencies have so far been inconsistent and incomplete. At a 2006 workshop of six southern African countries, it was recommended that existing guidelines be implemented more vigorously and systematically, with stronger support from United Nations Office for the Coordination of Humanitarian Affairs and UNAIDS. In most countries, the systematic mainstreaming of AIDS into UN coordinated contingency planning needs assessment, disaster relief and monitoring and evaluation had not yet taken place.

23. Existing <u>financial tracking systems</u> tend to capture either long-term HIV funding or humanitarian assistance, but not both. The AIDS components of humanitarian appeals are increasingly been funded, although to a lesser extent than other components. Half of the proposals submitted to the Global Fund to Fight AIDS, Tuberculosis and Malaria by countries with significant refugee populations have included specific activities targeting AIDS among refugees. The World Bank's Multi-Country HIV/AIDS Programme included projects in 19 of the 28 refugee-hosting African countries. The United Kingdom Department for International Development recently provided US$11 million for a joint UN system programme to specifically scale up HIV services to populations of humanitarian concern.

D. AIDS and SECURITY

24. A number of <u>linkages between AIDS and state security</u> have been described and/or postulated. These range from demographic impacts (such as an increase in the number of orphaned youth committing crimes or being recruited as child soldiers), the macro-economic effects and the inability of states to cope with the extra costs incurred by AIDS, to the functioning of key government departments, due to the severe loss of human capital caused by AIDS illness and death. It has also been suggested that the epidemic could lead to perceptions and actions that challenge government legitimacy and exacerbate existing tensions between different groups within countries, for instance because of differences in access to treatment[21].

25. Nonetheless, there is currently <u>little evidence that AIDS in itself has directly led or will lead to state failure</u>, even in countries with very high HIV prevalence. Rather, the impact of the epidemic on state stability is thought to be indirect, only becoming visible when HIV combines with and exacerbates other factors that threaten livelihoods, e.g. by gradually eroding the state's law and order and welfare functions. The absence of demonstrable proof of a direct security threat against any given state at this moment does not mean that there is no such danger or that such a threat will not emerge if national epidemics remain unchecked. It also does not mean that significant threats to human welfare and survival - security in a wider sense - do not already exist.

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[20] Algeria, Angola, Burundi, Cameroon, Central African Republic, Republic of Congo, Cote d'Ivoire, Democratic Republic of Congo, Djibouti, Egypt, Ethiopia, Gabon, Ghana, Guinea, Kenya, Liberia, Namibia, Rwanda, Senegal. Sierra Leone, South Africa, Sudan, Togo, Uganda, Tanzania, and Zambia

[21] Garrett, L.HIV and National Security: Where Are the Links? Council on Foreign Relations, .New York, 2005.

26. There is evidence, however, to suggest that <u>armed uniformed forces</u>, especially the military, are at risk of contracting HIV, and that AIDS impacts on their effectiveness – HIV as a threat to security in a narrower sense. Whether operating in a crisis situation or at peace time, armed services personnel, mostly young and male, constitute a high risk, occupational group.

  a. <u>HIV vulnerability and transmission patterns</u> are determined by a range of factors, including: long periods away from their spouses or regular partners; reduced behavioural constraints of family and community life; increased peer pressure that embraces values favouring risky behaviours; increased likelihood to engage in drug use, including injecting drug use; sufficient means to purchase sex; and injuries in combat requiring blood transfusions. Combatants, especially undisciplined groups, may also use their power and weapons to exploit or abuse others and to force sexual relations, thereby risking transmitting the virus to others and/or becoming infected themselves.

  b. <u>Women</u>, who account for up to 1/3 of regular army personnel in some countries, are believed to be particularly vulnerable, since they are often disadvantaged in sexual negotiations, including the use of condoms. Spouses, girlfriends and casual partners of uniformed services are also at risk, especially during breaks in service and demobilization. <u>Child soldiers</u> are often coerced into sexual activity and sexually active at a young age and therefore potentially exposed to HIV.

  c. Data from such countries as Ethiopia[22] and India[23] suggest that<u> prevalence among new recruits may be low, and perhaps lower</u> than among civilians of the same age. Recruits tend to be young men between 17 and 22 years who are frequently recruited from poorer rural areas, where prevalence is lower, and many armies routinely screen recruits, excluding those testing positive for HIV. However, infection rates are expected to increase with age and time spent in service, unless successful prevention programmes are put in place[24].

  d. <u>Infection rates among armed forces may rise</u> disproportionately if they are involved <u>in conflict or war</u> operations. Increased infection rates following such deployment have been reported from several armies, including those involved in the Angolan wars.

