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**30<sup>th</sup> Meeting of the UNAIDS Programme Coordinating Board**  
Geneva, Switzerland  
5-7 June 2012

**AIDS, Security and Humanitarian Response**

**Additional documents for this item:** *none*

**Action required at this meeting - the Programme Coordinating Board is invited to:** *take note of and give its on comments on this report.*

## Introduction

1. This report has been prepared to update the Programme Coordinating Board on progress made on implementation of the recommendations related to AIDS, Security and Humanitarian Response adopted at the 27th Meeting of the Programme Coordinating Board held in Geneva, Switzerland in December 2010 (see Annex I). It builds on the progress report submitted to the Programme Coordinating Board meeting of December 2010 and is structured around the recommendations made by the Programme Coordinating Board at its 19th meeting in Lusaka, Zambia, December 2006 (see Annex II).
2. The report focuses on how the UNAIDS family and its partners have supported the response to HIV in a variety of humanitarian emergencies (natural disasters and conflict settings). This includes advocacy and capacity building at national and regional levels creating an enabling and responsive environment for mainstreaming HIV into the humanitarian response as well as the transition from emergency to development. Furthermore, the report highlights strides made in HIV prevention efforts among uniformed services and the wider security arena, notably the unanimous adoption in June 2011 of the United Nations Security Council Resolution 1983 on HIV and peacekeeping, and the follow up activities undertaken by main stakeholders. The *2011 Political Declaration on HIV and AIDS : Intensifying efforts to Eliminate HIV and AIDS* calls for partners to ensure that particular attention is paid to women and girls, young people, orphans and vulnerable children, migrants and people affected by humanitarian emergencies, prisoners, indigenous people and people with disabilities, depending on local circumstances. While calling for specific, time-bound, measurable results, the 2011 Political Declaration emphasizes that results will be achieved through strong partnerships, including with civil society and national governments.

### **UNAIDS Division of Labor "Addressing HIV in Emergencies"; transition from the Interagency Standing Committee (IASC) HIV Task Force in Humanitarian Situations**

3. Based on the revised UNAIDS Division of Labour in 2010, UNHCR and WFP were designated co-conveners in the area "*Addressing HIV in humanitarian Emergencies*", in partnership with WHO, UNODC, UNFPA, UNICEF UNDP and with the support of the UNAIDS Secretariat. This Division of Labour area lays the foundation for ensuring that issues related to HIV in humanitarian settings are addressed.
4. Global coordination of HIV in humanitarian settings is now carried out through the Inter Agency Task Team (IATT) that succeeded the Interagency Standing Committee (IASC) Task Force on HIV in Humanitarian Situations. Apart from relevant UN partners, the IATT has expanded its membership to include international organisations such as the International Organization for Migration and the International Federation of Red Cross as well as representatives of civil society and academia aiming to establish a bridge between humanitarian and development actors and to improve effectiveness in HIV preparedness and response. The IATT has established linkages with regional Inter Agency Working Groups, notably in South and East Africa, West and Central Africa, Latin America and Asia Pacific, to strengthen coordination of the HIV response along the humanitarian continuum: before, during and after humanitarian emergencies. As a part of the IATT, WFP and UNHCR hosted an NGO forum with the UNAIDS PCB NGO Members in November 2011, to ensure that best practices inform future responses in this area.
5. One of the IATT's aims in emergencies is to ensure that access to antiretroviral therapy (ART) including for prevention of mother to child transmission programmes is maintained and that food insecurity and malnutrition do not create barriers. Typical issues that

governments and humanitarian organisations have to deal with include identifying patients previously receiving ART, maintaining the supply chain for ART, access to health care including reproductive health services as well as access to prevention and broader care and support services including gender-based violence (GBV).

