The President's Emergency Plan for AIDS Relief

Report on Refugees and Internally Displaced Persons

February 2006

House Report 109-152, accompanying H.R. 3057, called upon the Office of the United States Global AIDS Coordinator to report as follows:

> *The Committee requests the Global HIV/AIDS Coordinator, in consultation with USAID, the Bureau of Population, Refugees, and Migration, and other stakeholders, to develop a comprehensive approach to addressing the special HIV/AIDS needs of refugees and internally displaced persons (IDPs). The Committee notes that refugees and IDPs are especially vulnerable to HIV/AIDS, due to fragmentation of families, frequent movement, increased sexual violence, and greater socio-economic vulnerability. Many countries in Africa face a double burden of HIV/AIDS and large numbers of refugees or IDPs. Nine such countries—Cote D'Ivoire, Ethiopia, Kenya, Namibia, Rwanda, South Africa, Tanzania, Uganda, and Zambia—are also Emergency Plan focus countries. The Committee urges the Office of the U.S. Global AIDS Coordinator, in coordination with others in the State Department and USAID that have special expertise on refugees, to develop a comprehensive approach to addressing the special HIV/AIDS needs of refugees and IDPs.*

Report to Congress Mandated by House Report 109-152
Accompanying H.R. 3057

Submitted by the Office of the U.S. Global AIDS Coordinator
U.S. Department of State

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I. EXECUTIVE SUMMARY

Under the United Nations Convention on the Status of Refugees, a refugee is a person who, "owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership in a particular social group, or political opinion, is outside the country of his nationality, and is unable to, or, owing to such fear, is unwilling to avail himself of the protection of that country." Internally displaced persons (IDPs) are people who have similarly been forced from their homes, but have not crossed an internationally recognized state border.

Extended displacement and the disruption of refugees' lives can put them at increased risk for HIV/AIDS, due to factors such as exposure to sexual violence, economic vulnerability, and increased contact with surrounding populations with higher HIV prevalence. The United Nations High Commissioner for Refugees (UNHCR) reports that, on average, refugees will spend seventeen years outside of their home country.[1] Approximately eighty percent of refugees are women and children. Considering the economic, social, and health risks that accompany displacement, HIV/AIDS services are important in order to protect refugees as well as people in host communities and countries of return.

The United States (U.S.) recognizes the particular responsibility of the international community for refugee welfare and the need for adequate services to be provided to refugees. In Fiscal Year (FY) 2005, the U.S. Government, through the Department of State's Bureau of Population, Refugees, and Migration (PRM), provided nearly $1 billion to support international efforts to protect and assist refugees, conflict victims, and vulnerable migrants.

No single international organization is exclusively devoted to addressing the protection and assistance needs of IDPs. Although there is less available data about displaced populations, they often face similar risk factors for HIV/AIDS as refugees. However, addressing

[1] Spiegel, B.; A. Miller, A., M. Schilperoord. *Best Practice Strategies to Support the HIV-related Needs of Refugees and Host Populations*. UNHCR/UNAIDS. (2005).

the protection and assistance of IDPs may require overcoming other barriers as well. In FY 2005, USAID's Food For Peace program provided almost $600 million in food and program support resources to refugees and IDPs through the World Food Program (WFP) and other partners. These resources included approximately $400 million for IDPs.

Many of the countries that receive funding from the President's Emergency Plan for AIDS Relief (the Emergency Plan), including some focus countries, have significant refugee and/or displaced populations.[2] In FY 2005, the Emergency Plan supported HIV/AIDS prevention, treatment and care interventions for some refugee populations, including programs supported through PRM. In FY 2005, planned funding for activities targeting refugees or IDPs was $27 million; in FY2006, $53.7 million is planned for these activities.

It is the Emergency Plan's goal that refugee populations in focus countries have access to the same level of prevention, treatment, and care as nationals of those countries. In some cases, host governments (with or without Emergency Plan funds), UNHCR, and other international partners have adequate resources to provide this level of access. In most cases, however, host governments do not incorporate refugees into their HIV/AIDS programs. Resource constraints limit the ability of UNHCR and its partner organizations to provide the same level of HIV/AIDS services enjoyed by host nationals.

