Tri-Country HIV/AIDS and Refugees Workshop

Kenya, Tanzania, Uganda

Group Photo, December 2002

10-13 December 2002, Entebbe, Uganda

Paul Spiegel, MD MPH
Snr. HIV/AIDS Technical Officer
Health & Community Development Section
Division of Operational Support

HCDS/WR/02/008

CONTENTS

ABBREVIATIONS i

EXECUTIVE SUMMARY 1

CONSENSUS STATEMENT 3

Summarised Minutes of HIV/AIDS and Refugees Workshop
Day 1: 10 December 2002 **5**
Keynote Address by Dr. Kirungi, Ugandan AIDS Control Program (UACP) 6
Presentation - Behavioural Surveillance Surveys (BSS) 6
Summary of Group Discussion on BSS 7
Sharing of Information-Education-Communication (IEC) Materials Session 8

Summarised Minutes of HIV/AIDS and Refugee Workshop
Day 2: 11 December 2002 **9**
Presentation - Karago Youth Centre in Kibondo, Tanzania 9
Presentation - Integrated Multi-Sectoral Community Development Approach 11
Presentation - Voluntary Counselling and Testing (VCT) 12
Discussion of Ugandan Government's Involvement with Refugees and Self-Reliance Strategy 15

Summarised Minutes of HIV/AIDS and Refugee Workshop
Day 3: 12 December 2002 **17**
Presentation - Prevention of Mother to Child Transmission (PMTCT) 17
Presentation - Home Based Care (HBC) 20
Post Exposure Prophylaxis (PEP) 21
Planning Sessions for 2003 22

Summarised Minutes of HIV/AIDS and Refugee Workshop
Day 4: 13 December 2002 **23**
Planning for 2003 23
Planning for Kenya 2003 23
Planning for Tanzania 2003 32
Planning for Uganda 2003 38
Workshop Evaluation 49

Appendix 1 Signatories of Consensus Statement 50
Appendix 2 List of Participants 51
Appendix 3 Workshop Agenda 52
Appendix 4 HIV/AIDS/STI Surveillance in Uganda (Presentation) 53
Appendix 5 Karago Youth Centre in Tanzania (Presentation) 58
Appendix 6 Integrated Multi-Sectoral Community Development Approach (Presentation) 61
Appendix 7 Integrating Multi-sectoral Education (Presentation) 63
Appendix 8 Voluntary Testing and Counselling, Kakuma, Kenya (Presentation) 64
Appendix 9 Prevention of Mother to Child Transmission, Ngara, Tanzania (Presentation) 67
Appendix 10 Home Based Care, Ngara, Tanzania (Presentation) 70
Appendix 11 Workshop Evaluation Form 72

ABBREVIATIONS

AIC	AIDS Information Centre
ANC	Antenatal Clinic
ARVs	Antiretroviral Medications
BO	Branch Office
BSS	Behavioural Surveillance Survey
CDC	Centers for Disease Control and Prevention
HBC	Home Based Care
IEC	Information-Education-Communication
IRC	International Rescue Committee
NACP	National AIDS Control Program
NASCOP	National AIDS and STI Control Program
NGO	Non-governmental Organisation
NPA	Norwegian Peoples AID
OIs	Opportunistic Infections
PEP	Post Exposure Prophylaxis
PLWH/As	Persons living with HIV/AIDS
PMTCT	Prevention and Mother to Child Transmission
SRS	Self-reliance Strategy
STIs	Sexually Transmitted Infections
UACP	Ugandan AIDS Control Program
UNHCR	United Nations High Commissioner for Refugees
URC	Ugandan Red Cross Society
VCT	Voluntary Testing and Counselling

EXECUTIVE SUMMARY

A tri-country HIV/AIDS and Refugees workshop was organised by the United Nations High Commissioner for Refugees (UNHCR) for Kenya, Tanzania and Uganda from 10-13 December 2002. The objectives of the workshop were to improve the quality and to standardise the various HIV/AIDS programs implemented in the refugee camps in the three countries as well as to plan for 2003. Representatives from various non-governmental organisations (NGOs), UNICEF and the Ugandan government, all of whom work in the refugee camps, participated in the 4-day event. An HIV/AIDS resource package containing guidelines, policies and seminal articles was provided to the participants. Model HIV/AIDS programs were presented by chosen NGOs to provide an example of what can be achieved in refugee camps as well as to discuss ways to improve and adapt the programs according to the different settings in the three countries. A standardised matrix was provided to the participants to plan and prioritise their 2003 HIV/AIDS programs by country.

A consensus statement was developed and signed to emphasise the deep commitment of the participants to fight this pandemic and to provide a forum for these multi-disciplinary professionals to state their expert opinions on what needs to be done in the future to combat HIV/AIDS among refugees. The vulnerable and unique situations of refugees, as well as their interaction with host communities during their exile, and with country of origin communities when they repatriate are emphasised. HIV/AIDS programming may need to be modified from those established in developing countries to target refugees' particular circumstances. Finally, refugee situations both within and between countries are different and programs must be adapted accordingly. For instance, refugees in Uganda live among local populations in huge settlements where they can grow crops, raise animals, and even get work permits. Camps in Kenya and Tanzania are relatively small circumscribed areas with restricted movement, relatively separated from local populations, and with limited ability for income generating activities. The stigmatisation of HIV/AIDS is less in Uganda than in Kenya and Tanzania. These factors all affect program planning.

Behavioural and biological HIV surveillance has only commenced recently in some refugee camps in the three countries. Various behavioural surveillance surveys in refugee camps were examined and found to be of poor methodology and lacking standardised questionnaires. Participants agreed to modify existing standardised questionnaires to include questions of displacement, distribution, and other factors unique to refugees. Furthermore, participants agreed to discuss their methodology and questionnaire at a co-ordination meeting with their peers before undertaking such surveys. UNHCR agreed to make consultants available to help NGOs undertake such surveys if needed and funding permits.

There is an acute lack of appropriate HIV/AIDS information-education-communication (IEC) materials in local languages in all refugee camps in the three countries. Participants agreed that the best way to develop such materials is to work with the community to develop culturally appropriate messages and then have refugee artists develop the material. Messages need to be targeted to various high risk and vulnerable groups. Furthermore, it was emphasised that depending upon the maturity of the epidemic and the level of services offered, messages may be different in various camps and messages need to evolve over time. In order to bridge the gap, participants agreed to use some of the existing IEC materials that were presented by some NGOs. Existing materials will only be provided to camps that have the same ethnic groups as those for whom the materials were created (e.g. Burundian refugees in Tanzania and Uganda). UNHCR will pay for the duplication and distribution of the materials to the three countries.

Youth are at increased risk for HIV/AIDS and the NGOs in Tanzania have created multi-functional youth centres, some of which provide family planning services, treatment for sexually transmitted infections, and voluntary testing and counselling (VCT). In some camps, the latter three services have increased among the youth as confidentiality, acceptability, and

ease of use, as facility hours were adopted to their schedules, improved. However, several constraints still need to be overcome: girls do not use the centres as much as boys; parents and leaders of the camps were neither involved in the process nor sensitised sufficiently, and thus have been obstacles in some circumstances; sustainability is difficult as funds for infrastructure, materials and personnel are lacking. Uganda settlements do not have youth centres and questions arose as to the number required to be built in such large areas and the consequent cost. UNHCR agreed to write a lessons learned paper on the youth centre experience in Tanzania together with participating NGOs.

HIV/AIDS is not simply a health issue, and thus an integrated and multi-sectoral approach is necessary. These words are easy to say but actually doing it is more difficult. Participants agreed that various NGOs in camps do not often co-ordinate and communicate well causing duplication of services. Protection officers in UNHCR do not necessarily see the connection between legal protection and human protection. IEC materials for health may also be suitable for schools, but this is rarely co-ordinated. It was suggested that an HIV/AIDS focal point be identified in each organisation at the various field offices and that regular meetings between these focal points occur.

VCT is an essential link between prevention and treatment and if not done properly can set back an HIV/AIDS programme. There is a wide variation in the quality of VCT programs within and between countries. Testing algorithms, availability of tests, time to receive results, confidentiality, accessibility and data management are all problems that exist in various sites. IRC in Kenya has developed a model VCT system that includes post test clubs, referral systems, and a computerised data management system. Forms were provided to the participants and the computer software will be made available to all. Due to limited resources and large settlements, Ugandan refugees are mostly served by mobile clinics that come irregularly, if they have access to VCT at all. Furthermore, in southern Uganda, refugees are required to pay a user fee that discourages use. UNHCR has agreed to pay the user fee for refugees as well as for locals in the settlements. Participants emphasised the importance of training both government and NGO workers as well as providing services to local populations and refugees. One example was to ensure adequate VCT services exist in the referral hospital that serves both refugees and locals.

- Must consider future as epidemic matures and more people infected with HIV develop AIDS. Must plan now. Increase resources, personnel, reliability = ultimately money.
- Learn from the experience of other countries.
- Need funding- work closer with UNAIDS and host governments; get them to include refugees in their proposals and national programs; especially those in refugee affected districts/regions.

CONSENSUS STATEMENT

HIV/AIDS has become the leading cause of suffering and death in sub-Saharan Africa. This pandemic is now two decades old and a breakthrough to halt the spread is not foreseen. The pandemic is a serious threat to society and global security threat. Uganda, Tanzania and Kenya are among the highly affected nations in the world and can barely cope due to the huge burden of the disease among their nationals. Civil strife in neighbouring countries and the continuing influx of refugees and internal displacement has severely strained and continues to weaken the coping mechanisms of these countries.

On 27 June 2001, the United Nations General Assembly held a special session to adopt a resolution declaring their commitment to fight HIV/AIDS. In response, the United Nations High Commissioner for Refugees (UNHCR) developed an HIV/AIDS and Refugees Strategic Plan for 2002-2004. The plan outlines UNHCR's commitment and plan of action to fight this scourge.

The interactions between HIV/AIDS and persons displaced by complex emergencies is little understood and is only now being recognised as a major problem. Refugees may have an increased risk of contracting the virus due to poverty, disruption of social structures and health services, and exposure to sexual violence and an increase in socio-economic vulnerability but HIV prevalence data in such situations are scarce. However, it is important to combat the false perception that 'refugees bring AIDS with them to local communities', which may lead to increased xenophobic tendencies against the refugees.

We, multidisciplinary professionals working with refugees from various NGOs, Governments, UNHCR, and UNICEF are concerned about the impact HIV/AIDS is having on this vulnerable population. In Entebbe, Uganda from 10-13 December 2002 we deliberated, suggested mechanisms for improved co-ordination, learnt from each other, and hereby state the following as a way forward:

1 HIV/AIDS is not just a developmental issue. It thrives on conflict and displacement, social upheavals, poverty, and inequity. Humanitarian agencies needs to address HIV/AIDS interventions at the onset of their involvement in a refugee emergency.