### **Integration of HIV as cross-cutting issue in IASC clusters.**

6. Guidance at global, regional and field levels for the integration of HIV as a cross-cutting issue in all clusters has been provided through the IASC guidelines for Addressing HIV in Humanitarian Settings ([www.aidsandemergencies.org/cms/documents/20101015/IASC\\_HIV\\_Guidelines\\_2010\\_En.pdf](http://www.aidsandemergencies.org/cms/documents/20101015/IASC_HIV_Guidelines_2010_En.pdf)). HIV focal points for each cluster have been appointed. When appropriate, deployment of human resources to support initial inter-agency assessments and the design of response plans and humanitarian funding proposals has been undertaken. In addition, many clusters have included HIV as a module in their guidelines; for example, a module on HIV was included in the Global Nutrition Cluster Handbook. In other cases, HIV and gender have been simultaneously integrated. For example, UNDP, UNFPA and UN Women, in the context of the Interagency Steering Committee on disarmament and demobilization developed a training module on gender and HIV for the annual DDR and Gender Training Course.
7. Joint collaboration with UNAIDS, WFP, WHO, UNHCR and UNICEF and partners such as IFRC, MSF and others was initiated in 2010 and 2011 to support country-level training workshops of the previously issued IASC guidelines for Addressing HIV in Humanitarian Settings in Nepal, Sri Lanka, Panama, Haiti, Central African Republic, Democratic Republic of Congo, and Zimbabwe in an effort to translate recommendations into national policies and strategies. These guidelines take into account, among other things, the growing understanding that ART and related medical care can be provided in low-resource settings including in conflict zone, protection and prevention are important elements in a response as well as the latest normative guidance on food security, nutrition and livelihood support. To help translate recommendations into national policies and strategies, the IAWG in Latin America supported roll-out of the IASC guidelines in Haiti, and provided advocacy in the regional humanitarian Risk, Emergency, and Disaster Task Force Inter-Agency Workgroup for Latin America (REDLAC).

### **Humanitarian and development HIV funding mechanisms and the “transition”**

8. Since 2008 to 2012, the UNAIDS has been implementing a global grant funded by a major donor totaling Euro 3,700,000. The programme directly addresses HIV and AIDS in humanitarian response through technical and financial support to priority emergency-affected countries, strengthening emergency preparedness, promoting coordination mechanisms for addressing HIV in emergencies, and integrating HIV in emergency settings and into national policy and planning instruments. Through partnership with the wider humanitarian community, progress has been made in these areas. Specific support has been provided at country-level to Central African Republic, Chad, Myanmar, Afghanistan, Mozambique, Colombia, Zimbabwe and Libya. This includes the continuation of critical HIV-related health services to populations directly affected by humanitarian crisis, specifically: training in blood safety and syndromic management of STIs and capacity building to establish a protection and referral service for survivors of gender based violence. Programmes also included the provision of food and nutrition, housing and livelihood support to PLHIV, targeted interventions to provide social and health services to people who use drugs, and training on the integration of HIV counseling and testing and sexual and reproductive health services to displaced and mobile populations. Strategic support has been provided to key personnel actively engaged with regional coordination mechanisms established to monitor and drive the

agenda on HIV in emergencies with national partners. UNICEF and UNAIDS are conducting research to examine why HIV is often excluded in humanitarian responses through the lens of adolescents. The research will take place in the DRC and Haiti and begin in April 2012. UNICEF and UNAIDS looked at estimating the numbers of people living with HIV affected by emergencies by regions. The numbers are important for advocacy and supporting the notion that in order to achieve our targets (including universal access) people affected by emergencies must be considered.