27. There is little doubt that <u>AIDS can threaten military effectiveness.</u> According to public statements in Malawi, troop strengths decreased by 40% due to AIDS related deaths. Less is known about risk behaviours and <u>HIV levels in police forces.</u> According to one unconfirmed report from Mozambique in 2002, more than half of all new police recruits tested positive, and a significant number of police personnel died from AIDS[25]. Little is known about risks and HIV infection rates experienced by the various other categories of military and paramilitary uniformed services.

28. Of particular interest to international security is <u>the impact of the epidemic on both potential and existing UN and other peacekeepers.</u> As of September 2006, there were approximately 90,000 UN peacekeepers in 18 missions worldwide, many of them in Africa. HIV prevalence in the armies of some troop contributing countries, such as India, Pakistan and Bangladesh is generally low, and as a result, most of their focus has been on the risk their troops face of contracting HIV while deployed. <u>D</u>eployment would indeed seem to increase the risk of HIV

[22] Abede, Y; Schaap, A; Mamo, G. et al., "HIV prevalence in 72,000 Urban and Rural Male Army Recruits, Ethiopia," *AIDS,* 17, 2003, pp. 1835–40.
[23] Barnett T and Prins G. LSEAIDS. HIV/AIDS and security: fact, fiction and evidence—a report to UNAIDS, India case study, 2005
[24] Whiteside A., De Waal A, Gerbre-Tensae, AIDS, Security and the Military in Africa: A sober appraisal, *African Affairs* , 2006, 0, 10-41
[25] "AIDS Kills 150 Mozambican Policemen," *Agencia de Informacao de Mocambique,* September 11, 2002.

infection. In a recent knowledge, attitude, practice and behaviour survey conducted by UNAIDS, the Department of Peacekeeping Operations and the United States Centres for Disease Control, among 667 peacekeepers deployed to Liberia: approximately 25% of those questioned had sexual intercourse within the mission area; 31% had 2 or more partners; and 21% reported not using condoms despite their availability [26]. Increased infection rates have been reported from among Nigerian peacekeepers returning from deployment in neighbouring countries, as well as Indonesian troops returning home[27][28].

29. The risk of peacekeepers contracting HIV during missions has been closely associated with the possibility of their spreading HIV to host communities. The Cambodian government claimed that the rise of HIV in the country was due to the presence of UN peacekeepers during the early 1990s. NGOs as well as other groups have raised similar concerns regarding peacekeepers in Timor Leste and Kosovo [29]. The absence of reliable baseline data has made it difficult to assess the actual impact of the presence of peacekeepers on national epidemics.

30. The increased vulnerability of uniformed services personnel to HIV, and their potential role in spreading HIV to host populations during conflict settings, should not prevent them from becoming agents of change and role models in the fight against the epidemic. By targeting them with intensive HIV prevention efforts, countries not only help protect their uniformed services personnel from infection, they also can alter social norms regarding sexual behaviour change in the society-at-large.

E. RESPONSES TO AIDS AS A SECURITY THREAT

31. Since the adoption of Security Council Resolution 1308 in 2000, the UNAIDS Office on AIDS, Security and Humanitarian Response, has been a powerful advocate for AIDS and security. Together with the Department of Peacekeeping Operations, it has regularly reported to the Security Council on progress in the implementation of the resolution 1308 and has advocated for the inclusion of AIDS in Security Council Resolutions establishing peacekeeping missions e.g. in Burundi, Cote d'Ivoire, Haiti and Sudan. In July 2005, the Presidential Statement issued at the Security Council Special Session on AIDS commended the UNAIDS Office on AIDS, Security and Humanitarian Response and the Department of Peacekeeping Operations on the progress made in programmes for uniformed services and international peacekeepers[30] and confirmed the Council's readiness to further promote and support the implementation of this resolution.

32. Since 2001 the UNAIDS Office on AIDS, Security and Humanitarian Response, together with the United States Department of Defense, has been chairing an international Task Force for strengthening and coordinating implementation of AIDS strategies among uniformed services worldwide. Additionally, as result of continued advocacy, leading regional security

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[26] Bazergan, R. HIV/AIDS Knowledge, Attitude and Practice Survey: Uniformed Peacekeepers in Liberia. Department of Peacekeeping Operations Peacekeeping Best Practices, February 2006.
[27] Yeager, A. Civil-Military Alliance response to the HIV/AIDS epidemic in Nigeria, concept paper for the Leadership in Fighting the Epidemic (LIFE) project for Nigeria, US Agency for International Development, Geneva, 2000
[28] Soeprapto, W; Ertono, S; Hudoyo, H; Mascola, J; Porter, K; Gunawan, S; Corwin, A L. HIV and peacekeeping operations in Cambodia, *The Lancet*, 346, 1995, pp. 1304-5
[29] Bazergan, R. HIV/AIDS Policies for Blue Helmets, Occassional Paper 96, Institute for Security Studies, November, 2004
[30] S/RES/1308 on the responsibility of the Security Council in the maintenance of international peace and security: HIV/AIDS and international peacekeeping operations, Monday, 18 July, 2005

bodies have increasingly acknowledged the need to mainstream AIDS in their operations. The UNAIDS Office on AIDS, Security and Humanitarian Response has worked closely with the Commonwealth of Independent States, the African Union and its Peace and Security Council, and has formalized partnerships with the Commission for Prevention and Control of HIV/AIDS in the Latin American Armed Forces, the Caribbean Community and Common Market, and the Pacific Islands Chief of Police Forum.