2 A minimum package of HIV/AIDS interventions need to be initiated at the onset of the refugee emergency and evolve according to needs throughout the phases of the crisis and the severity of the epidemic in the population. These activities should be integrated into existing programs and mainstreamed into organisations' regular programming and funding cycles as soon as possible.

3 Refugee women and youth are particularly vulnerable to HIV due to poverty, limited access to resource, social status, and gender-based violence.

4 HIV/AIDS is not solely a health issue. It requires a multi-sectoral approach from all sectors including protection, education, community services, water/sanitation, religion, security, and food and nutrition.

5 Co-ordination, collaboration and co-operation among the various actors are essential. These include refugees, host communities and governments, UNHCR, UNAIDS, and other UN organisations, local and international NGOs, donors, and persons living with HIV/AIDS (PLWH/As). A community development approach that empowers individuals and families to reduce their vulnerability to infection is essential.

6 Prevention of HIV/AIDS should be linked to care and treatment of which voluntary counselling and testing is an integral component. All interventions for refugees generally

need to incorporate the host government's guidelines and protocols. Moreover, host governments should incorporate refugee needs into their national policies and programs; donor agencies should encourage governments to do so.

7 The reduction of discrimination and stigmatisation is essential in combating this disease at all levels of the community.

8 Surveillance (both behavioural and biological), monitoring, and evaluation improve the effectiveness and the quality of programming and are key components of HIV/AIDS interventions throughout all phases of a refugee emergency.

9 HIV/AIDS does not respect boundaries. Refugees cross borders and will hopefully return to their country of origin or be resettled in a third country. Therefore, we support regional and sub-regional initiatives that seek to improve co-operation, co-ordination, and quality of HIV/AIDS programs among countries, such as the Great Lakes Initiative for AIDS.

10 As the effects of the pandemic worsens, future plans for HIV/AIDS programs must be established because:

  (a) Deaths of young adults will reduce household disposable income and agricultural produce making refugees more dependent on external aid.

  (b) There will be an increase in the number of orphans in need of support, care and treatment; a burden that will have to be borne by the elderly.

  (c) As deaths of young adults increase leaving behind orphans, programs addressing psychosocial needs of the affected families and communities will be crucial.

  (d) As new and innovative HIV/AIDS interventions are developed and included in host country protocols, such as antiretroviral medications, similar interventions will need to be considered for refugees.

11. Organisations have a responsibility to educate their employees on HIV/AIDS prevention, ensure measures that reduce their exposure to HIV on the job, and care for those who are infected.

In conclusion, we, the participants of this HIV/AIDS and Refugees workshop, hereby commit ourselves to address the aforementioned issues in the interest of refugees and host communities. We ask our respective institutions to move forward and address these issues in a comprehensive and holistic manner (see signatories in Appendix 1).

SUMMARISED MINUTES OF HIV/AIDS AND REFUGEES WORKSHOP
DAY 1: 10 DECEMBER 2002

Introduction

Dr. Paul Spiegel, Senior HIV/AIDS Technical Officer, UNHCR, Geneva, began the meeting by stating that this was a unique opportunity to discuss HIV/AIDS programs and learn from each other about HIV/AIDS and refugees. All participants introduced themselves (see Appendix 2). Dr. Spiegel then discussed the contents of the workshop binder and plastic package that included mission reports from Kenya, Tanzania, and Uganda, four CDs of HIV/AIDS resource materials, various published HIV/AIDS articles and guidelines, summaries of HIV/AIDS programs in various camps, and presentations on the topics to be discussed during this workshop (see Appendix 3).

Mr. Saidy, the UNHCR Representative of branch office (BO) Uganda was introduced by Dr. Tibyampansha, Senior Health Co-ordinator, BO Uganda. Mr. Saidy officially opened the workshop after Dr. Spiegel introduced its objectives:

1. To improve and standardise HIV/AIDS programs in Kenya, Uganda, and Tanzania.
2. To discuss HIV/AIDS programs with UNHCR and non-governmental organisations (NGOs) both within and between countries; certain NGOs were chosen to present their programs on specific topics.
3. To plan and prioritise HIV/AIDS programs for 2003.

Mr. Saidy welcomed everyone and stated that HIV/AIDS has no national boundaries and consequently a global effort is needed to fight this disease. Differences in the way we approach combating the disease was mentioned although a concerted effort in dealing with HIV/AIDS was stressed. Mr. Saidy stated that Uganda has done tremendous work to combat HIV/AIDS; the number of women insisting on use of condoms has doubled according to recent reports, however, young girls, who are most affected by HIV, are often ignorant about the disease. He further stressed that refugees are not immune to HIV/AIDS. Poverty rates in the settlements increase the vulnerability of refugee women. Refugees intermarry with the surrounding local population and therefore both refugees and locals are affected. The host community and not only the refugees must also be reached and educated on the fight against AIDS. Mr. Saidy concluded by wishing the group well on their deliberations and officially opened the workshop.

Next, an activity to place various actions, drawn on cards, that could or could not transmit HIV/AIDS onto five different categories of AIDS transmission (No risk, Very low risk, Low risk, Medium risk and High risk) was undertaken. The participants were divided into four different groups; each group viewed the other groups' card placements and then discussion occurred. Overall, there were differences among the groups, primarily due to the literal interpretation of modes of transmission compared to interpreting how the actions on the cards could influence behaviour (e.g. bottle of alcohol).

KEYNOTE ADDRESS BY DR. KIRUNGI, UGANDAN AIDS CONTROL PROGRAM (UACP)

Dr. Kirungi of the UACP was introduced by Dr. Tibyampansha. The presentation focused on the methodology of how to conduct HIV/AIDS surveillance in Uganda. Uganda was among the earliest countries to be affected by the pandemic. The HIV/AIDS surveillance system was established in 1986 and has evolved over time.

There is a systematic process of compiling collecting, analysing and disseminating data. Differences between active and passive surveillance as well as surveys was discussed. Various methodologies have been used to collect HIV data in Uganda; currently they are using second generation surveillance systems. Most of the regions in Uganda have antenatal sentinel surveillance sites. Trends between 1989 to 2001 have both increased and decreased. However, most sentinel sites reported increasing HIV prevalence in the 1990s that decreased in the early 2000s. Behavioural surveillance surveys are planned to be implemented more frequently throughout the country to help explain the changing trends of HIV prevalence. Furthermore, incidence of sexually transmitted infections (STIs) are followed and add important data to help explain varying trends of HIV prevalence. There are plans to strengthen second generation surveillance in Uganda as well as to undertake a national HIV prevalence survey. However, surveillance alone is not sufficient; policy makers and influential people must continue to discuss the importance of HIV/AIDS and ways in which to decrease transmission and stigmatisation.

HIV sentinel surveillance among refugees in Uganda is being planned for this year. Discussions are underway between the Government of Uganda, UNHCR, and the Centers for Disease Control and Prevention (CDC). Such activities are already being undertaken in Kenya and Tanzania (see Appendix 4 for PowerPoint presentation).

PRESENTATION- BEHAVIOURAL SURVEILLANCE SURVEYS (BSS)

(Ms. Liri of the Ugandan Red Cross Society (URC))

URC, funded by UNHCR, works with refugees in Nakivale and Oruchinga, Uganda. A baseline BSS was carried out in June 2001, followed by another BSS one year later. URC has been one of the only NGOs at the workshop who has undertaken serial BSSs. The methodology of the surveys included focal group discussions to help develop the individual questionnaire. The surveys were undertaken by women's groups and community leaders in the local languages. The trends between the serial surveys for Nakivale camp are similar to that for Oruchinga camp and consisted of the following:

1. HIV/AIDS knowledge among populations increased.
2. Majority received knowledge through radio followed by health workers.
3. Condom use among those surveyed increased.
4. A majority of the population in both camps are willing to take an HIV test.
5. Stigmatisation against those living with HIV/AIDS remained high, however, majority of respondents would support family members if sick from HIV.

Ms. Dominica Liri stated that there is a need for URC to increase the use of condoms, improve the knowledge, and produce more education and training materials. Transport is a major constraint.

Before the participants divide into groups to examine 2-4 different BSSs undertaken in the three countries over the past 5 years, Dr. Spiegel made the following points on serial BSSs:

1. Serial survey forms should be standardised to ensure comparability.
2. Methodologies must be clearly stated in reports and must be population-based with equal probability of all to be chosen.
3. Family Health International (FHI) has much experience with HIV/AIDS BSSs and have developed standardised forms as well as detailed methodologies for serial surveys; these materials are included in workshop CDs.
4. BSSs must differentiate between behaviours of persons with regular partner versus non-regular partners.
5. Behaviour takes time to change. Frequency of serial BSSs should be every 2-4 years.
6. Finally, data must be interpreted and recommendations clearly stated in report.

Then four groups were tasked to evaluate various BSSs, concentrating upon 1) objectives of survey; 2) methodology; 3) questionnaire; and 4) conclusions and recommendations.

SUMMARY OF GROUP DISCUSSION ON BSS

1. First baseline BSS provides data for comparison and trends for future serial surveys; it is more difficult to make concrete recommendations as when have trends from serial surveys.
2. Objectives of surveys often not stated in report.
3. Methodologies of BSSs, including sample size, type of sampling (and if multi-staged, description of all stages), age groups, training, focus groups, survey design, etc. were not clearly stated so it was difficult to know if surveys were representative of population. Questionnaires used in survey were not commonly attached as appendix to report.
4. Questionnaires varied greatly; although most surveys studied were not serial but “one-offs”, they were not comparable to other surveys.
5. Qualitative methods, such as focus group discussions and key informant interviews are important to help in designing questionnaires; few surveys studied here did this.
6. Results were reported but conclusions and recommendations did not always logically follow from the data.
7. Reports not well structured; often methodology, results, conclusions, and recommendations were intermixed. There is a need to standardise reporting formats.
8. Stating time and cost of survey divided into its various components (e.g. personnel, training, materials, duration of survey, and transport) would be helpful. This was not comprehensively done in any of the surveys.
9. Feedback to community was rarely mentioned.
10. Need for proper technical support and capacity building BEFORE NGOs undertake BSSs.
11. Often UNHCR personnel were not informed before studies carried out.
12. Proposal to develop peer review of such studies among various NGOs and UNHCR BEFORE studies are carried out; this will ensure quality and standardisation of BSSs within countries. This can be done at UNHCR country medical co-ordination meetings
13. When feasible and needed, UNHCR can contribute to costs of providing technical assistance.