9. Governments, UNHCR and its partners advocate and support the integration of HIV interventions among refugees and surrounding host populations. Over 30 million dollars during the past four years has been provided by the World Bank (the Great Lakes Initiative on AIDS and the Intergovernmental Authority on Development and the US President's Emergency Plan for AIDS Relief. WFP and UNAIDS is working with Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund) through the Irish grant to roll out first Nutrition Assessment Education and Counseling in the Central African Republic. This model could eventually inform the national nutrition strategy, and is the first such programme in a fragile state.
10. Discussions with the Global Fund on aligning funding with humanitarian HIV and transition needs in countries affected by humanitarian emergencies have not been completed as of the end of 2011. However, some efforts are already being made. For example in Haiti, where UNDP, as the principal recipient, adopted a holistic approach by building linkages between its work on poverty and early recovery with its work on HIV, health, human rights and gender equality. It helped mainstream HIV and health-related initiatives into different phases of early recovery to ensure that people living with HIV and other important groups including sex workers, MSM and youth are able to access life-saving HIV services. Due to these grants, approximately 32,000 people are accessing ART services and HIV is mainstreamed into programmes on cash-for-work and gender based violence (GBV). At global level, the IATT for HIV in Emergencies will pursue the advocacy work to encourage the Global Fund to integrate humanitarian HIV and transition needs into national responses.
11. Increased resources for HIV programming among uniformed services have been made available, notably through the United States President's Emergency Plan for AIDS Relief and other development partners such as the European Union (EU) and the Global Fund. United States programme funding for military-to-military assistance with HIV related activities has enabled a fivefold increase in the number of military programmes during the past decade.
12. In 2010, an analysis of HIV National Strategic Plans (NSPs) and Global Fund approved proposals for HIV and malaria from rounds 1-8 for countries in Africa hosting populations of  $\geq 10,000$  with refugees and/or internally displaced persons (IDPs) was undertaken to document their inclusion. A majority of countries did not mention IDPs (57%) compared with 48% for refugees in their HIV NSPs. The majority of countries with  $\geq 10,000$  refugees and IDPs did not include these groups in their approved Global Fund proposals (61%-83%) with malaria having a higher rate of exclusion than HIV (<http://www.conflictandhealth.com/content/4/1/2>). Since 2010, several countries that have revised their NSPs in 2011 have included a range of provisions and tailored HIV responses for the needs of populations of humanitarian concern. Critical reviews to ensure the integration of humanitarian factors and the respective needs of affected populations have been carried out with national HIV planning processes, namely in the Democratic Republic of the Congo, Dominican Republic, Guatemala, Haiti, Kenya, South Sudan and Zimbabwe. Continued strong and concerted advocacy at global, regional and country levels is needed to ensure that populations affected by humanitarian emergencies are included in countries' HIV NSPs.

## Gender-Based Violence (GBV) and related issues

13. With the influx, displacement and disruption of societal structures during and after humanitarian emergencies, GBV increases. GBV is frequently used as a weapon of war in conflict. While, men and boys can be subject to abuse and violence, woman and adolescent girls are the most likely targets.
14. The Inter-Agency Working Group (IAWG) on Reproductive Health in Crisis promotes access to quality sexual and reproductive health care for population affected by humanitarian emergencies and the linkages between reproductive health and HIV. To strengthen the humanitarian response, the working group recently adapted the Interagency Field Manual on Reproductive Health in Humanitarian Settings ([http://www.iawg.net/resources/field\\_manual.html](http://www.iawg.net/resources/field_manual.html)), which provides tools and guidance to ensure HIV is addressed among priority life-saving interventions in humanitarian settings. Reducing the transmission of HIV is of the five objectives of the Minimum Initial Service Package on Reproductive Health in Crisis, an inter-agency package of priority life-saving interventions that is part of the SPHERE Standards. In addition, the IAWG is functioning through sub-working groups, among them the HIV sub-working group led by UNHCR.
15. The alignment of HIV prevention with GBV prevention is at the heart of the proposed agenda on AIDS and security that aims to both harness high-level political commitment and provide guidance to countries on how to scale up interventions that address the intersections of HIV and GBV. In a meeting co organized by the UN Action, the US National Institute for Health (NIH), UNAIDS and the Social Science Research Council in March 2012, a multidisciplinary group of experts from biomedical, public health, social science and policy communities came together to set the foundations for research and empirical evidence on the role of conflict-related sexual violence in HIV transmission. The meeting addressed research design, data collection and measurement challenges of capturing the social dynamics that may contribute to the incidence of sexual violence and HIV risk in conflict affected settings. The meeting put forward policy and programme options and implications with regard to the alignment of HIV and sexual violence prevention, response, treatment and care, particularly in conflict affected environments.