The Emergency Plan encourages country teams in focus countries to make a determined effort to consider the particular needs of refugees and IDPs, to make them eligible on an equal basis for Emergency Plan programs, and to make special arrangements where necessary to reach refugee and displaced populations that are not adequately served by other means. The Emergency Plan aims to implement international HIV/AIDS programs so that refugees and IDPs are not discriminated against in access to prevention, treatment, and care services.

The Emergency Plan will continue to emphasize prevention to protect refugee, displaced, and host populations. The Emergency Plan will

[2] The fifteen focus countries are: Botswana, Cote d'Ivoire, Ethiopia, Guyana, Haiti, Kenya, Mozambique, Namibia, Nigeria, Rwanda, South Africa, Tanzania, Uganda, Vietnam, and Zambia.

work along with international partners to identify unmet HIV/AIDS needs of refugees and IDPs, in order to ensure that they are adequately addressed.

II. REFUGEES and IDPs: CURRENT POPULATIONS

At the beginning of 2005, there were 13.4 million refugees recognized by the UN (9.2 under UNHCR[3] and 4.2 under UNRWA[4]) or governments that have signed the various UN or regional instruments relating to the status of refugees. Over twenty percent of the global refugee population is in Africa. Though the overall number of refugees worldwide has decreased in recent years, increases have occurred in Central Africa and the Great Lakes Region, East and Horn of Africa, as well as Asia and the Pacific. Together, women and children make up approximately 80% of the refugee population.[5] In many countries, refugee women and children are vulnerable to gender-based violence, abuse, and exploitation. In partnership with the UN, other international and non-governmental organizations, the U.S. Government (through PRM) has programmed resources to prevent and respond to these vulnerabilities.

In 2004, the Internal Displacement Monitoring Center estimated that there were approximately 25,000,000 IDPs displaced by conflict in 48 countries.[6] More than half of the world's displaced people live in Africa, and nearly half live in countries experiencing ongoing conflict. The displaced may have needs distinct from those of refugee populations; as such, emphasis is being placed on gathering data about, and advocacy for, the displaced.

[3] UNHCR Global Appeal (2006)
[4] Report of the Commissioner General of the United Nations Relief and Works Agency for Palestine Refugees in the Near East (2004-2005)
[5] UNHCR Global Appeal (2006)
[6] http://www.internal-displacement.org/8025708F004CE90B/(httpPages)/22FB1D4E2B196DAA802570BB005E787C?OpenDocument&count=1000

III. The Challenge of HIV/AIDS and Refugees and IDPs

Risk Factors for Refugees and IDPs

Factors that place refugees and IDPs at risk for HIV infection include the following:

- Displacement
- Social instability
- Increased mobility
- Sexual and gender-based violence
- Exploitation and abuse
- Poverty and food insecurity
- Lack of access to health services
- Lack of linguistically and culturally appropriate health information

HIV Prevalence Among Refugee Populations:

Research indicates that the relationship among vulnerability to HIV, conflict, and displacement is complex. In some situations, refugees have a lower rate of HIV than their host communities, but the inverse has also been documented.[7] Data collection on the HIV prevalence of refugee populations has increased dramatically in recent years. UNHCR studies have documented both the vulnerability and variability of HIV prevalence in refugee populations.[8] Effective prevention programs seek to keep the HIV prevalence rate of refugee populations from increasing.

Although refugees may have higher or lower HIV prevalence rates than their host communities, they often suffer from the perception that they "bring HIV/AIDS" with them.[9] Studies have documented that despite

[7] *Refugees, HIV and AIDS: UNHCR's Strategic Plan 2005-2007* (2005)

[8] Strategies to Support the HIV-related Needs of Refugees and Host Populations: A Joint Publication of the Joint United Nations Programme on HIV/AIDS (UNAIDS) and the United Nations High Commissioner for Refugees (2005); *Best Practice Strategies to Support the HIV-related Needs of Refugees and Host Populations* (2005); *Refugees, HIV and AIDS: UNHCR's Strategic Plan 2005-2007* (2005).