<u>SHARING OF INFORMATION-EDUCATION-COMMUNICATION (IEC) MATERIALS SESSION</u>

UMATI- Tanzania, IRC- Tanzania, URC –Uganda, ADEO- Uganda, and NCCK- Kenya presented various materials they have developed for HIV/AIDS IEC; these included posters, pamphlets, newsletter, training materials, videos, banners and T-shirts. After discussion of pros and cons of various materials presented, it was concluded that there were insufficient IEC materials of appropriate local languages in the camps. Although everyone agreed that the best methodology to create such materials is to work with the refugee community from the materials inception, this is costly and time consuming. Such a procedure should occur in many camps in the future, but as a stop gap measure, existing materials that incorporated this process would be shared only among refugee camps with the same ethnic group. Furthermore, it was noted that HIV/AIDS messages change over time depending on what has occurred in the community previously (e.g. prevention messages, available services messages, care and treatment messages, anti-discrimination messages, etc.) For the most part, the majority of IEC materials were in English, Kirundi and Kiswahili (appropriate for refugees from Rwanda, Burundi and DRC). Some were in Arabic and Madi (appropriate for refugees from Somalia and Sudanese refugees, respectively). There is a dearth of IEC materials for Sudanese and Somali refugees.

Recommendations

1. To fill a gap, existing posters that were agreed upon by the group to be appropriate for specific ethnic groups in refugee camps will be printed in Uganda and distributed to the different countries. UNHCR will pay for the printing and transport costs. These will be distributed in first quarter of 2003.
2. Country UNHCR co-ordinators together with NGOs will meet to discuss methods and funding to create HIV/AIDS IEC materials in local refugee dialects. Refugees will be consulted at all levels of process, and whenever possible, local refugee artists will be asked to create materials.
3. IEC materials need to be targeted at specific vulnerable groups; types of messages and media used will vary according to situation, services available, maturity of epidemic.

Dr. Stephen Macharia, IRC Kibondo, presenting IEC materials

SUMMARISED MINUTES OF HIV/AIDS AND REFUGEE WORKSHOP
DAY 2: 11 DECEMBER 2002

Introduction

Dr. Spiegel read an e-mail from Ms. Laurie Bruns, UNHCR Program Officer in South Africa, on the future of HIV/AIDS in South Africa: a system need to be put into place where parents declared who will look after their children once they have died; UNHCR and the local NGOs cannot afford to pay for the coffins and funeral services because too many people are dying; and urban refugees with AIDS in South Africa are being thrown out of their homes because they can no longer afford the rent - UNHCR and NGOs must now consider how to provide shelter for such people. South Africa has a more mature HIV/AIDS epidemic than many East African countries. We will need to learn from their experiences, and use this to plan for the future in East Africa.

PRESENTATION– KARAGO YOUTH CENTRE IN KIBONDO, TANZANIA

(Dr. Macharia, International Rescue Committee (IRC))

Dr. Macharia briefly discussed the refugee situation in Kibondo district, Tanzania as well as IRC's comprehensive primary health care program which began in 1995. Karago camp was established in 1999. A comprehensive HIV/AIDS program exists with health education, universal precautions, condom promotion and distribution, and treatment of AIDS patients. It was felt that youth visits to the hospital in Karago lacked privacy for the youths, so preparation of a youth centre began in October 2000 with funding provided by WHO. IRC handed over to UMATI, a local health NGO, several activities such as voluntary testing and counselling (VCT), family planning, and health education. The beneficiaries of the centre are refugee youth between 12 - 24 years.

The project began with the sensitisation of the community. Services are offered to youths of both sexes and parents are kept informed of what occurs at the youth centre. Specific services offered include skills training, such as tailoring, basket weaving; sports, such as football and volleyball; entertainment with video and library books; family planning; treatment of STIs; and VCT. Karago youth centre has a part time clinical officer, VCT counsellor, and family planning counsellor who attend the youth centre. Overall, there are 23 staff at the youth centre; 22 refugees and one national. Hours of operations are tailored to fit the schedules of youth.

VCT data from August-December 2002 show that clients were few at the beginning and increased with time. There were 3,571 clients during this period of whom 44% were females. STI clinics in Karago treat more youth due to the presence of the youth centre. Syphilis was high in 2000 and dropped over time in the youth. More youths go to the youth centre compared to the clinic/hospital for treatment of STIs. Family planning acceptance among the Burundian refugees is low because it is believed they wish to replace children that died during the war. Since the youth centre opened, more adolescents have been accepting family planning than before. Finally, the youth centre provides a place for youth to go and helps to decrease idleness.

There are numerous constraints to this project, three of which are listed below:

1. Girls do not come to the youth centre as much as boys.
   (a) Girls have to do chores in house, parents do not want girls mixing with boys, rumours about "what goes on in the youth centre".
   (b) To combat this, parents and religious and camp leaders have been sensitised and have taken tours of the centre. This should have been done earlier.

2. Insufficient funds from donors limits what can be done at centre.
3. Income generating projects began but not very successful.

An evaluation of Karago youth centre by an external consultant is currently underway and will finish in January 2003 (see Appendix 5 for PowerPoint presentation).

Discussion

The amount of money involved in constructing, training and sustaining youth centre was not known. Money from the Ted Turner fund from UNHCR and PRM funds to UNICEF in Tanzania have allowed most camps in Tanzania to build such youth centres. However, they are lacking in most settlements in Uganda as well as in Dadaab, Kenya. Dr. Macharia drew a blue print of the Karago youth centre to show the various rooms and how privacy to the STI treatment, family planning and VCT is maintained by two different entrances and a common room so people do not know where youth are going. This design can be used as a model for other camps.

Other NGOs in Tanzania discussed their youth centres and the various problems they encountered:

1. Insufficient volunteerism; youth wanted incentives for peer education and to volunteer their services.
   - Similar problem with adult participation.
2. Similar problems with poor participation by girls.
3. Insufficient funds to:
   - Hire someone to help organise services in conjunction with youth.
   - Have sufficient health staff to provide services at youth centre.

Dr. Mohamed Qassim and Ms. Schilperoord of UNHCR discussed the history of the youth centres in Tanzania and how they evolved. It was agreed that a standardised and structured summary of descriptions and lessons learned from the NGOs' youth centre projects in Tanzania would be written by Ms. Schilperoord and Dr. Qassim.

Numerous other questions arose regarding youth centres that will be addressed in the summary mentioned above:

1. Availability of land and who pays for it.
   - Tanzanian government provided land.
2. Specific hours of activities offered at youth centre.
   - VCT is open from 15h00-17h00.
3. Costs and staffing.
   - Can have basic structure using locally made materials to keep down costs.
4. Do locals as well as refugee youth use it.
5. How can this activity be sustainable (e.g. income generating activities).

Again, differences between Uganda settlements and Kenya and Tanzania camps were emphasised:

1. There is less mixing of local and refugees in Kenya and Tanzania than in Uganda.
2. Settlements in Uganda are very large; one youth centre may not be easily accessible to all youth; creating more than one centre becomes more costly.

3. Available funding for programs . It appears that more funding is available in Tanzania and Kenya for these type of activities than in Uganda.

Discussion of data management and key indicators:

- Number of youths who use services over total number of youths in camps
  - Disaggregated by sex and age.
- Compare statistics before and after services were offered at youth centre to truly document differences in usage by youth.

PRESENTATION – INTEGRATED MULTI-SECTORAL COMMUNITY DEVELOPMENT APPROACH

(Ms. Linnie Kesselly, Community Services, UNHCR BO Kampala and Ms. Dorothy Jobolingo, Education, UNHCR BO Kampala)

Community Services

Community services focus on self reliance by the refugees themselves. An integrated approach is reflected in the collaboration by sectors in the community- this is UNHCR policy. The key component is capacity building, and partnership is essential. Therefore, training is for all stakeholders and monitoring and evaluation of programs is crucial. The community's involvement at all levels of program implementation is very important, as is awareness raising, community mobilisation and other activities that call for active involvement of refugees and their community. Clearly in the youth centres discussed previously, there was lack of parental involvement.

In the current environment, we need to more effectively use less resources. The real needs should be those identified by the community and sustainability is dependent upon community involvement. For example, the development of HIV/AIDS information-education-communication (IEC) materials for a particular community must involve health workers, community workers, refugees, youth, government authorities, military personnel, and the various sectors.

Challenges include inter-sectoral collaboration and commitment, getting stakeholders truly involved in development and implementation of HIV/AIDS programs , good monitoring and evaluation including uniform standards and indicators, surveillance of programs for both nationals and refugees, and co-ordinated planning (see Appendix 6 for PowerPoint presentation).

Education

In terms of education, HIV/AIDS fits in the category of life skills. In Uganda, there are 79,000 refugee youth of whom 67,000 are attending school. UNHCR has adopted the Ugandan government’s HIV/AIDS curriculum in refugee school education through the use of multiple methods (e.g. teaching, drama, sport) and multiple channels (e.g. classes, after school, sport). Some adults attend classes and are also made aware about HIV/AIDS. Special programs such as Olympic Aid are encouraged to provide messages about HIV/AIDS. Cultural sensitivity is also needed. Peer educators need to undergo training to be able pass on the messages correctly.

School children are a ready audience. Adolescents need to learn judgement and reasoning to make important and informed decisions. Refugees are encouraged to campaign within their own group about HIV/AIDS (peer education). Teachers often spend more time with students than their parents and are sometimes freer to speak to their students about reproductive health. Most children trust their teachers; HIV/AIDS educational activities in school are low cost and

sustainable. A multi-sectoral approach in HIV/AIDS education is needed for partnership and to share various activities and resources. There are many children out of school and they need to be targeted as well. However, IEC materials are often not available in refugee schools and are very much needed. Promotion of HIV/AIDS awareness through World AIDS day and other occasions are also needed.

There are more community-based people in the field than in health. Community services people should have a good understanding of HIV/AIDS to be able to involve the community. Refugee situations in East Africa differ. Most refugee children in Uganda are in school while in Tanzania they are not. Community services and health sectors need to plan together to better educate refugees on HIV/AIDS. The nature of our programs in all regions are different but the goal is the same. Therefore, joint planning and monitoring are required.

Most protection personnel do not involve themselves in multi-sectoral dynamics. This problem needs to be fixed. We must make them understand that they are also involved in this campaign to combat HIV/AIDS. Focal points in various sectors, both in headquarters and in the field should be appointed (see Appendix 7 for PowerPoint presentation).

Discussion

Integration and co-operation with other organisations:

1. UNHCR funding is limited; we must work with the host government, other UN agencies and NGOs.
2. Logistics of collecting and distributing IEC materials for health and education is difficult; we need to combine forces and share materials.
3. Community meetings have been successful when incentives, such as food, are provided; however, there is often insufficient funds for this and then meetings do not occur.
4. We cannot separate health and community services.