### **Case study- Integration of HIV and Gender into DDR and Early Recovery Programming**

In addressing HIV and GBV in fragile states, UNDP provided financial support for the program entitled "*A Gender-Responsive Approach for Reintegration and Peace Stabilization*" in Aceh, Indonesia. Funding provided support to 450 vulnerable persons, with a focus on women, including female ex-combatants, women associated with armed forces and groups, and conflict victims (focus on victims of GBV) in high conflict villages. The project also mapped key HIV target groups in Aceh and strengthened the capacity of relevant government stakeholders with respect to addressing needs of these populations in government planning. Results: a) Most vulnerable persons supported through reintegration phase and equipped to move forward with viable livelihood option; b) mapping of HIV target groups increased awareness of HIV and served as the first step towards ensuring a continuum of care; and c) local government equipped to include HIV target groups in development planning.

## **Global and Regional initiatives**

### **Global**

16. Capacities of national counterparts have been built to ensure the integration of HIV into preparedness plans in disaster-prone areas. Training, in-depth guidance, and awareness raising in Africa, Asia, Middle East and North Africa, Europe and the Americas on the principles of HIV programming in emergency settings were conducted with United Nations Country Teams, UN Joint Teams on AIDS, UNAIDS Country Coordinators, IAWGs, representatives from National AIDS Commissions, government disaster management units, International Federation of Red Cross and Red Crescent Societies and Civil Society Organizations.
17. Recent analysis of the joint programme of support of the 38 high impact countries conducted by UNDP show that only 4 countries (Nigeria, India, Russian Federation, and Ukraine) still have HIV-specific restrictions on entry, stay and residence. While in many of the reviewed countries, people living with HIV among populations affected by humanitarian emergencies do not face such restrictions, this is not the case in some countries in the Middle East and North Africa, where disclosure of HIV status can be a reason for being expelled. Much greater investment should be made to address stigma and discrimination that continue to be high.
18. Access to ART for refugees has greatly improved during the past four years through advocacy for inclusion of refugees in National AIDS programmes, better identification of people in need of treatment, and efficient referral to health structures providing treatment. In 2011, 93% of refugees in Asia, Africa, Latin America and the Middle East and North Africa regions have access to ART at a level similar that of the surrounding population (n=41 countries). Access to PEP for survivors has improved to reach 66% in Africa (n=16 countries) and 85% in Asia (n=4 countries). Seventy-five percent (75%) of pregnant refugee women had access to PMTCT programmes in Africa (n=18 countries) with great improvements since 2008 to 2011 for in countries such as Djibouti (51% to 98%) and Chad (2% to 55%).

### **Africa**

19. Continued support and facilitation of the work of two regional IAWGs on HIV in Emergency Settings has included facilitating training and harmonization of tools by regional partners in the IAWGs and the coordination of inter-agency technical support missions to Kenya, Malawi and South Sudan. A satellite session was organized for the International Conference on AIDS and STIs in Africa on addressing HIV in humanitarian settings in the East and Southern Africa region based on country case-studies in collaboration with inter-agency working groups.
20. The inter-agency working group on GBV and HIV in emergencies for East and Central Africa was created in 2004. The group is co-chaired by UNHCR and Help Age International. UNAIDS Regional office for Southern and Eastern Africa in Johannesburg provides technical assistance to the group. The group is represented in the global IATT on HIV in emergencies, ensuring linkages and its efforts are in line with the IATT's objectives. In 2011, the IAWG for East and Central Africa noted an increase in stakeholder participation and prepared advocacy material for the regional humanitarian partnership forum for supporting the mainstreaming HIV and GBV in the regional response to the drought situation. The group conducted a satellite session on HIV in emergencies in the region at ICASA 2011 to disseminate lessons learnt and to advocate for more involvement of regional actors in addressing HIV and GBV in emergencies.