33. AIDS progammes for militaries have existed since the early 1990s. For instance, in Ethiopia and South Africa, the armed forces acknowledged the seriousness of the epidemic and took measures to counter it, well in advance of civilian sectors. Building on these initial efforts, the UNAIDS Office on AIDS, Security and Humanitarian Response has been working with various partners to provide technical and financial support to address AIDS among uniformed services, including military and civil defense forces. Programmes have been designed and implemented in more than 60 countries, worldwide. For instance, in early 2005, India's military entered into a formal partnership with the UNAIDS Office on AIDS, Security and Humanitarian Response to promote AIDS prevention among the country's 2.5 million uniformed personnel. In El Salvador, it is working closely with the National AIDS Programme and the Ministries of Defense and Public Security to implement AIDS education in all training institutions for militaries and police forces. Similarly, in Russia, it is assisting the Ministry of Defense in organizing AIDS peer education among 1.2 million young recruits.

34. These programmes include HIV education, condom promotion and distribution, the establishment or strengthening of counseling and testing services, and training of military health personnel in the provision of AIDS specific treatment and care [31]. A range of practical tools, including a comprehensive programming guide, peer education kit and AIDS awareness cards have been produced and translated into several national languages. Working with wives of military personnel has become an increasingly important part of these programmes, for instance, in the case of the Assam Rifles in India. An external review of these programmes is currently underway.

Thailand: HIV Prevention in the Royal Thai Army

Between 1993 and 2003, the prevalence of HIV among new recruits to the Thai Army had fallen from 4% to 1%. The combination of a top-down approach involving the leadership of the army, and the creation of a supportive environment through linkages with civilian sector AIDS programmes had proven to be a successful recipe for curbing new HIV infections among the Thai military.

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35. A major focus of AIDS and security work since the adoption of Security Council Resolution 1308 and the Declaration of Commitment on HIV/AIDS, has been the establishment of AIDS programmes for UN peacekeeping forces. The continued collaboration between the UNAIDS Office on AIDS, Security and Humanitarian Response and the Department of Peacekeeping Operations has resulted in the integration of AIDS prevention into pre-deployment training for all UN peacekeepers. Under a Cooperation Framework signed by these two partners in 2001, the UNAIDS Office on AIDS, Security and Humanitarian Response had placed a full-time advisor in the Department of Peacekeeping Operations, in charge of AIDS policy. The Department of Peacekeeping Operations has now appointed its own full time advisor. As a result of continued advocacy and successful lobbying, there are now AIDS Advisors or Focal Points in all 18 peacekeeping missions worldwide. With original contributions from the UNAIDS Office on AIDS, Security and Humanitarian Response, the

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[31] UNAIDS. On the Frontline: A Review of Policies and Programmes to address AIDS among Peacekeepers and Uniformed Services, UNAIDS, 2005.

Department of Peacekeeping Operations also maintains a trust fund to sustain AIDS activities among peacekeepers. With the increasing focus on regional troop and mission management for peacekeeping, the UNAIDS Office on AIDS, Security and Humanitarian Response has also supported the African Union with its AIDS programmes for African Union peacekeeping forces as well as African militaries.

36. Key components of peacekeeper AIDS programmes include: awareness training, personal risk assessment, behaviour change counselling, provision of condoms and post-exposure prophylaxis kits, and voluntary counselling and testing. Missions typically develop peer education programmes, drawing on the UNAIDS peer education kit and AIDS awareness cards that have been translated into several national languages and distributed to over 1 million peacekeepers. While promoting condom use as a life-saving measure, the Department of Peacekeeping Operations and the UNAIDS Office on AIDS, Security and Humanitarian Response have also worked to ensure that prevention training clearly reinforces codes and conduct that educate peacekeepers regarding prohibited behaviours.

37. Pre-deployment training tools for use during standard peacekeeper training have been developed, and national governments are encouraged to include AIDS into pre-deployment training. Pre-deployment awareness training has, for instance, been provided to Guatemalan and Peruvian peacekeepers to be deployed to Haiti, and Rwandan soldiers deployed to Sudan and African Union soldiers who served under the African Union in Burundi before becoming UN peacekeepers. During missions AIDS advisors provide induction and awareness training, keeping up with troop rotation and the arrival of new staff.