PRESENTATION– VOLUNTARY COUNSELLING AND TESTING

(Ms. Esther Mwanyika of the International Rescue Committee)

IRC in Kakuma refugee camp began VCT in April 2002 with financial and technical support from CDC and Kenya's National AIDS and STI Control Program (NASCOP). Data will be presented from April to October 2002. The objectives of the presentation are to provide a program overview, discuss lessons learned, and state next steps.

Kakuma refugee camp has approximately 85,000 refugees with a crude mortality rate (CMR) of 0.2 /1,000 persons /month. Seventy-five percent of the refugees are from Sudan. IRC's HIV/AIDS programs in the camp follow UNHCR policies as well as Kenya's national HIV/AIDS policies. Refugees in Kakuma have increased risk factors for the transmission of HIV including sexual mixing with the local nationals, many young males without family member who are on their own (i.e. lost boys of Sudan).

Two VCT centres exist in the lower and upper parts of Kakuma camp; they are strategically positioned so clients are able to walk in and out freely and privately. Services are provided free of charge. Two parallel and different rapid tests are used with a third different rapid test as a tie-breaker; same day results are given. At the VCT sites, in-house lectures on HIV/AIDS are provided as well as post-test counselling. The centres also act as meeting places for the youth, and provides space for community mobilisation and training. Condom demonstrations are provided together with condoms to the clients. The window period for HIV conversion is also

discussed with clients; they are encouraged to return for more counselling and another test after three months if they wish.

IRC reaches clients through relatives and friends, health workers, posters and signs etc. The majority of clients are youths between 18-25 years (~ 63%). Kenyan government requires that no one below 18 years of age should receive VCT. However, the VCT counsellor can decided to counsel and test clients <18 years in rare and special circumstances. It is believed that youth use these services to help them plan their future.

Between April and October 2002, 1602 persons were counselled and tested for HIV of whom 373 were female and 1229 were male. Among the females, 22 (5.9%) were positive while 21 males (1.7%) were positive. Seventy-five percent of HIV positive persons are less than 30 year of age. Post-test clubs are very popular. Voluntarism and confidentiality is strictly enforced; coded results are locked in a cabinet. These codes are on the clients cards and only the counsellor has access to them. Clients are advised to give their mother's maiden name or another name they can easily remember to use for confirmation together with their code. Post test counselling is used. Training of community by community outreach teams has been employed. CDC and NASCOP has developed a user-friendly data management tool using EPIINFO software.

Lessons learned include the importance of training and HIV/AIDS education and community mobilisation before VCT is established. The quality of the training of staff is very important. Ways forward including extending VCT services to other camps (i.e. Dadaab refugee camp) and to redesigning the VCT HIV prevalence report. Various challenges faced include the high turnover of staff due to resettlement, as well as various cultural and religious issues that must be considered throughout the process (see Appendix 8 for PowerPoint presentation).

Before group discussion, Dr. Spiegel stated the following points:

- Among and between the three countries, there are huge variations between VCT programs in the camps.
- Testing algorithms, type and sufficient supply of HIV tests, and quality of labs vary greatly.
    - Many places do not have a specified tie-breaker test.
    - This has particularly been a problem in Uganda.
- Some camps use static VCT centres while others use mobile VCT centres.
- Reporting formats for VCT services varies greatly, with only Kenya having a computer program that allows for good analysis.
    - This program will be shared with all NGOs; they will need to work with UNHCR and their National AIDS Control Programs (NACPs) to modify and implement this programme.
- VCT in Tanzania has been abused by religious leaders to demand that persons who plan to marry have an HIV test; in some cases, if one of the persons is positive, the leader will not marry the couple. This has been addressed by the following manner:
    - Sensitising community and religious leaders on the rationale of VCT.
    - Asking counsellors to emphasise the voluntary nature of VCT to the clients, especially those who plan to get married.
    - Ensuring that counsellors do not write down the results to give to third parties.
    - If third parties wish to have results, after the client(s) agree in writing, all of them can meet with the counsellor to discuss the result.
- Sentinel surveillance data cannot be interpreted for individual camps unless sample size is sufficient; in Tanzania, camps were combined to provide an HIV prevalence per district.
    - Therefore, we must be careful with how we interpret these data.

Group Discussion

- Existing VCT sites:
  - Kenya: two static VCT sites exist in Kakuma refugee camp. No VCT sites exist in Dadaab refugee camps. Sentinel surveillance is planned for Dadaab in Dec. 2002/Jan. 2003 and VCT should be implemented in first half of 2003.
  - Tanzania: static VCT sites exist in all camps. Some are functioning better than in others.
  - Uganda:

    AIDS Information Centre (AIC), a Ugandan NGO provides VCT to populations in Southern Uganda, including refugee settlements (Oruchinga and Nakivale). Their funding comes from USAID who requires them to charge 1,000 Ugandan Shillings for the service. In the two refugee settlements that receive VCT via AIC's mobile clinics, one had to close because refugees were not interested or could not pay the fee while the other has had sporadic service from AIC. AIC has received funding from ECHO to provide VCT services in Northern Uganda that will include numerous refugee settlements; ECHO does not require them to charge a fee and thus the services will be provided to all persons free of charge.

    Mobile sites already exists for Rhino and Imvepi settlements as well as in settlement in Mbarara; ? level of functioning?

    AIC will be implementing with Ugandan Government and UNHCR three VCT sites in 2003: two in Adjumani and one in Moyo.

- Lacor hospital in Gulu, Uganda gives written test results as they are advocating openness and assistance for those who are positive. Discussion regarding individual human rights and confidentiality versus public health risk ensued. Some persons believed that in future HIV results will not be confidential, as drugs will become available, stigma will be reduced, and assistance, both food and non food items will become available.

- Discussion of food assistance to those with HIV/AIDS and others with chronic of life threatening diseases was discussed. Currently it appears that WFP has agreed to provide different amounts of supplemental food to AIDS patients in different camps/regions. Questions regarding supplemental food for HIV positive persons compared to those with AIDS was discussed without conclusion. Ways to ensure confidentiality of HIV status but still allow persons to receive supplemental food were discussed. Conclusion is that persons who have AIDS should be considered as any person with a chronic disease, such as tuberculosis patients, and should be labelled "chronic disease" and not AIDS.

- VCT is both a preventive as well as treatment and care service. Studies have shown that VCT can change persons behaviour.

- Prophylaxis for those who are found to be HIV positive was discussed without conclusion. Depends on several factors, including NACP's guidelines (appears that Trimethoprim/Sulfa is given for prophylaxis for bacterial infections while Isoniazid was generally not provided for prophylaxis to those HIV positive persons who do not have active tuberculosis.

Recommendations Coming from Group Discussion

1. VCT testing protocols should be standardised.
   a. If possible, three different rapid tests should be used: i) screening, ii) confirmatory, and iii) tie-breaker.
   b. Same day results should be provided.
   c. Sufficient stocks should be available.

2. Quality control for HIV tests should be implemented.
   a. When possible, VCT counsellors should be trained to perform rapid tests as opposed to laboratory technicians.

3. Standardised data program for VCT questionnaire and results should be implemented in each country based on the Kenyan EPIINFO 2000 version.
   a. A CD of the program will be sent to all countries, who will have to work with NACPS on implementation.

4. Ensuring that VCT counsellors provide only oral results to clients except in exceptional circumstances (e.g. repatriation or 3rd country resettlement) when the client needs a written record.

5. Static or mobile VCT centre depends upon situation.
   a. Ugandan Government has implemented a self-reliance program for the refugees that included providing them large plots of land for living and agriculture as well as freedom of movement; therefore mobile clinics may be appropriate in some situations as people have to travel tens of kilometres to go to static VCT site.
   b. Kenya and Tanzania Governments keep refugees in closed and much smaller camps than the Ugandan government; consequently, static clinics may be easier to implement.

6. Whenever possible, counsellors should encourage couples to come for tests together.

7. All VCT centres in the three countries appear to have sufficient and safe record keeping.
   a. Counsellors should not write down HIV results to give to 3rd parties; if 3rd parties wish to have results, after the client(s) agree in writing, all of them can meet with the counsellor to discuss the result.

8. Refugees should not be charged a fee for VCT. This is a public health service and persons should be encouraged to use it. Consequently, UNHCR will attempt to pay the 1,000 Ugandan Shillings for both refugees and locals who use the mobile clinics in Southern Uganda (Oruchinga and Nakivale settlements).

9. Efficient referral systems should be put in place for those who are HIV positive. Kakuma has developed a form (provided in the Kenya/Tanzania mission report) that includes referrals for more counselling, treatment for opportunistic infections (OIs), religious counselling, supplemental food, etc.).

DISCUSSION OF UGANDAN GOVERNMENT'S INVOLVEMENT WITH REFUGEES AND SELF-RELIANCE STRATEGY

(Sr. Edith Mudhiri, Co-ordinator of HIV/AIDS for Ugandan Government in Arua District and Mr. Christopher Vuzza, HIV/AIDS Government focal point based in Adjumani District)

Ms. Mudhiri

Arua district has 7 counties, 6 sub-counties, and 2 refugee settlements. In 1999, the Ugandan government and UNHCR agreed on self-reliance strategy (SRS). They identified with the local government in the districts the various sectors that they would implement. The Ministry of Health (MOH) was the first sector to be identified and their staff underwent training. National staff and refugee health were employed with the latter's salary paid by UNHCR. Refugees were also added on the government's plans for beneficiaries of drugs. Both Government and UNHCR supply drugs to the hospitals and the referral system benefits both refugees and nationals. The AIDS Information Centre (AIC), a local Ugandan NGO, and the staff from Arua hospital go to refugee settlements to sensitise the refugees on HIV/AIDS. There are insufficient HIV/AIDS counsellors.

Mr. Vuzza

Adjumani district was part of Moyo before but became its own district. It has a population of 222,290 of whom approximately 50,000 are refugees. SRS makes refugees reliant and not refugees as such. In education and community services. The locals have benefited by the improvement of the referral hospitals and the improved referral system (e.g. District received three ambulances instead of the one that was available previously). Training of health workers includes both refugees and nationals. Some District health staff are not content with SRS, primarily because transport is a major problem and they are understaffed; in particular, more nurses are required. In-patient rates is high in Adjumani hospital consisting of many refugees. Some persons feel refugees receive too much aid. The government gives them land to farm and become self reliant, but they still receive goods from NGOs and UNHCR.