21. Initiatives to address HIV vulnerabilities with cross-border and mobile populations are underway, with the development of a strategy on HIV and cross-border and mobile populations in the Horn of Africa. It focuses on refugees, internally displaced populations, migrants and pastoralist communities in the sub-region who are often not covered by national AIDS responses. Furthermore, a ground-breaking initiative and study in response to cross-border mobility, maritime transportation and impact on vulnerability to HIV is underway addressing the Red Sea Ports area, with leadership from Ministries of Health and civil society. It hopes to identify entry-points to identify where vulnerabilities arise and adapt HIV programming accordingly, without forgetting the intersections with GBV.
22. Regional networks on AIDS and militaries have been supported throughout the past two years in developing regional minimum standards for HIV programming among uniformed personnel (SADC); harmonization of prevention activities (East Africa Community) and advocacy, resource mobilization and networking (West and Central Africa network on military and AIDS).

### **Case study-Horn of Africa**

As in any situation, national ownership and leadership is critical to success in addressing HIV prevention, treatment, care and support needs of emergency-affected populations. UNHCR and WFP, in consultation with the UNAIDS Secretariat, coordinated with regional and country partners to gather vital information on the HIV epidemic among emergency-affected populations in the Horn of Africa, and facilitated consultations with stakeholders on effective strategies that can reduce the risk of exposure to HIV and provide adequate services to people living with HIV through full integration of HIV interventions within the broader humanitarian response, as outlined in the revised 2010 “*IASC guidelines for addressing HIV in humanitarian settings*”.

In Kenya, UNHCR and IOM led the efforts to support the government to ensure that HIV services were made available in the emergency affected areas. The two agencies represent the UN Joint Team on AIDS at the humanitarian cluster meetings and work closely with the National Steering Committee for AIDS in Emergencies. This is done with support from WFP, UNICEF, WHO, UNDOC and the UNAIDS Secretariat. UNHCR is conducting baseline surveys in the refugee camps and WFP is providing data on Nutrition and HIV for the North and North Eastern provinces, where drought-affected local populations also require continued HIV prevention, treatment, and care and support services.

In Dadaab refugee camps in Kenya that host over 500,000 Somali refugees, comprehensive reproductive health and HIV services were established within the health facilities that include: a) comprehensive emergency obstetric services in all camp hospitals; b) management of HIV including access to ARV treatment through the national programme; c) HIV and reproductive health services for key populations at higher risk; d) Prevention-of-mother-to-child-transmission services; e) promotion of condom use and provision is ongoing (as the HIV prevalence in the general population is low, higher risk populations are targeted). There are adequate stocks of male and female condoms. Systems to provide medical services, such as PEP for HIV, emergency contraception, STI prophylaxis and psychosocial support are available for survivors of sexual violence at all camp hospitals. A reproductive health working group was newly formed in 2011. However, with the onset of the current emergency, reproductive health and HIV have been integrated into the existing emergency response mechanisms.

In Ethiopia, a government-led task force is supported by UNAIDS, UNFPA, UNHCR, UNICEF, WFP and NGOs. The roll-out of a minimum intervention package at regional levels

has begun. UNHCR is leading the coordination of health and nutrition activities and is scaling up its capacities for refugees who have arrived en masse from Somalia. The agency is working with partners to reduce the transmission of HIV, prevent sexual violence, and provide care for survivors of sexual violence, including PEP kits. Health promotion and public education has continued to ensure that refugee families are aware of the existing health services and male condoms have been made available from the start of the emergency. Blood safety measures are reinforced and for people living with HIV, the national ARV protocol (CD 4 testing; clinical monitoring; adherence promotion) is followed. More than 10 international NGOs are supporting the HIV intervention in the refugee camps.