38. In collaboration with UN Theme Groups, AIDS advisors also seek to mainstream AIDS into mission mandates (such as the training of local police in Haiti) and undertake outreach to local communities (such as collaboration with the Society for Women and AIDS in Africa in Sierra Leone). In Eritrea, peacekeepers organized joint peer education training on HIV with the national army.[32] Overall, outreach education among uniformed services personnel and communities has reached several million men and women directly or indirectly. Best practices in incorporating AIDS prevention into the programmes of national uniformed services (in the case of Thailand, Eritrea and Ukraine) have also been documented.

United Nations Mission in Liberia (UNMIL): AIDS prevention among peacekeepers and communities
The UN mission in Liberia was the first peacekeeping operation to include an HIV policy adviser, now a standard in the personnel tables of new missions. Over 15,000 uniformed peacekeepers from 59 countries are deployed with UNMIL, rotating every 6-12 months. Since 2005, over 10,000 UNMIL personnel have undergone awareness training on HIV, including personal risk assessments. The unit has also launched its peer education programme with the aim of making peacekeepers part of the response to prevent HIV transmission and has conducted outreach programmes, including the training of peer educators among religious leaders.

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39. A more recent focus of work within the field of AIDS, security and national armed forces is the integration of HIV into disarmament, demobilization and reintegration programmes. In 2004, a UN Inter-Agency Working Group was established to develop clear and practical policies, guidelines and procedures for the planning, implementing and monitoring of disarmament, demobilization and reintegration programmes. Recognizing the increased vulnerability of emergency affected populations in post-conflict situations, AIDS has been

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[32] UNAIDS. 2003. Fighting AIDS: HIV/AIDS prevention and care among armed forces and UN peacekeepers. The Case of Eritrea. August 2003

integrated throughout these guidelines, and a specific AIDS module has also been developed. The guidelines are due to be launched at the end of 2006 or early 2007. Interagency missions have already been undertaken to pilot-test them in Sudan and Cote d'Ivoire, and support is also being provided to develop AIDS <u>disarmament, demobilization and reintegration </u>strategies in these countries and to implement activities.

40. Actions <u>that may have mitigated the threat that AIDS poses to state security in a broader sense </u>have also been implemented. These have for instance included: measures to address the macroeconomic impacts of AIDS in hyper endemic countries; extensive orphan support programs reducing the risk of orphaned young people to resort to criminal activity and violence for survival; and, perhaps most importantly, continued donor support in conflict and fragile state situations. Insufficient attention has, however, been given to the epidemic's impact on local administrations, police, judicial and court systems, and welfare functions, which are critical for the provision of basic security and protection.

F. THE WAY FORWARD - REQUESTED DIRECTION TO UNAIDS

41. **<u>Expanding the evidence base</u>: Further investigating the complex linkages between security, humanitarian emergencies and HIV vulnerability and service needs:**
Significant progress has been made in documenting the linkages between AIDS, security and humanitarian emergencies in recent years, in collaboration with partners like the London School of Economics[33]. Further research on: the impact of AIDS on the stability and security of states; AIDS and emergencies; AIDS and uniformed services; and AIDS and sexual and gender based violence needs to be conducted. UNAIDS will continue to support and collaborate with various institutions like the Netherlands Institute of International Relations[34] in these endeavors.

42. **<u>Scaling-up responses </u>at country level: Making AIDS in emergencies an integral part of the Towards Universal Access agenda. The PCB is requested to:**

- **Call on** UN Resident and Humanitarian Coordinators, Theme Group Chairs and UNAIDS Country Coordinators to actively address the AIDS needs of emergency-affected populations and uniformed services at country level, through promoting the systematic use of existing guidelines, and through building and sustaining and AIDS mainstreaming capacity within UN Country Teams and national partners.

- **Endorse** the plans by UNAIDS and its partners (such as DPKO), to continue addressing AIDS within national uniformed services and peacekeeping forces, including through the better integration of military with civilian national AIDS programmes and the promotion of comprehensive prevention, treatment, care and support services.

- **Recommend** that UNAIDS address the impact of AIDS on key government cadres other than the military, including the judiciary, police and local government. Prison and detention center staff, and customs and immigration officials must be targeted as they provide important entry points for programmes targeting vulnerable groups.

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[33] Barnett T and Prins, G. (2005) LSEAIDS. HIV/AIDS and security: fact, fiction and evidence -a report to UNAIDS
[34]The Netherlands Institute of International Relations 'Clingendael' and in cooperation with the Social Science Research Council (20 October 2005), AIDS, Security and Conflict Initiative (ASCI), Project Proposal.