[9] Spiegel, B., A. Nankoe. *UNHCR, HIV/AIDS, and Refugees: Lessons Learned* (2003); SMEC International, *A Social and Gender Assessment of HIV/AIDS among Refugee, IDP and Host Populations in the Great Lakes Region of Africa* (November 2005).

their displacement and disruption of their normal lives, HIV prevalence in several refugee communities was actually lower than the surrounding population. A 2002 UNHCR surveillance study among pregnant women in more than 20 camps housing 800,000 refugees in Kenya, Rwanda, Tanzania and Sudan found low HIV prevalence among refugees compared to the surrounding local population.[10]

Table 5: HIV Prevalence in Refugee Camps*

Host Country *(Country of Origin)*	Year	HIV Prevalence in Refugee Population	HIV Prevalence of Surrounding Population	HIV Prevalence in Country of Origin
Rwanda *(Burundi)*	2002	1.5%	6.7%	Unknown
Kenya *(Sudan)* *(Somalia)*	2002 2003	5.0% 0.6%	18.0% 4.0%	2.3% Unknown
Tanzania *(Burundi)* *(DRC)*	2002 2002	2.3% 2.5%	Unknown Unknown	Unknown Unknown
DRC *(Angola)*	2002	2.4%	Unknown	Unknown
Sudan **(Eritrea)**	2002	4.1%	4.0%	4.0%
Uganda *(Sudan)*	2005	2.1%	4.4%	2.3%

* Data from *Refugees, HIV and AIDS: UNHCR's Strategic Plan 2005-2007* (2005)

More recently, preliminary results from a 2005 HIV and syphilis sentinel surveillance survey conducted in Mwange and Kala camps, Zambia, found an HIV prevalence rate of 2.4% among pregnant women who were attending antenatal care for the first time during their current pregnancy.[11] These rates were much lower than the general population prevalence rate in Zambia. Considering the refugees' vulnerability and the length of time they may remain in Zambia, this is a critical opportunity to implement prevention programs to maintain low prevalence among the refugee population.

The focus of UNHCR's HIV/AIDS activities is prevention, to ensure that those who are HIV-negative remain so. UNHCR's 2005-2007 strategic plan for HIV/AIDS in refugee populations stresses the need for: integrating refugees into HIV/AIDS policies, funding proposals,

[10] *Refugees, HIV and AIDS: UNHCR's Strategic Plan 2005-2007* (2005).
[11] Briefing to UNHCR of preliminary results from Sentinel Surveillance 2005, November 3, 2005.

and programs of countries of asylum; addressing the needs of refugee women and children, the most vulnerable of an at-risk population; developing sub-regional approaches that reflect the cycle of displacement; and eliminating HIV-related discrimination against refugees and other persons of concern to UNHCR**.**

Obstacles to Meeting HIV/AIDS Needs of Refugees and IDPS

While some HIV/AIDS services needed by refugees and IDP populations already exist in their host countries, several challenges limit their access to those services. These challenges include:

- The mobility of some refugee and displaced populations, which poses a challenge to ensuring continuity of care;
- Limited resources of both host countries and refugee relief organizations;
- The location of many refugees and IDPs in rural and remote areas, which may limit their ability to access host country health services, especially beyond the most basic level;
- Poor roads leading to refugee camps, limiting the ability of service providers to provide health services;
- Language and skills barriers, including the limited availability of personnel who understand both HIV/AIDS and the languages and customs of the refugee and displaced populations; and
- Omission of refugees, and in some cases, the internally displaced, from host governments' national strategic plans for health, particularly HIV/AIDS.

Internally displaced persons, since they remain inside their own countries, may face additional challenges because:

- They may be unable to depend on their own governments for protection and services;
- Their governments can block or restrict humanitarian assistance;
- They may be affected by ongoing conflict and insecurity; and

- They may be hard to reach, and to gather data about, because they often live with families or are well integrated into their host communities.

IV. EMERGENCY PLAN STRATEGY AND PRIORITIES

Through increased attention, funding, and interagency collaboration, progress can be made in protecting refugees and IDPs. The Emergency Plan works with PRM, USAID, host governments in focus countries, UNHCR, and other U.S. implementing agencies and international partners to identify gaps in refugee HIV/AIDS services. Emergency Plan programs include:

- An emphasis on prevention, which helps ensure that the HIV prevalence rates of refugee and displaced populations do not increase, and is a critical element of the Emergency Plan's strategy;
- Promoting integration of HIV/AIDS services for refugee and host communities, where appropriate, to avoid duplication and to improve the effectiveness and sustainability of health service infrastructure;
- Promoting continuity of services for repatriated refugees; and
- Gathering information to ensure that program planning is driven by recent and relevant data.