Discussion

- Refugees are allowed to move freely in Uganda.
- Besides refugees being given land to farm and raise animals, refugees who are qualified are allowed to get a work permit.
- Role of NGOs has been shrinking in some districts with SRS as Ugandan government takes over functions previously provided by NGOs.
- Births and deaths records are kept. Refugees are registered in settlements and certificates are issued by Ugandan government there.

SUMMARISED MINUTES OF HIV/AIDS AND REFUGEE WORKSHOP
DAY 3: 12 DECEMBER 2002

PRESENTATION– PREVENTION OF MOTHER TO CHILD TRANSMISSION (PMTCT)

(Ms. Masini, UNICEF and Dr. Ngwalle, Norwegian Peoples AID (NPA))

Ms. Tezra Masini, UNCEF, Kasulu, Tanzania

PMTCT is currently being implemented in four districts in Tanzania. In Ngara district, PMTCT included refugees and nationals. A PMTCT needs assessment among refugees was carried out in 2002. Its main purpose was to collect information on the magnitude of the problem, assess the capacity, resources, and training needs as well as to review the current practises. Then training for VCT and improved perinatal practices was conducted for both refugee and national staff. In order to integrate PMTCT into existing maternal child health (MCH) services, capacity building and the hiring of more staff was needed. Lukole camp in Ngara run by NPA was identified as a pilot site. Sensitisation meetings were carried out with the community.

Progress made to date includes the development of an integrated plan, the provision of technical support, modification of existing counselling rooms in hospital, and training for the laboratory and VCT. Constraints included delayed funding that made implementing the proposed activities according to a planned timeline impossible, increased workload on staff as well as high staff turnover requiring more training, and meningitis outbreak during this time period. Lessons learned included the need for high level commitment from all partners, integration of PMTCT activities with existing MCH programs and not making a parallel PMTCT programme, importance of technical guidance and the sensitisation and training of the community, and close collaboration with the MOH (see Appendix 9 for PowerPoint presentation).

Dr. Ngwalle, NPA, Ngara, Tanzania

PMTCT planning and training began near the end of 2000 and actual implementation began in April 2002. The HIV prevalence among the refugees was very low according to previous antenatal sentinel surveillance results. NPA received funds from UNICEF and began to expand on the rooms for antenatal care, hire additional staff, buy various materials, procure more drugs, and undergo training. Key health staff were trained and then began to be trainer of trainers. The community was also sensitised. NPA visited Bukoba hospital in Tanzania and Mulago hospital in Uganda to examine their PMTCT programme, share their work plan, and learn from their experiences.

Key things of practical importance:

- Existing VCT and MCH programs were used as core of PMTCT programme.
- Pregnant women are provided with comprehensive health education during antenatal services.
- Client first goes for group counselling with other pregnant women for 30-40 minutes and then individual counselling follows to see if woman wishes to give consent for HIV test and possible antiretroviral medications (ARVs) if HIV positive during labour (and dose for the newborn).
- Individual consent and blood is taken by counsellor; in future, the counsellor will also be doing the tests but at present it is done in the laboratory.
- While blood is taken, routine antenatal care continues; results are provided the same day.
- Confidentiality is ensured by using code numbers.

- Obstetrical care nurses underwent training. They use two different delivery sets, two different scissors in operating theatres, and do not use forceps. Newborn is given nevirapine syrup and wiped with a warm solution.
- Pregnant woman is provided a dose of nevirapine at 34 weeks in case she undergoes labour at home and is not able to get to camp hospital. All women are encouraged to deliver at home. The disadvantage is that we are not sure about the drug quality when it is kept by the woman and have to believe the woman if she says she took the drug when her labour started and then arrived at hospital for delivery or with baby after delivered at home. Nevirapine is also available at the maternity ward. If the woman had a false labour and took the medication, she is given another dose at the proper time.
- Follow up of newborn's HIV status is at 15 months. If negative, that's it. If positive, do repeat test at 18 months to ensure he/she is remains positive.
- Exclusive breastfeeding is encouraged up to 6 months with rapid weaning.

Challenges

- Dealing with mother who is HIV positive and wishing to prolong her life as much as possible.
  - In future, give her long term ARVs?
  - Staff and clients who repatriate; not sure of continuation of treatment.
  - Partners of pregnant women who are HIV +ve.
  - Encourage pregnant woman to tell partner and the partner to go to VCT while ensuring confidentiality and protection of pregnant women.

Dr. Gaetano Azzimonti, AVSI, Hoima, Uganda – Discussant

AVSI, an Italian NGO, collaborates with the Hoima District for the implementation of its HIV programme. AVSI provides technical specialists and data collection expert. The PMTCT program is functioning well at the main hospital and the plan is to extend the program to other parts of the District. Have started at one health centre outside of Hoima town one month ago and plan to begin in Kyangwali, a refugee settlement, early next year. Training for counsellors and training of trainers is provided so that refugees will do most of the counselling together with some National staff counsellors.

Individual counselling for pregnant women had an acceptance rate of 97% but AVSI was not able to counsel all pregnant women because of lack of rooms and personnel. Then changed to group counselling but the acceptance rate decreased. AVSI has less counsellors compare to NPA in Ngara, Tanzania. A discussion of the flow of the various PMTCT process by AVSI and NPA occurred. . In Hoima district, most people deliver at home so they give the nevirapine and tell the mothers to bring the baby the next day for the syrup. Dr. Azzimonti stated that proper preparation is the first and minimum requirement for PMTCT. Whenever possible, pregnant women are not being tested alone but as a couple. In Kyangwali, some mothers ask if they will be provided long term ARVs and when told they will not, they refuse to the tested .

Discussion

- Providing Nevirapine to pregnant woman at 34 weeks to take during labour or giving it to pregnant women only at hospital:
  - Refugee camps in Kenya and Tanzania are relatively small and delineated as compared to large Districts. Therefore, it is possible for women in camps to get to the camp hospital before or during delivery and receive Nevirapine there. Furthermore, the trend over the last few years is for the majority of women in the camps to deliver in the camp hospitals.

- This may not be the case in Uganda where settlement are very large.
- When making decisions on HIV/AIDS programs for refugees, national programs and protocols may need to be modified to suit the unique environment of refugees.
  - Pregnant women who are HIV positive must be encouraged to deliver at hospital.
- Need to treat them as high risk pregnancy patients to ensure that they are followed closely.
  - URCS refers pregnant women who are HIV positive to the main hospital at an early stage to avoid complications.
- This can be expensive as woman stays in hospital longer than normally would be and is disruptive to her household, especially if she has other children.
- Expanding to other sites in Tanzania.
  - Dr. Spiegel mentioned that UNICEF may be under some pressure by donor to expand to other sites in Tanzania. However, he felt that there was much to learn from Ngara before expanding.
  - UNHCR sent a consultant to Ngara to examine the data collection system and various indicators used to monitor and evaluate the programme. The report will be ready by January 2003.
  - Other NGOs in Tanzania said they were ready to begin in January 2003. The have been trained and their populations were sensitised.
  - Still some questions to be answered and indicators need to be finalised. For instance, if an HIV positive woman delivered her child at home but did not take her nevirapine and now comes to the hospital with her newborn soon after birth, should the child receive nevirapine?
  - UNHCR, UNICEF and NGOs agreed to hold further meetings to discuss expansion before it goes ahead.
- Some minimum requirements before implementing PMTCT.
  - Basic antenatal care (e.g. screening for and treatment of STIs).
  - Functioning HIV/AIDS program with minimum essential elements.
  - Functioning VCT.
  - PMTCT exists in the host country's National AIDS Control Program policies.
  - Funding for training, building appropriate space in hospital and antenatal clinics (ANC), hiring of staff, etc.
  - Time to implement program carefully.
  - Examine stability of refugee situation. Concern regarding starting complicated and long term programs when repatriation may be imminent.
- Encouraging HIV positive woman to disclose results to partners.
  - Those pregnant woman coming for to the ANC for the first time are encouraged to come with their partners. However, some undergo counselling and either don't come back for anymore ANC or refuse to be tested.
  - Debate ensued about disclosure of results to the partners and potential abuse from husbands. One participant discussed time when partner was told about his wife's HIV status and then he abandoned the wife and children.
- Public health versus individual human rights.
  - Discussion ensued regarding rights of child to have chance to reduce HIV infection versus right of mother's confidentiality and her choice to decide to have HIV test and then take ARVs.
  - In some PMTCT circles, opting out is being implemented. Here, the pregnant woman at the ANC site is told of the various tests that will be taken, including haemoglobin, syphilis and HIV. She does not undergo counselling for HIV and it is up to her to opt out = say that she does not want any or all of the tests. If she does not do so, she tested for HIV. This is not common practise yet and cannot be considered unless it is the host government's policy.

PRESENTATION– HOME BASED CARE (HBC)

(Dr. Ngwalle, NPA)

HIV Program in Lukole, Ngara, Tanzania started in 1997. In 2000 noted that chronic diseases, many due to AIDS were taking up 30% bed occupancy for adults. NPA began to register all chronically ill patients and found there were 158. In order to reduce the amount of chronic disease bed occupancy in hospital, NPA decided to implement HBC in the camps. Training of health providers in the clinical case definition of AIDS occurred and 122 patients were identified. Established HBC teams that comprised of clinical officers, counsellors, nutritionists, and community health workers. There were some people in community that were also Another training in early 2001 was done. There were approximately 20 community based groups in the camp doing a wide range of activities. NPA registered the various community groups and trained them on HBC for AIDS patients. These activities are voluntary and the groups are not paid or provided an incentive. However, there work was haphazard and disorganised. They had no transport to get around the camp to visit the various patients in their homes.

The key elements of HBC are to provide community-based care to AIDS patients consisting of clinical care, nutrition care, counselling including spiritual aid as well as to educate the provider of the services, family members and neighbours. Referrals for HBC come from the community based volunteers, the community health workers, and clinic and hospital.

There are many challenges: stigma is still very high, dependency on the government authorities, insufficient and disorganised volunteers with large number of clients. Orphans have been identified but are not tested for HIV. However, they receive HBC. The future plan is to continue with the program and attempt to reduce stigma. NPA plans to establish HIV clubs and link VCT to HBC.

As of last month, 134 people were registered in HBC program (see Appendix 10 for PowerPoint presentation).

Discussion

- Composition of various teams and frequency of visits:
  - There are 2 teams, one organised by NPA that are facility-based composed of doctors, nurses, counsellors, and others listed above and another team organised by the community consisting of community volunteers. All have received training.
  - When visiting a chronically ill patient, the facility-based teams send one person to visit one patient. They try to match the patient's needs with the person's skills, but generally the same person visits the patient for future visits.
  - Facility-based team has two days to visit in a week; so if lots of patients, very difficult to see them consistently.
  - AVSI HBC teams visit patient with 2 counsellors, and a neighbour; sometimes he feels they create stigma by doing this.