43. **Increased funding** for addressing the AIDS needs of emergency-affected populations and responding to the impact of AIDS on security. The PCB is requested to:

- **Call** on both national governments and international donors to incorporate funding to address the HIV needs related to security and humanitarian assistance in their AIDS activities. Development and humanitarian funding instruments should be adapted to allow sufficient HIV funding during the transition between emergency and post-emergency periods.

44. **Strengthening coordination and partnerships:** Engaging AIDS, security and humanitarian partners.

- Recognizing the already ongoing collaboration between the UNAIDS and partners both within and outside the UN, **the PCB is requested to recommend:** that steps be taken to formalize this collaboration, through the development of a strategic framework for action between United Nations Office for the Coordination of Humanitarian Affairs and UNAIDS; through the formal membership of the UNAIDS Secretariat of the global-level United Nations Inter-Agency Standing Committee and through strengthened leadership in the Task Force on AIDS and Security. The Committee of the Cosponsoring Organizations has also recommended that the UNAIDS Secretariat become a member of the Inter-Agency Standing Committee. The roles and responsibilities related to humanitarian coordination of UNAIDS Regional Support Teams and Country Offices should also be defined.

Appendix A: Responses to HIV, security and humanitarian emergencies by UNAIDS co-sponsors and Secretariat

The following is a summary description of the role and work of UNAIDS co-sponsors and the Secretariat in the area of HIV, Security and Humanitarian Response. The work in this area is rapidly evolving and expanding.

1. ILO

The ILO's focus is on the development of HIV workplace policies and programmes to protect the rights of working age people, their families and the community. ILO recognizes the special pressures on, and needs of, workers involved in security and humanitarian emergencies, and seeks to guarantee that they benefit from workplace programmes, such as occupational safety and health, and the right to non-discrimination, and that employers or decision-makers not view staff as less important than the emergency or security response itself. The ILO's Programme on Crisis Response and Reconstruction has integrated advice on the risks of, and responses to, HIV in crisis and emergency settings into their training and guidance materials. The ILO ensures that employment creation and skills development programmes to support reconstruction integrate components on HIV: a recent example being the Liberia Emergency Employment Programme. The ILO has also targeted ex-combatants (through reintegration programmes) and young people for training and support, since they may be more susceptible to involvement in civil unrest if they lack employment opportunities and hope for the future. The ILO's HIV Programme is also working closely with its   International Programme on the Elimination of Child Labour – as well as fellow cosponsors - to protect children in emergency situations from exposure to child labour.

2. UNDP

The focus of UNDP's HIV, Security and Humanitarian work is on recovery and reintegration, including mainstreaming HIV into disarmament, demobilization, reintegration and rehabilitation (DDRR), and more generally, into development instruments and programmes. In this context, UNDP has been actively involved, together with UNAIDS and UN Department of Peacekeeping Operations in the elaboration of relevant guidelines and the integration of AIDS elements and plans of action into processes for DDRR in post-conflict situations. UNDP has also begun to work through UN Country Teams and Resident/Humanitarian Coordinators to more effectively incorporate AIDS and emergency affected populations into development frameworks and humanitarian plans, including a joint initiative with the World Bank and the Secretariat, to build country capacity in mainstreaming AIDS into Poverty Reduction Strategy Papers in countries recovering from post-conflict. UNDP has also provided regional training and a generic guide for mainstreaming HIV into sectors, including ministries of defense, local governments, and community service organizations. Furthermore, in collaboration with other UN agencies, UNDP is planning to identify and develop means to address some of the underlying factors that make women and girls especially vulnerable in humanitarian situations. Livelihood strategies focusing on women and girls are currently being developed in Southern Sudan.

3. UNESCO

Cognizant of the education needs of emergency-affected populations, UNESCO has been working with UNCHR to develop guidance materials for policy-makers and implementers in ministries of education, civil society organizations, and donor and development agencies involved in emergency, reconstruction and development responses for these populations. This includes a forthcoming policy paper on "Educational responses to HIV and AIDS for Refugees and Internally Displaced Persons: Strategies for Decision-makers", as well as materials for

EDUCAIDS, the UNAIDS Global Initiative on HIV & AIDS and Education, led by UNESCO. EDUCAIDS materials on education sector responses for refugees and internally displaced persons include a brief for decision-makers and an overview of practical resources, which highlights the most useful resources on this issue for education programme implementers and managers. UNESCO has also developed a foundation course on quality education for post-conflict countries that was piloted with the Liberian Ministry of Education and other key education sector stakeholders in that country.