Emphasis on Prevention

Prevention is the principal focus of Emergency Plan activities targeting refugees and IDPs; these activities include PMTCT and efforts to reduce sexual transmission. In Ethiopia's Gambella region, the Emergency Plan supports interventions to promote abstinence (including delayed onset of sexual activity) and faithfulness, as well as the provision of condoms and information on their appropriate use. In Kenya, the Emergency Plan supports an activity to reduce sexual transmission among young refugees who have been separated from their families.

Coordination and Cooperation with International Partners

The Emergency Plan coordinates and partners with PRM, UNHCR, UNAIDS, the Global Fund to Fight AIDS, Tuberculosis and Malaria, the World Bank (through its Multi-Country AIDS Program), NGOs, and host governments to identify gaps in HIV/AIDS services to refugees. Because U.S. bilateral programs are implemented on a decentralized basis, in-country collaboration with these partners is important to address identified gaps. The Emergency Plan works with other national and international actors to collect reliable data on refugees and promotes sharing of findings among partners to inform implementation. The Emergency Plan works with USAID and other partners on the collection of similar data for displaced populations. The Emergency Plan and PRM works with UNHCR to bring refugee needs to the attention of the international community. The Emergency Plan and PRM also encourage UNHCR collaboration, where possible, with UNAIDS and the Global Fund to Fight AIDS, Tuberculosis and Malaria.

Service Integration Building on Existing Health Infrastructure
PRM already supports basic health services in refugee camps through its substantial support to UNHCR, ICRC, and other international organizations and NGOs. Expanding HIV/AIDS activities within existing health infrastructures help reach more refugees and displaced persons sooner. For example, the Emergency Plan is supporting the integration of PMTCT services into routine maternal and child health services in several refugee camps in Uganda.

IDPs who are not served by established camps present special challenges for service provision. Those who reside with relatives may have access to existing HIV/AIDS services in their host communities. However, IDPs often settle in urban slums or squatter settlements that are under-served by the formal health sector. Therefore, a key challenge is to improve access to HIV/AIDS prevention, treatment, and care services to those living in such marginal settlements.

Integration of Services for Refugees, IDPs, and Host Communities:
Members of the local host community should also benefit from HIV/AIDS-related services provided for concentrations of refugee and displaced populations, just as services in host communities should be

available to refugees and IDPs. This reciprocity increases program reach, fosters good will between the affected populations and host communities, and avoids unnecessary duplication. In some cases, such services provided in refugee camps are currently available for the local non-refugee population as well. The Emergency Plan works with partners to share lessons learned from effective integration of refugee and host government HIV/AIDS services in Uganda, Kenya, and Tanzania. At Kyangwali and Palorinya settlements, in Uganda, both refugees and the local populations are accessing counseling and testing, prevention of mother to child transmission (PMTCT), and other programs jointly supported by the government and UNHCR. In Northern Kenya, refugee health services are integrated within national district hospitals and clinics, providing access to both the surrounding population and refugees.

Continuity of Care

Providing continuous services to refugees and IDPs is a challenge in part because the duration of their displacement may vary greatly and is subject to factors outside their control. Treatment with antiretroviral therapy (ART) requires strict adherence, a lifetime supply of drugs, and regular monitoring and follow-up. Although provision of ART is difficult, some refugees and IDPs are already benefiting; further achievements are possible, especially where sub-regional initiatives are active, such as the Great Lakes Initiative on AIDS (GLIA). The GLIA is a new international organization, owned and managed by six Great Lakes countries in Africa (Burundi, Democratic Republic of the Congo, Kenya, Rwanda, Tanzania, and Uganda). Working in close collaboration with the GLIA, the World Bank provides HIV/AIDS support to refugees, IDPs, and affected areas surrounding the refugee/IDP communities. The Emergency Plan is exploring ways to work with PRM, USAID, and the World Bank to leverage resources of the GLIA and complement its efforts.