## **Americas**

23. The UNAIDS Regional Support Team in Latin America, has joined forces with UN Women and UNHCR in the establishment of a framework for monitoring the implementation of SCR 1983 in priority countries with high incidence of GBV such as Central American countries as well as countries in conflict including Colombia and Haiti.

### **Case study- Tropical depression**

In October 2011, the Tropical Depression 12E hit Central America and Mexico. El Salvador, Guatemala, Honduras and Nicaragua were affected by heavy rains provoking landscape and flooding. Through OCHA coordination, the Risk, Emergency, and Disaster Task Force Inter-Agency Workgroup for Latin America & the Caribbean (REDLAC) mobilized to respond to the emergency at the national level. The clusters ensured that HIV was a priority cross-cutting issue in the humanitarian response. As a direct result of joint efforts in coordination and advocacy, HIV was included in the humanitarian response. More notably, in El Salvador, WFP worked with UNAIDS, the Ministry of health, MINSAL, NGOs and the Humanitarian Network to: (1) include HIV in Rapid Need Assessments; (2) ensure that National Hospitals immediately dispensed the ARV to any PLHIV who had lost his treatment in the emergency; (3) the inclusion of PEP and the inclusion of condoms in hygienic kits; and (4) collection of information to inform future responses.

## **Asia**

24. There are approximately 88,000 registered refugees and another 60,000 unregistered persons living in nine temporary shelters along the Thai-Myanmar border. Although a large number of Myanmar refugees were resettled to third countries, they have been replaced by new comers who often arrive with inadequate information on HIV and AIDS and with limited knowledge of health issues. In 2010-2011, interventions were introduced to provide prevention services and post-exposure prophylaxis (PEP) for survivors of sexual violence, to target key populations at higher risk of HIV, and to develop capacities of different actors. The operations faced several challenges such as difficulties in integrating affected populations into health insurance systems and limitations of Myanmar refugees living with HIV to accessing ART. The NAPHA Programme for non-Thai persons including migrants and refugees will end in 2013 and the treatment plan and budget after 2013 are yet to be determined. Advocacy should continue for the inclusion of Myanmar refugees and migrants to have access to the national care and treatment programme as well as to explore opportunities for inclusion of newly identified cases.

## **Key populations at higher risk of HIV infection**

25. A regional initiative on sex work in humanitarian settings was implemented in East Africa. Intervention involved partners and Ministries of Health to address the special health and protection needs of sex-workers, adolescents involved in survival sex and sexual exploitation and Men Having Sex with Men. Assessments and programmes were developed and/or strengthened in key countries, with in particular training and support of multifunctional teams in 4 countries (Ethiopia, Kenya, Zambia and Uganda) where HIV, Sexual and Reproductive Health (SRH) services for sex workers have significantly improved, community sensitized and peer-led networks developed.
26. A practical guide to launching interventions: an issue affecting women, men, girls, boys and communities based on field experience from the East and Horn of Africa HIV and sex work in refugee situations. The tool is intended to assist those working to slow transmission of HIV and other sexually transmitted infections (STIs) in humanitarian settings.
27. UNODC and UNHCR established and improved HIV prevention, treatment and care services for Afghan refugee drug users in Iran and Pakistan, and returnees in Afghanistan that included the following interventions: conducting a mapping and vulnerability study among returnees; capacity development in strengthening service provision for NGO and law enforcement staff; implementing interventions in the border area (Iran, Pakistan); provision of humanitarian services for people who inject drugs together with UNAIDS and WHO; supporting drop-in centres and outreach HIV services; and establishing a methadone maintenance therapy programme in Kabul. In response to Pakistan's devastating floods, humanitarian responses included health and protection interventions such as counseling and HIV prevention services, in particular for women and children and those highly vulnerable to drug addiction, sexual abuse, and human trafficking.