4.UNFPA
UNFPA works with partners to ensure that the specific needs of women are factored into the planning of all humanitarian assistance, by addressing reproductive health needs that are sometimes forgotten, including the need for emergency medical supplies, interventions to ensure safe motherhood, HIV and Sexually Transmitted Infections prevention, and the prevention of, and response to, gender-based violence. UNFPA has been working closely with UNHCR to address the reproductive health needs of refugees and internally displaced persons, through: sexual and reproductive health education programmes, the provision of male and female condoms, sexually transmitted infections drugs, emergency health kits, contraceptives and post-exposure prophylaxis. Since 2005, UNFPA has supplied over 2.7 million condoms to refugees and displaced populations, and another 12.5 million condoms will soon be distributed in 22 countries in Africa and Asia. UNFPA is also working in collaboration with UNICEF to develop programme guidelines and tools for adolescents in emergency/post-conflict settings. UNFPA has been actively collaborating with other agencies to develop comprehensive and coordinated sub-regional strategies on HIV prevention targeting emergency-affected populations. UNFPA has been member of the Global Task Force on HIV among uniformed services, and together with UNAIDS and the UN Department of Peacekeeping Operations has worked towards mainstreaming HIV, reproductive health and gender issues among uniformed services (such as international peacekeepers, national police forces and militaries), and in disarmament, demobilization and reintegration settings.

5. UNHCR
UNHCR is a key actor in the field of HIV among conflict-affected and displaced populations, and the lead organization for HIV and refugees and internally displaced persons, according to the UNAIDS division of labor. Its 2005-07 HIV Strategic Plan follows a protection and human rights framework. Even before joining UNAIDS as a Cosponsoring Organization in 2004, UNHCR had already been advocating for and implementing HIV policies and programmes among refugees and host populations as well as undertaking monitoring, evaluation and programmatic research among these affected populations. In the past two years, UNHCR has assessed the HIV needs of, and collaborated with partners to develop comprehensive HIV programmes for, refugee populations in more than 20 African countries in Africa, Asia, the Middle East and Eastern Europe. More recently, UNHCR has taken up its lead organization function on HIV among internally displaced persons (IDPs). Activities have included assessment missions in Asia and Eastern Europe and a desk review of the IDP situation in 8 countries. The development of assessment and planning tools, and the establishment of a global consultative forum for HIV among IDPs is underway. UNHCR has reviewed national AIDS plans, Global Fund to Fight AIDS, Tuberculosis and Malaria, Multi-Country HIV/AIDS Programme and President's Emergency Plan for AIDS Relief project documents to establish baselines with regard to the inclusion of refugee populations and internally displaced persons, and has been a vocal advocate for addressing their HIV needs in such development and humanitarian frameworks and funding schemes. UNHCR is also one of the few agencies that have documented lessons learnt and best practices in the area of HIV in emergencies.

6. UNICEF

The mandate of UNICEF is to focus on the HIV needs and vulnerabilities of children and adolescents, including those affected by emergencies. In this context, UNICEF has been supporting HIV prevention and care initiatives for emergency affected populations in several countries, by providing post-rape care supplies and post-exposure prophylaxis and training opportunities. UNICEF has also provided information to young people about HIV transmission and prevention, including where to access HIV prevention services, and facilitated access to Prevention of Mother to Child Transmission services. Through protection interventions, targeting emergency-affected children and adolescents, separated and unaccompanied children, and children associated with armed groups/ forces, UNICEF addresses a number of HIV related concerns and vulnerabilities outside the strictly medical programming sphere. At global level, UNICEF is playing a critical role in establishing baseline information and monitoring systems related to HIV in emergencies. This includes the analysis of HIV programming and funding within humanitarian appeals, the development of a methodology for estimating the number of people affected by emergencies living with HIV and indicators to measure implementation of relevant programs, in close collaboration with the UNAIDS Secretariat and other partners. At field level, UNICEF has been extensively involved in rolling out capacity building initiatives, and training their own staff as well as staff from other UN agencies, NGOs, and government counterparts in the use of the United Nations Inter-Agency Standing Committee Guidelines for HIV/AIDS Interventions in Emergency Settings.

7. UNODC

UNODC is the lead agency for HIV and injecting drug use, and HIV/AIDS in Prison Settings. Within the wider UN family, UNODC is also responsible for developing a response to HIV/AIDS associated with human trafficking. UNODC is actively involved in HIV awareness-raising and sensitizing all uniformed services, including law enforcement, prison and other detention facilities and border guards, the military, the North Atlantic Treaty Organisation and the UN Department of Peacekeeping Operations. It provides technical support and training to establish enabling environments for HIV programme implementation, and supplies effective HIV prevention and care for internally displaced persons, persons in prisons, and human trafficking victim/witness support programmes. UNODC assists Member States in implementing existing terrorism instruments, particularly the 1997 International Convention for a Terrorist Response, which includes provisions against the use of biological weapons. It is working with Member States to develop a comprehensive Terrorism Convention, which will address, inter alia, specific HIV measures.