    It was suggested that an NPA team with varying skills visits a patient in order to assess and provide needed care.
  - Volunteer teams have between 4-6 individuals with a supervisor; generally a mixed group from the refugee camp. As with the NPA teams, one person is organised to be visiting the same person all the time.
  - Regarding volunteers, a debate ensued regarding volunteerism versus better organised care with provision of incentives such as packages with gloves, cleaning materials, etc.. as well as T-shirts and bikes.
  - Suggested that people living with HIV/AIDS should be included as part of volunteer teams.

Agreed but there are few people so far in camp who have come out and declared themselves HIV positive.

- Maintaining confidentiality of AIDS patients.
  - HBC is for chronically ill patients not just AIDS patients (e.g. TB, cardiac, etc.) However, realistically, community has an idea who has AIDS.
  - Developed referral codes that were put on patients' cards so HBC volunteers would not know diagnosis of patient when became sick and felt needed to be referred to hospital. This did not work because the refugees removed their own codes from the cards.
  - If NPA HBC team went to household, would park car away from house and walk in order to attract less attention.
  - Concern mentioned that if NPA group went as team to house it would draw attention.
  - There are different levels of stigmatisation and discrimination in the countries and camps we are operating in. In Uganda, it appears the level of stigma has gone down compared to Kenya and Tanzania. How we implement programs depends upon this.

TASO, a local Ugandan AIDS organisation, has a good book on HBC for reference. We need to sort out the IEC materials to be used in refugee affected areas ensuring they are in local languages. Books for educating the refugees about HIV/AIDS are needed. All things selected will be printed and sent to refugee affected areas. Immediately and who should be responsible. The posters that required different wording were done.

POST EXPOSURE PROPHYLAXIS (PEP)

A policy is in place to have PEP available to all UN employees in all duty stations. This does not apply to NGO staff or refugees. UNDP receives the PEP kits and provides it to UN agencies within that country. PEP is to be used for occupational exposure and cases of rape. It is only to be prescribed by a doctor. However, most participants agreed that PEP kits were not available to UN staff in most duty stations. NGO workers need to ask their headquarters what their policy is regarding PEP for their workers. Each kit costs approximately US$ 230. Organisations need to educate their staff regarding their policies and guidelines for PEP.

There is currently a sexual gender based violence pilot study underway in Tanzania with IRC and UNFPA to study the use of PEP for rape cases in refugees. Depending upon the results of the study, PEP may become officially available to refugees in camps post rape.

PLANNING SESSIONS FOR 2003

For the rest of the afternoon, groups according to country were formed and planning for 2003 occurred. Groups were asked to produce a standardised matrix using the headings from Dr. Spiegel's mission reports (i.e. prevention and its subheadings, care and treatment and its subheadings, and surveillance, monitoring and evaluation and its subheadings). Groups were asked to prioritise their activities. For each activity, a column should be added for 1) who provides funding, 2) if funding exists for 2003, 3)- if funding is from UNHCR, state whether it is or needs to be from core funding (i.e. country budget) or from headquarters (i.e. HIV VAR project), 4) approximate amount.

Uganda team undertaking HIV/AIDS planning for 2003

SUMMARISED MINUTES OF HIV/AIDS AND REFUGEE WORKSHOP
DAY 4: 13 DECEMBER 2002

PLANNING FOR 2003

Country priorities for HIV/AIDS programs depend upon existing programs. All countries stressed importance of behavioural surveillance surveys, home-based care, and post-exposure prophylaxis for their staff. Dadaab and Uganda also stressed sentinel surveillance among pregnant women and those with STIs and implementation or improved VCT services.

On the following pages you will see the Presentations of Plans for 2003 by country presented to the workshop.

Following the presentation of the country plans, Dr. Spiegel summarised the main points of the workshop and thanked the participants for their active and valuable participation. He then officially closed the workshop.

KENYA

Introduction

About 210,000 refugees, mostly from Somalia and Sudan, live in camps in Dadaab and Kakuma in North Eastern and Turkana Provinces. Majority of the refugees were in the camps for more than 8 to 10 years. While Southern Sudanese are mostly Christians, Somali are mainly Moslems. Both communities practice polygamy, multiple marriages and wife inheritance, conditions that increase transmission of the disease.

Both Kakuma and Dadaab camps are located in arid regions of Kenya not suitable for cultivation. They are far from economic centres of the country. In addition, the encampment policy of the Kenya Government limits movement of refugees outside the camps. Therefore, refugees have hardly any access to labour market and are highly dependent on food donation.

Poverty, loss of hope, powerlessness, idleness and social instability is highly prevalent in the camps; factors that favour spread of the disease. Behavioural assessment carried out in Dadaab and Kakuma by UNHCR and IRC suggest that considerable number of refugee women exchange sex with gifts while many girls start sex as early as 10 years. Use of alcohol and other drugs is common in the camp, including youth groups. Condom acceptability is quite low and denial of transmission of HIV/AIDS by various refugee communities is highly prevalent. Gender inequality among the refugee community lead to increased risk of HIV to women in general and to young girls in particular.

According to antenatal sentinel surveillance, prevalence of HIV is 5% in Kakuma and 14% in Garrissa town. The prevalence of the disease is not known in Dadaab camps, although it is generally believed that it is low. However, refugees in Dadaab camps share the same cultural and religious background as the population in Garrissa town and the two groups interact considerably. It is unlikely that the prevalence of HIV in Dadaab is very different from that of Garrissa town.

Safe blood transfusion, universal precautions, condom distribution and limited awareness raising of the disease among the refugee population had been established in the camps early in the refugees program. STD case management and syphilis screening are also ongoing activities. In 2002, IRC has introduced voluntary HIV testing and counselling and prevention of parent-to-

child transmission. However, control of the disease in Dadaab is still limited to the above "essential minimal elements" that were introduced 10 years ago.

In both camps, there is an urgent need to strengthen ongoing HIV control activities and to expand the services both in prevention and care components. Kenya program took the opportunity provided by the HIV/AIDS workshop held in Kampala in December 2002 to review HIV/AIDS control activities in the camps and to plan for 2003. The activities outlined in the table below reflect measures agreed by the stakeholders to be implemented in 2003 with a view to strengthen ongoing activities and to introduce important missing elements.

Situation analysis (magnitude of the problem)

HIV prevalence

	Kakuma	Dadaab
Antenatal surveillance	5% in 2002	?
Blood donor screening	3.9% 2002	
VCT	2%	
STIs Sentinel surveillance	9%	
TB patients	28.3%	
ANC syphilis	7%	

The prevalence of 5% among the antenatal women is a good estimate of the level of the disease among adult population 15-49 years. Assuming situation is stable (mortality is equal to incidence of the disease) among the 32,000 adults in Kakuma, 1,600 are expected to be HIV positive. From the 3,000 deliveries in 2002, 150 mothers are expected to be HIV positive. Assuming transmission from mother to child is 25%, 40 of the children born to the mothers were HIV positive. While the yearly incidence of the disease is not known, if we assume an incidence of 0.4% yearly, about (0.4%X32,000) about 128 new cases are expected from the current Kakuma population every year.

Nonetheless, the number of refugees known to have HIV or AIDS in the camp is quite low. The difference probably is a good reflection of the gap in the information of the HIV/AIDS in the camps and how much progress need to me made in this area. In the case of Dadaab, no meaningful comment could be made due to lack of information

Prioritisation

For Kakuma, the activities are ranked as follows:

1. Strengthening condom promotion and distribution.
2. Development of appropriate IEC materials.
3. Strengthening of Universal precaution.
4. Strengthening STI case management.
5. Introduction of home based care.
6. Expansion of youth centres and introduction of life skill training, peer educators and RH services.
7. Repeat sentinel surveillance activities.

For Dadaab, the activities are ranked as follows:

1. Antenatal and STI sentinel surveillance.
2. Assessment on behaviour change and communication.
3. Introduction of VCT.

4. Strengthening of condom distribution and promotion.
5. Strengthening case management of STIs.
6. Development of appropriate IEC materials.
7. Establishment of youth centres.
8. Introduction of home based care.

In both camps, community participation and multi-sectoral approach are considered as crosscutting issues that will be pursued in 2003. Mitigation of strong cultural and religious barriers to the implementation of the HIV control activities will be streamlined in the various activities of the assistance program.

KAKUMA

Ongoing Activities	New/Future Activities	IP & timeframe	Funding
Prevention Universal Precaution - Sterilisation/disinfection at the health facility is adequate. - Hand washing facility with running water and soap in place. - Safe Disposal of sharps and medical waste is generally adequate, but needs installing incinerators at the health clinics. - Protective gears; most of the materials (gloves, aprons etc) required in the delivery ward and at the health clinics are available. - Training of the health workers is planned. - HIV denial and stigmatisation of HIV positive individuals is quite high among the refugee community.	2 extra incinerators Mobilise community through various groups such as women, youth, leaders etc. Involve PLWAs in the de-stigmatisation process. Develop standard HIV-education package for use by all agencies in the camps.	IRC - June 03	UNHCR
Blood transfusion screening all in place; blood is screened of HIV and Hepatitis B.	Guideline on indications for blood transfusion needs to be put in place	IRC – Mar 03	IRC
Condom distribution and promotion are currently carried out through the Community Health Workers and NCCK. Supply is irregular and documentation of distribution is incomplete. Channels of distribution are quite limited. Strong cultural and religious barriers of condom use exist.	Increase the supply to meet 300/1000/month for male and 50/1000/month for female. This will be 300,000 male and 48,000 female condoms per year. Review the distribution system to increase channels of distribution and target groups; Sex workers, Bar owners, youth etc. Promote proper use and disposal of the condoms Mitigate misconceptions on condom use. Develop short and long strategies to address cultural and religious barriers to the prevention and control of the disease. Link condom promotion with peer educator’s training.	IRC Throughout 03	UNFPA