## **HIV, Security and Uniformed Services**

28. Progress has been made in the area of HIV, Security and uniformed services. The adoption of Security Council Resolution (SCR) 1983 in June 2011 with a broader scope for actions, has laid the foundation for a reinvigorated agenda around AIDS and security that recognizes the pivotal role of uniformed personnel not only in achieving universal access and advancing the national AIDS responses, but also eliminating all types of violence in conflict. SCR 1983 reconfirms the mandate of its predecessor SCR 1308 and introduces new important elements in the AIDS and Security agenda by recognising that uniformed personnel are important agents of change in the AIDS responses and elimination of GBV . It calls for coordinated action and alignment of HIV prevention and response with prevention of and response to GBV as well as stronger efforts for integrating HIV in demobilization, disarmament and reintegration processes (DDR) and security sector reforms
29. SCR 1983 was introduced to high ranking representatives from more than 90 national militaries participating at the 39th International Congress on Military Medicine, held in Abuja, Nigeria in November 2011. As part of their Memorandum of Understanding, the International Committee on Military Medicine (ICMM) and UNAIDS have developed a clear plan of cooperation to support implementation of SCR 1983 among all members of ICMM. The Global Task Force on HIV and uniformed services has been the driving force for building the capacities of the regional networks and development of standards for HIV programming among uniformed services. In addition, the Task Force has developed an options paper for HIV pre deployment testing policies among troop contributing countries and defined a research agenda in AIDS and Security for up to 2015.

30. The global advocacy efforts of the UNAIDS family, DPKO and their partners have resulted in increased recognition and commitments from top leadership that all uniformed services should address AIDS. 60% of 53 low and middle income countries surveyed have integrated HIV programmes for military; police and other uniformed personnel into their national AIDS programmes although without clear budget allocations from domestic resources. DPKO has mainstreamed HIV into every United Nations peacekeeping mission. Pre-deployment HIV training has become standard practice for all troop and police-contributing countries. The coverage and quality of HIV prevention and care services varies between peacekeeping missions and countries. Although interventions have increased HIV knowledge, their effects on high-risk sexual and drug-related practices are still very difficult to assess in the absence of effective monitoring and evaluation systems. Condom use is still inconsistent. The effectiveness of stand-alone peer education programmes has been questioned due to the high mobility of trained peers.
31. Peacekeeper induction training on HIV awareness has increased almost seven-fold between 2005 and the end of 2012. In the same period, the number of peacekeepers in field missions increased from 69 838 to nearly 100 000. In 2005, 11% had received HIV induction training. By the end of December 2011, this had increased to 55%. Action has focused on reducing risks for peacekeeping operations but also for host communities and on addressing the related challenges of GBV in armed conflict.
32. UNFPA and UNDP have been leading in addressing HIV within DDR settings as well as strengthening linkages between GBV and HIV programmes with uniformed and demobilized personnel. At the global level UNFPA, UNDP and UN Women co-chair the Gender, HIV-DDR sub working group which aims to coordinate efforts and implement joint programmes with demobilized personnel on the ground. Under the auspices of this sub working group, UNFPA and UNDP, with funding from the European Commission in collaboration with the International Centre for Research on Women (ICRW), are currently conducting an HIV operational research study in several countries (e.g. Cote d'Ivoire, Sudan, Republic of Congo, Rwanda) to identify potential gaps and opportunities for addressing HIV in DDR and strengthen joint efforts in linking HIV-DDR programmes with GBV, livelihood and broader health efforts.
33. UNFPA has worked closely with UN partners, peacekeeping missions and national counterparts to strengthen HIV and gender mainstreaming programmes within national militaries and police forces (such as Nepal, Bangladesh, Pakistan, DRC, Haiti, Sudan to name a few) and peacekeeping missions (such as Cote d'Ivoire, Darfur). This is part of the wider agenda of UNFPA that is currently supporting national militaries and police in over 45 countries as well as working directly with 10 peacekeeping missions for HIV programming within the mission as well as integration into disarmament, demobilization and reintegration processes.