8. WFP

WFP, the largest humanitarian organization in the UN system, provides food assistance and nutritional support to people infected and affected by HIV and AIDS in emergency situations, as well as in protracted relief and recovery settings. WFP is integrating HIV/AIDS into its vulnerability assessment tools and methodologies, to ensure a comprehensive analysis of the impact of HIV on food security in affected households, and, especially in Southern Africa, an adequate response to the triple threat. WFP provides nutritional assistance in emergencies and recovery settings to people on anti-retroviral therapy, mothers in preventing mother-to-child transmission programmes, people living with HIV and Home-Based Care clients, Tuberculosis patients, orphans and vulnerable children. Food and nutritional assistance is increasingly recognized as a key component in a comprehensive care

and support approach. Livelihoods and food security levels of affected households are often severely compromised as a result of the combination of HIV and recurrent crises.

9. WHO

WHO is the lead agency for the HIV response in the health sector and the global standard-setter for health issues. Several departments at WHO have been involved in the provision of policy and technical guidance and assistance for HIV responses in emergency settings. The AIDS department has been instrumental in, and will continue to provide policy and technical guidance on essential AIDS service delivery for emergency-affected populations, in particular HIV testing and anti-retroviral provision for HIV prevention and treatment. In September 2006, WHO hosted a critical consultation on minimum standards and requirements for anti-retroviral therapy (ART) in emergency settings, which concluded that the provision of essential services can and should include ART. Keen to contribute to emergency preparedness through the collection of strategic information, the HIV department supports capacity building and training in selected countries, as well as the evaluation of HIV health services, including availability, quality, patient tracking, and adherence in emergency settings. WHO's Programme on Health Action in Crises coordinates health responses in emergencies, including programming relating to HIV and Tuberculosis, and has been training health professionals to be deployed in acute emergencies right from the onset. WHO also implements activities related to gender-based violence, including the development of methodologies to estimate its frequency.

10. World Bank

The World Bank hosts the AIDS Strategy and Action Plan (ASAP) service, on behalf of UNAIDS. ASAP responds to country requests, including those from post conflict countries, for support in developing well-prioritized, evidence-based, results-focused, costed AIDS strategies and action plans. The Bank has also been involved, together with UNDP and the UNAIDS Secretariat, in mainstreaming AIDS into development instruments including in Poverty Reduction Strategy Papers in countries that are in the process of post-conflict recovery. The Bank's estimates of the impact HIV may have on national economies have been influential in judging whether HIV may be developing into a risk to state security. Together with UNAIDS and other partners, different scenarios have been developed to assist in predicting the future of AIDS in Africa. Through the Multi-country HIV/AIDS Program for Africa, the Bank has financed (US$ 20 million grant) the Great Lakes Initiative on AIDS that addresses HIV/AIDS in the six Central and Eastern African countries. This project, a partnership involving UN organizations, bilateral and multi-lateral donors, non-governmental organizations and the private sector, provides for prevention, care, and treatment programmes for large numbers of refugees, migrant and transport workers, highly infected groups, and others who move between the five Great Lakes countries, with a strong emphasis on coordinating a regional, cross-border response to combating the disease.

11. UNAIDS Secretariat

The UNAIDS Secretariat has been a powerful advocate for AIDS and security. It has regularly reported to the Security Council on progress on implementation of resolution 1308 and has advocated for the inclusion of AIDS in Security Council Resolutions establishing various peacekeeping missions. Since 2001, the UNAIDS Secretariat, together with the United States Department of Defense, has been chairing an international Task Force for strengthening and coordinating the implementation of AIDS strategies among uniformed services worldwide. Additionally, the UNAIDS Secretariat has worked closely with various regional bodies to advocate for AIDS interventions for uniformed services. The UNAIDS Secretariat has also been

working with various partners to provide technical and financial support to over 60 countries to address AIDS among uniformed services, including military and civil defense forces. In collaboration with other partners, it has produced a range of practical tools including: a comprehensive programming guide, peer education kit and AIDS awareness cards which have been translated into several national languages and distributed widely. Furthermore, the continued advocacy by the UNAIDS Secretariat and Department of Peacekeeping Operations has resulted in the integration of AIDS prevention into pre-deployment training for all UN peacekeepers. There are now AIDS Advisors (or Focal Points) in all 18 peacekeeping missions. The UNAIDS Secretariat has also supported the African Union with its AIDS programmes for African Union peacekeeping forces as well as for African militaries. Building up on past achievements, the UNAIDS Secretariat continues to collaborate with DPKO, regional bodies, member states, and other partners to continue to advocate for AIDS and security issues. Additionally, the UNAIDS Secretariat has collaborated, and continues to collaborate, with key research institutions to expand the evidence base to inform programmatic interventions.