Ongoing Activities	New/Future Activities	IP & timeframe	Funding
Voluntary Counselling and Testing (VCT) in place	Post-test clubs to be strengthened. Refresher training of health workers and counsellors and community sensitisation are required.	IRC - May 03	CDC
Prevention of Mother to Child Transmission (PMTCT) in place	Additional space and equipment is required. Expansion of counselling capacity is needed.	IRC - July 03	UNHCR CDC
Prophylaxis of OIs and TB in place	Additional stock for INH, co-trinoxazole, antifungals are required.	IRC - April 03	UNHCR
Community participation and multi-sectoral approach are weak.	Guideline on multi-sectoral collaboration should be developed along the lines of the SGBV guideline with a view to develop co-ordination mechanisms both at Kakuma and Nairobi levels. Community participation should be strengthened, although a suitable platform of doing this needs to be identified. Promote a more effective form of participatory educational theatre in the camps. Identify focal person in each agency.	IRC - June 03	UNHCR
Youth centre: Ongoing Kakuma I, but does not exist in Kakuma II and III.	Extra centres Kakuma II and III Strengthen reproductive health education in schools. Training of peer educators among youth in and out of school. Introduce Ministry of Education Curriculum on HIV/AIDS in the schools. Increase youth vocational training.	IRC NCCK LWF – August 03	UNHCR CDC
Home Based Care (HBC) and palliative treatment.	To be introduced in 2003	IRC - June 03	CDC
IEC lacking, including effective general community mobilisation and HIV/AIDS information/education (BCC)	Develop IEC materials for VCT and for HIV/AIDS education; posters, leaflets and flipcharts in local languages.	IRC - April 03	
STD services ongoing but weak	To be strengthened along the recommendation of Dr. Otido consultancy.	IRC - March 03	
Needs of specific risk groups are hardly addressed in the camps.	Develop strategies addressing the needs of specific target groups such sex workers, HIV/ADS positive and youth.	IRC - March 03	

Ongoing Activities	New/Future Activities	IP & timeframe	Funding
Surveillance	Health information format to be modified to include HIV/AIDS data. BCC surveys and ANC/STI sentinel surveillance to be continued in 2003. Documentation clinically of AIDS patients in the to be promoted. Use VCT, STI data for surveillance.	IRC - Jan 03	UNHCR CDC
Training needs and implementation should be systematically documented.	Training needs in each camp should be identified and planned for in 2003.	IRC - March 03	

DADAAB

Ongoing Activities	Future Plans and Strategies	Action/IP	Funding
Voluntary Counselling and Testing (VCT).	To put one VCT in each of the 3 camps. Training of HIT, CSW, and Counsellors etc. Form post VCT clubs and form HIV support group(s).	IRC, MSF-B NCCK - April 03 CARE	CDC, UNHCR CDC
PTCT	Explore possibilities of establishing the services after the VCT takes off.	IRC - Sept 03	UNHCR, CDC
Prophylaxis of OI and TB ongoing.	Co-ordinate these activities by linking tuberculosis treatment with care to AIDS patients.	MSF - March 03	UNHCR
Palliative care Nutrition	Establish these services within the home based care.	MSF, CARE	UNHCR, WFP

Ongoing Activities	Future Plans and Strategies	Action/IP	Funding
Prevention: Activities of universal precautions are in place, however, goggles and masks are absent in the health facilities. Condoms distribution is quite weak and cultural and religious barriers are strong. HIV denial and stigma among the community is quite strong.	Assess adequacy of the existing measures and Strengthen existing activities; e.g. use of incinerators for disposal. Increase condom distribution/supply usage to 300/1000/month for males and 50/1000/month for female. Mitigate cultural and religious barriers to the use of condoms. Participatory development of an advocacy package for abstinence, faithfulness and condom use. Promote condom use through the peer educators. Mobilise the community through peer educators among the various community groups. Involve PLWAs in the advocacy against stigma. Develop standard HIV education package, which could be equally used by all agencies in the camps.	MSF - Feb 03 MSF-B/NCCK - June 03	UNHCR UNFPA MSF-B
STI services in place.	Assess facilities and confidentiality before establishing STI services on syndromic management within the outpatient departments and antenatal clinics. Adequately equip the clinics to ensure proper examination and confidentiality. All outpatient clinics should be equipped similarly. Train health workers on syndromic case management. Strengthen contact tracing and outreach follow of the STI services. Target special risk groups such sex workers and youth.	MSF - ongoing	UNHCR

Ongoing Activities	Future Plans and Strategies	Action/IP	Funding
Surveillance	BCC survey has been completed. Conduct antenatal/STI HIV sentinel surveillance. Include HIV/AIDS reporting in the monthly health information format. Use statistics from - ANC - Case determined clinically - VCT data - STI prevalence data	MSF/UNHCR Complete by March 03 Ongoing in 03	UNHCR
HBC	Harmonise ongoing activities in Dadaab camps in preparation of setting a HBC. Use national guidelines to establish the services. Identify possible existing voluntary groups in Dadaab camps. Train CHWs, CSW and various community groups on HBC. Develop HBC along the Ngara experience. Link HBC services with the clinical care provided in the health centre. Involve other stakeholders such as community services NGOs.	MSF NCCK CARE June - 03	 UNHCR
PLWAs	Arrange visits of PLWAs to the camps to educate and share experiences with the refugees. Explore the stigma level before introduction. Give social support to PLWAs in the home based care.	MSF NCCK CARE UNHCR Consider this in September 2003.	UNHCR
Orphan Ongoing	Register with UNHCR Foster parents	CARE UNHCR May 03	UNHCR

Ongoing Activities	Future Plans and Strategies	Action/IP	Funding
Blood Donor ongoing	Assess if Hepatitis B is screened. Introduce national blood transfusion guidelines of Kenya in the camps.	MSF May - 03	UNHCR, CDC
Youth centres activities exist in Dadaab camps.	Review existing services and accordingly establish youth centres that will act as recreational facility for the youth in the camps. Train the youth on life-skills and establish peer educators. Provide RH services in the youth centres in co-ordination with the services provided in the health centres. Introduce Ministry of Education curriculum on HIV/AIDS in the schools. Increase youth vocational training.	MSF/NCCK March - 03 CARE July - 03	UNHCR
Community participation; hardly exist. Co-ordination of control activities is weak.	Establish linkage with existing community groups who can support HIV/AIDs control activities. Develop guideline on multi-sectoral approach along the same lines as the SGBV guideline. Improve participatory educational theatre activities in Dadaab camps. Identify a focal person for HIV/STI in each organisation.	MSF/NCCK/CAR E March - 03	
IEC materials are lacking	Develop group specific posters, leaflets and flip charts in the local languages	MSF/NCCK/CAR E March 03	UNHCR
Training	Identify training needs in the camps related to HIV/STI promotion.	IRC - March 03	
Collaboration with the reproductive health activities in the local population.	Co-ordinate HIV/STI activities in the camp with those in the District.	IRC - March 03	
Monitoring and evaluation.	Develop indicators for monitoring of programs in each camp and agree on expected impact as a benchmark for evaluation. Use existing protocols of Ministry of Health.	IRC - March 03	

TANZANIA

Introduction

After extensive discussions and wide range sharing of experiences on HIV/AIDS control activities in the refugee camp settings in East Africa during the Entebbe workshop 10–13 December 2002, UNHCR, UNICEF and representatives from Implementing Partners (TRCS, NPA, IRC, CORD & UMATI) in Western Tanzania agreed on a plan of activities to be implemented in 2003 based on the mission report of Dr. Paul Spiegel of June 2002.

Tanzania is hosting about 500,000 refugees in western Tanzania who hail from Burundi, DR Congo and Rwanda. Some of these refugees have been in Tanzania since 1994. Although HIV/AIDS control activities have been introduced in all the refugee camps since their inception, not much significant behavioural change has been observed among the refugees and hence the challenges to enhance and introduce more interventions to avert the pandemic. No comprehensive behavioural change and communication studies have been undertaken in order to gauge any changes. HIV sero prevalence among the refugees ranges from 2 to 10% compared to at least 15% in the general Tanzanian local population.

As is the case in all refugee situations in Africa, idleness, hopelessness, powerlessness and poverty is glaring in these refugee camps. Prostitution as a means of survival or making ends meet is quite common too and there are all kinds of harmful practices, traditional and otherwise, which are of concern because they will make worse the pandemic.

HIV/AIDS control activities introduced in these camps comprise universal safety precautions, screening blood for HIV and hepatitis B, syphilis screening for all pregnant women, condom promotion and distribution, syndromic management of STIs and making available IEC materials to the refugees including mobilising the refugees themselves to undertake drama and other folklore activities to make the larger uninformed refugee community get to understand and act accordingly on the pandemic. In spite of these efforts, a lot remains to be done in the area of PMTCT, VCT and even in the other preventive, promotive, support and care of those individuals and families affected by the disease.

In Tanzania UNICEF, UNFPA, IPs and UNHCR are making every effort to jointly work together to fight the pandemic. Below you will find the activities identified which are planned to be undertaken in 2003 in the spirit of the continued fight against the pandemic.

Activities and resources available for 2003 programs

Activities	Funding /supplies possibilities
Condoms	UNFPA
Training of new VCT counsellors	UNFPA
Training of Supervisors of VCT counsellors	UNFPA
Reprinting of IEC – small grants	UNFPA
Training of facilitators on community based response to HIV/AIDS pilot site Kibondo	UNFPA
Reproductive health training (on request)	UNICEF
Prevention of maternal to child HIV transmission	UNICEF
Adolescent sexual and reproductive health	UNICEF
Orphans care and support	UNICEF
Development of IEC materials related to reproductive health interventions	UNICEF

Gaps identified in the current HIV/AIDS program activities

1. Prevention: Inadequate training on universal safety precautions and blood supply to lower and middle level health staff.

2. Safe blood supply: Inadequate supplies for screening blood donors and persons presenting themselves for VCT.

3. Behavioural change and communication: Baseline surveys to be conducted for the purpose of ensuring more effective strategies to facilitate positive behavioural changes.

4. Voluntary Counselling and HIV testing: Training of 20 additional counsellors to cope with the increasing turn up of VCT clients. Construction of counselling rooms in Lugufu camps.

5. Care and treatment of STIs and HIV/AIDS: There is a need to strengthen and improve care and management of patients referred from STI clinics, VCT, PMTCT and home based care programs. Training of clinical officers and assistant medical officers on management of opportunistic infections.

6. Home Based Care: Training of HBC support groups of volunteers using the national guidelines.

7. People living with HIV/AIDS: As the strategy to fight stigma opportunities to PLWHA to go for inter camps exchange visits.

8. Care and support to orphans: Cost effective and practicable proposals for orphans care and support are invited by UNICEF from all IPs.

9. Sentinel surveillance: Resources allocated in the regular budget is not sufficient to cater for surveillance as well, additional resources especially RPR, capillus and determine test kits.

10. Training: Development of soap radio scripts as a means to achieve rapid awareness raising. Inter camp and inter country exchange visits to enhance knowledge, practice and skills through the exchange of experiences.

Prioritisation of activities and additional financial needs for 2003

The following activities will only be undertaken if we can get the additional funds highlighted against each activity. Hopefully, the office of the HIV/AIDS Technical Advisor at HQs. will try his level best to get us the needed funds.