## **Conclusion**

34. Although progress has been made in addressing inequitable access to HIV services for affected populations, additional work is needed to ensure that HIV is adequately included during all phases of the humanitarian response. The IATT will continue to work towards ensuring that HIV is integrated into the response. In addition to this, lessons learnt from the response need to be captured so as to improve the evidence on how best to address HIV in emergencies, particular in the 'transition' phase.
35. Significant progress made in addressing HIV among international peacekeepers and national militaries has been attained. However, more needs to be done with regard to

HIV responses among other uniformed personnel. Integration of HIV into DDR and SSR processes needs to be expanded in terms of both number of countries supported and scale of programmes. The Uniformed Services Task Force will continue to coordinate the AIDS and Security agenda as well as expand its scope of work to better reflect the call of action of SCR 1983 particularly with regard to alignment of HIV prevention with GBV prevention and enrolment of uniformed personnel as agents of change for eliminating all types of gender violence in conflict and post conflict situations.

[Annex to follow]

## ANNEX I

### **Excerpt from Decisions, recommendations and conclusions from the 27<sup>th</sup> meeting of the UNAIDS Programme Coordinating Board in Geneva, Switzerland, 6-8 December 2010**

#### **Agenda item 4: AIDS, Security and Humanitarian Response**

1. *Takes note* of the progress made in the thematic area of HIV and Security and Humanitarian Response and *requests* UNAIDS to provide a comprehensive report on its security and humanitarian response work to the Programme Coordinating Board after UNAIDS' report to the UN Security Council on resolution 1308.

## ANNEX II

### **Excerpt from Decisions, recommendations and conclusions from the 19th meeting of the UNAIDS Programme Coordinating in Lusaka, Zambia, 6-8 December 2006**

- 9.1 Recognizing that AIDS policies and programmes are not consistently integrated into security and humanitarian responses, *calls* on UN Resident and Humanitarian Coordinators, UN Country Teams 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, through building and sustaining AIDS mainstreaming capacity within UN Country Teams and national partners, and through the cluster approach in humanitarian responses and to develop stronger linkages between humanitarian recovery and national development responses;
- 9.2 *Endorses* the efforts of UNAIDS and its partners (such as the Department of Peacekeeping Operations), 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;
- 9.3 *Recommends* that UNAIDS address the impact of AIDS on key government cadres other than the military, including the judiciary, police and local government, and *recognizes* that programmes must target other institutions and groups, taking into account the demands and challenges of the particular epidemic;
- 9.4 *Calls* on both national governments and international donors to ensure that AIDS is accounted for in humanitarian preparedness and response, including needs assessments and *further calls* on international donors to adapt development and humanitarian funding instruments to allow sufficient AIDS funding in humanitarian response and during the transition between emergency and recovery and reconstruction periods;
- 9.5 *Requests* UNAIDS to strengthen AIDS responses in humanitarian emergencies and security operations including through, inter alia, the development of a strategic framework for action between the United Nations Office for the Coordination of Humanitarian Affairs and UNAIDS; pursuing membership or formal association between the UNAIDS Secretariat and the global-level United Nations Inter-Agency Standing Committee and through strengthened leadership in the Task Force on AIDS and Security;
- 9.6 *Recognizes* that the complex links between security, humanitarian emergencies and HIV vulnerability and services demand further research, and *requests* UNAIDS to advocate, support and collaborate in such research; and
- 9.7 *Calls* on UNAIDS to intensify programmatic efforts on the intersection between gender- based violence and HIV, including but not limited to situations of conflict, particularly acknowledging the unique contributions of women survivors and those affected by violence.

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