The humanitarian response component of the UNAIDS Secretariat's work has been increasingly expanding to include: increased collaboration with United Nations Office for the Coordination of Humanitarian Affairs; the promotion and facilitation of training on the United Nations Inter-Agency Standing Committee Guidelines on HIV/AIDS Interventions in Emergency Settings, and their translation into different languages; collaboration with UNICEF and other partners to develop estimates of the number of people affected by emergencies living with HIV and indicators for HIV in emergency programmes; and support to cosponsors in their areas of comparative advantage. Discussions on the elaboration of a joint strategic framework with OCHA have started. The UNAIDS Secretariat is also coordinating the implementation of the UN system-wide programme to address the HIV needs of populations of humanitarian concern, funded by UK Department for International Development.

ANNEX   B: Selected Regional and Sub-Regional Initiatives on AIDS, Security and Humanitarian Emergencies

African Union Peace and Security Commission

The African Union (AU) has identified HIV as a priority area especially: strategic planning, HIV in the military, and women and gender. UNAIDS supports the AU's Conflict Management Division of the Peace and Security Commission in developing its HIV strategy in post conflict settings, particularly in the area of disarmament, demobilization and reintegration, Security Sector and Reconstruction.

Great Lakes Initiative on AIDS

The Great Lakes Initiative on AIDS programme covers the Democratic Republic of Congo, Burundi, Kenya, Rwanda, Uganda, and Tanzania. It focuses on prevention of HIV infection, care, treatment and mitigation for mobile and vulnerable groups. The programme has four components one of which focuses specifically on providing support to refugees and internally displaced persons in the areas of prevention, care and mitigation.

Horn of Africa Initiative on HIV Vulnerability and Cross-Border Mobility

This Initiative, covering Djibouti, Ethiopia, Eritrea, Somalia, Sudan, and Yemen, addresses HIV vulnerability and cross-border mobility (as a result of conflict, socio-economic instability, trade etc.) in the Horn of Africa. The objective of this initiative is to engender synergy among country programmes, and regional and international partners, to scale up access to HIV prevention, treatment care and support for mobile population groups.

Initiative of the Congo, Oubangui-Chari Riverside Countries

This Initiative covers the Central African Republic, the Chad, Republic of Congo and DRC; an area with an HIV prevalence rate of 5%. Each country is either in a conflict or post-conflict situation. The objective of the Initiative is to reduce the risk and vulnerability to HIV in the context of mobility and post-conflict situations, by addressing migrant and mobile populations (accounting for over 3 million persons, not usually included in national control strategies)

Mano River Basin Countries and Côte d'Ivoire on STI/HIV/AIDS

The objective of the programme is to reduce the vulnerability and risk of HIV infection among refugees, internally displaced persons, returnees, transit populations and their host communities in the Mano River Basin countries (Liberia, Sierra Leone, Guinea and Côte d'Ivoire). The initial phase of the project focused on the following refugee sites: Daloa, San Pedro, Man and Guiglo in Côte d'Ivoire; Kissidougou and N'zérékoré in Guinea; Kenema in Sierra Leone; and Nimba in Liberia.

Pacific Regional Police HIV/AIDS Initiative

The overall purpose of this initiative is to reduce the vulnerability of police officers and related communities to HIV infection, by establishing sustainable mechanisms for continuously

improving their knowledge and life skills on HIV prevention and care. This programme is a key part of the multi-sectoral response to curb the spread of HIV in the Pacific region, and maintain the capability and capacity of key services charged with upholding human rights, law and order, and national and international security. The Pacific Island Chiefs of Police is an organisation of commissioners, directors and police chiefs from 21 Pacific countries: Australia, American Samoa, Commonwealth of the Northern Mariana Islands, Cook Islands, Federated States of Micronesia, Fiji, French Polynesia, Guam, Kiribati, Nauru, Niue, New Caledonia, New Zealand, Palau, Papua New Guinea, Republic of Marshall Islands, Samoa, Solomon Islands, Tonga, Tuvalu, and Vanuatu.

Latin American and Caribbean Armed and Police Forces Committee for AIDS Prevention and Control

Latin American and Caribbean Armed and Police Forces Committee for AIDS Prevention and Control (LAC COPRECOS) is comprised of surgeon generals from armed and police forces in 12 countries. It provides technical and policy advice on HIV prevention, care and support services for military and police personnel, including peacekeeping missions, and a variety of national emergency and humanitarian interventions to relevant ministries. A partnership agreement between the UNAIDS Secretariat and COPRECOS has been signed, whereby the UNAIDS Secretariat and COPRECOS have agreed to collaborate on the regional coordination of activities among uniformed services.