Upon return to their countries of origin, regular monitoring and follow-up to ensure continuity of care to refugees is a particular challenge. Whether refugees qualify for ART and how treatment can be maintained is a judgment that must be made based on the overall situation of each population. The U.S. Government intends to

maximize the ability of refugees to benefit from ART, but is not in a position to be responsible for on-going treatment in the case of repatriation to countries such as Angola, Sudan, Somalia or Liberia, which are not focus countries and where conditions do not presently exist that would allow widespread ART.

The Emergency Plan will encourage open dialogue among international partners, host countries, and countries of origin to ensure the continuation of ART and other services for repatriated refugees. The Emergency Plan works with partners to strengthen regional initiatives that serve refugees.

V. HIV/AIDS SERVICES TO REFUGEES AND IDPS: U.S. LEADERSHIP

The United States is a global leader in addressing the needs of refugees and displaced populations, and in fighting HIV/AIDS internationally. The Emergency Plan continues to work to ensure that country operational plans in the 15 focus countries address the needs of these affected populations.

In FY 2005, 61 Emergency Plan activities in focus countries, with total funding of $27 million, were specifically aimed at refugees and IDPs. In FY 2006, refugees and IDPs are referenced as target populations in 83 planned activities. Planned Emergency Plan funding for these activities is $53.7 million. In a number of Emergency Plan focus countries, activities focused solely on service provision in refugee camps are underway or scheduled for implementation in FY2006:

- In Kenya, women at the Kakuma camp can now access counseling and testing, PMTCT, and other services;
- In Zambia, the 24,145 refugees at the Mwange camp now have access to a variety of prevention services;
- 16,000 refugees living in Ethiopia's Sherkole camp are able to access counseling and testing; and
- In the Tigray region of Ethiopia, refugee orphans in ten communities are benefiting from Emergency Plan activities, including prevention, palliative care, reduction of stigma and discrimination, and treatment when needed.

Also in FY 2005, PRM funding for HIV/AIDS interventions included supporting access to PMTCT services for women in all of Tanzania's camps.

These figures and examples, however, tell only part of the story, since it has long been U.S. policy to encourage host governments to integrate refugees into nationally-provided services. Thus, some Emergency Plan activities benefit refugees, even if refugees are not the target population. For example, in Uganda, prevention of mother-to-child-transmission services intended for host country nationals are also accessed by refugees at the Kyangwali and Palorinya settlements, which host 220,000 refugees.[12]

The U.S. Government supports HIV/AIDS services to refugees and IDPs through several funding channels. PRM contributes to UNHCR, other international organizations, and NGOs for the care of refugees, conflict victims, IDPs, and vulnerable migrants. In 2005, PRM made significant contributions to UNHCR. USAID's Food For Peace program, through WFP and other organizations, provides resources for refugees and IDPs. WFP has incorporated HIV/AIDS prevention into the majority of its food distribution programs supported by USAID. USAID's Office of Foreign Disaster Assistance (OFDA) has a mandate to work with displaced populations in emergency settings and has prioritized the provision of HIV/AIDS prevention messages as part of primary health care provision. USAID's Displaced Children and Orphans Fund also supports projects to protect especially vulnerable children among internally displaced populations. The existing health and social services that the UN and other entities provide to refugees, such as education, water, and sanitation, can serve as a platform for extending the reach of HIV/AIDS services.

In other circumstances, the Emergency Plan funds PRM or one of the implementing partners working with PRM and/or UNHCR. At Kenya's Kakuma camp, home to about 90,000 refugees, the Emergency Plan is collaborating with the International Rescue Committee to build HIV/AIDS counseling and testing, treatment, prevention, and palliative

[12] UNAIDS. *Strategies to Support the HIV-related Needs of Refugees and Host Populations*. 2005

care services into existing health infrastructure. ART was initiated in FY 2005 on a pilot basis, with the aim to expand in FY 2006.

Addressing gender issues is central to all Emergency Plan activities. The U.S. Government aims to implement programs addressing gender issues in refugee and displaced populations, which benefit not only women, but also their children, whose risk factors for vulnerability increase through the illness or death of a parent or caretaker. The Emergency Plan is specifically addressing these issues, with initiative to increase gender equity in HIV/AIDS programs and services, reduce violence and coercion, and address male norms.