1. Orientation and adaptation of FHI guideline.
   Five days workshop for 25 participants US$ 8,000.

2. Behavioural change and communication baseline surveys in six refugee camps US$ 20,000.

3. Training courses on:
   a. Monitoring and evaluation of HIV/AIDS programs - 25 participants (tailor made training) – US$ 50,000 to be conducted in May or September 2003.
   b. Management of opportunistic infections - 25 clinicians and AMOs one week in March – US$ 2,500.
   c. Syndromic management of STIs / health education - 3 days training 25 participants to be conducted in April –US$ 1,500.
   d. Training of 20 new VCT counsellors six weeks training --US$ 8,000.

4. Development of soap radio scripts on HIV / SGBV/ Gender. Radio Kwizera and expanding other local radio networks - US$ 20,000.

5. Sentinel surveillance, VCT and safe blood supplies.
    a. Capillus 370 kits – US$ 82,500.
    b. Determine 37 kits – US$ 82,500.
    c. RPR 100 kits- US$ 4,000.
    d. Vacutainers 1,500 pcs – US$ 225.

4. Construction of counselling rooms in the Lugufu camps – US$ 3,800.

5. Exchange visits.
    a. 6 locations @ US$ 1,000 making a total of US$ 6,000.
    b. Inter country 6 locations @ US$ 2,000 making a total of US$ 12,000.

TANZANIA

ACTIVITY	CURRENT SITUATION	GAPS	NEW FUTURE ACTIVITIES	IP	FUNDING
Universal precautions.	Disinfection and sterilisation in all the health facilities is adequate. Running water and soap are available. Safe disposal of medical wastes in place. Protective gears are available in the wards and delivery rooms.	None	Continue to maintain the precautions without relenting. Train new staffs on universal precautions and refresh the old staff.	All IPs	UNHCR
Blood transfusion screening.	All blood is screened for HIV and Hepatitis B.	None	Maintain same standard.	All IPs	UNHCR
Condom distribution and usage.	Condom promotion and distribution is done through the health facilities, youth centres and toilet facilities. There are no female condoms introduced.	Usage rates very low across the board.	Find out reasons for poor usage of the male condoms and come up with more effective messages of promotion. Introduce and promote use of the female condom. Review the distribution system.	IPs	UNFPA
Voluntary Counselling and Testing.	Successfully introduced in 2002 by NPA and IRC in the camps they are working. CORD and UMATI are yet to start VCT in the camps under their jurisdiction.	Training of new VCT counsellors for the CORD and UMATI staff and additional one for NPA and IRC to be able to cope with demand.	VCT cautiously introduced and operating well in all the camps. Trainings undertaken for VCT counsellors and VCT supervisors. Construct VCT counselling rooms in the Lugufu camps.	All IPs	UNFPA
PMTCT.	Started only by NPA in the Ngara camps.	Non existent in the other camps.	Very cautiously replicate the Ngara program to the other camps	All IPs	UNICEF
Prophylaxis of OIs.	There are adequate stocks of cotrimoxazole and INH.	The clinicians are untrained.	Train the clinicians (Clinical Officers and AMOs) on management of OIs using the Tanzania Guidelines.	All IPs	UNICEF
Multi sectoral approach community participation	Attempts to involve and ensure refugees actively participate in HIV/AIDS activities have been	Many	Liaise with UNICEF, UNFPA, WHO and the IPs on how to go about this and resources required.	IPs	UNHCR / UNFPA

ACTIVITY	CURRENT SITUATION	GAPS	NEW FUTURE ACTIVITIES	IP	FUNDING
dynamics.	initiated by NPA and IRC, but need more fine tuning to ensure that the refugees themselves own these activities and continue to implement them without so much push by the IPs. There are no standardised guidelines on what the multi-sectoral approach is and how to implement it as it relates to HIV/AIDS programs .		Train Facilitators on community based response to HIV/AIDS (pilot project in Kibondo).		UNICEF
Behavioural change and communication (BCC).	Some enlightened campaigns and messages in form of workshops, seminars, IEC materials, dance and drama groups are taking place but no significant change has been observed e.g. condom usage is very low and STIs prevalence is not going down. We need baseline information and data against which to gauge BCC.		Baseline behavioural change and communication surveys planned in 6 of the camps.	All IPs	UNHCR
Youth Centres.	There are youth centres in all the camps. Some of the youth centres are already very good conduits for the youth to access condoms and STI services.		Enhance / current introduce more youth activities but upon agreeing with the youth what activities to introduce and / or enhance. Train peer youth educators on HIV/AIDS and STIs. Train key health staff providing STI services on the syndromic management of STIs.	All IPs	UNICEF
Home Base Care (HBC).	Initiated in the Ngara camps but still weak.	No guidelines and no trainings undertaken.	Resources permitting guidelines will have to be developed and trainings undertaken for persons involved in HBC and co-ordination structures established.	All IPs	
HIV/AIDS surveillance	Sentinel surveillance was started last year but has yet to be consolidated and	Training	Train key health staff on monitoring and evaluation of HIV/AIDS programs .	All IPs	UNHCR UNICEF

ACTIVITY	CURRENT SITUATION	GAPS	NEW FUTURE ACTIVITIES	IP	FUNDING
(monitoring and evaluations).	information collected analysed and made use of in terms of enhancing control activities. Reporting of AIDS cases and deaths needs to be streamlined. Reporting formats are yet to be agreed upon and put into use.		May / September 2003. Purchase additional capillus, determine RPR kits and vacutainers.		
Care and support to orphans.	Foster parenting of orphans and unaccompanied minors is the only means thus far being promoted by UNHCR and the IPs. UNICEF is willing to fund cost effective and practicable proposals.	Many	Needs assessment and proposals development and discussions with UNICEF.	All IPs	UNICEF
IEC materials development.	A few posters on HIV/AIDS have been developed in the local languages of the refugees which need to be reviewed and also new ones developed with the participation of the refugees. There are some drama and dance groups but no leaflets, teaching aids, news papers or school programs focussing on HIV/AIDS.	Several	Reprint and Develop more IEC materials. Develop soap radio scripts. Inter camp and inter country exchange visits to enhance knowledge, practice and behavioural change through exchange of experiences.	All IPs	UNHCR / UNICEF.

UGANDA

Introduction

Currently, Uganda hosts approximately 195,175 refugees. The majority of refugees are from Sudan who are about 85.3% of the total refugee population. In addition other refugees come from other countries such as Rwanda and Congo, compromising of about 14%. The remaining 1-% is from Somalia, Kenya, Ethiopia, Burundi and Eritrea.

Sudanese refugees have mainly been settled in the northern part of Uganda in Arua, Adjumani, Moyo, Hoima and Masindi Districts. Rwandan, Somalis and the rest of the refugees are settled in the southwestern part of the country in Mbarara, Hoima and Kyenjojo Districts.

Refugees are vulnerable to HIV/AIDS because of the situations they go into during fleeing process, during repatriation and in camps. In the camps ,there is social structure break down, powerlessness, idleness and poverty, this refugee situations are conducive to high-risk sexual behaviours and sexual abuse. Reports from the out patients department in the refugee settlement units between show high incidences of STI/STD (43/1,000 in 2001). This shows that partners have unprotected sex and therefore likelihood to get HIV infection. Condom acceptance as safer sexual practice among the refugee population still remains low despite stocks of condoms available in the districts.

The HIV/AIDS prevalence among the refugee population in Uganda is reported to be very low. The actual prevalence of the disease among refugees has not been established. Reported HIV/AIDS cases as per Health Information Management System for the past three years is as shown in the Table Below.

Clinical AIDS cases as seen among inpatients:

Year	1999	2000	2001
Total cases	37	63	26
Discharged	28 (0.3% of the Total)	43 (0.27% of the total)	22 (0.18% of the total)
DEATHS	9 (3.09% of the Total)	20 (4.6% of the total)	4 (1.3% of the total)

SOURCE: Health Management Information System, Annual Compilation.

The prevalence rate of HIV could not be estimated on the ground of few admitted cases in the wards. The incidence of sexually transmitted infections has been reported on the average to be 43/1000 refugees per year. It is evident that HIV transmission through sex is still a possibility. The Ugandan National prevalence rate of HIV/AIDS has gone down to 6.1% and this translates to about 10,800 cases of HIV/AIDS assuming that the refugee caseload is of protracted nature.

The magnitude of HIV/AIDS is undetermined partly because of lack of diagnosing HIV/AIDS in the absence of testing facilities and failure to link the existing national surveillance programs with refugee populations. The sentinel sites are far from refugee areas. There is generally poor accessibility of voluntary counselling and testing services in most of the districts for refugee populations, although a few have been established now. A number of HIV/AIDS refugee and national clients are registered and organised in some districts but still there are limited medical, nutrition and ongoing counselling.

Previous assessments of the knowledge, attitudes, practices and behaviours on HIV/AIDS which were conducted in three refugee studies, identified Voluntary Counselling and Testing (VCT) services in the settlement to be in big demand especially amongst the youth. It was also found that there is no viable Community/Home Based Care program for the HIV/AIDS infected and

affected families. Most of the intervention put in place has been addressing issues of advocacy to raise awareness. There were no interventions in mitigating the impact of HIV/AIDS at individual, family and community level. A comprehensive approach is now being promoted in order to link up prevention and care and strengthen monitoring and surveillance of the disease. SGBV is also common among the refugee populations therefore their vulnerability to risks of HIV infection is very high.

Sensitisation on creating awareness and behaviour change about HIV/AIDS is still ongoing in all refugee settlements. Various Information Education and communication activities have taken place. Health workers and Refugees have been empowered with counselling skills, mobilisation skills and community training skills. However there is still need for refresher courses and training's in new skills on care.

There is a school HIV/AIDS program targeting adolescent, young children and out of school adolescents and is more visible in Adjumani and Moyo. A home based care activity providing psychosocial support and education for people living with HIV/AIDS by MACI in Adjumani is being carried out. Palliative care is still lacking in all the refugee settlements. Condom promotion and community based distribution is being strengthened using supplies from Ministry oh Health Uganda. However, there is lack of lack of transport since the settlements are quite big. Voluntary counselling and testing services have been established in collaboration with the district in Adjumani Hospital and Kyangwali health centre. Nakivale, Oruchinga and Arua refugee settlements. VCT centres have been established in some refugee settlements by implementing partners and AIDS Information Centre (Uganda). More sites that are easily accessible to the refugee populations need to be established in Moyo and Adjumani Districts.

During HIV/AIDS held in Entebbe Kampala participant from Uganda came into consensus that there is need to continuously provide HIV prevention and care using comprehensive approaches that include issues on prevention, care and treatment, surveillance, monitoring and evaluation. In line with this, priority issues and activities were identified for 2003 as presented in the , Work Plan 2003 attached.

UGANDA

PREVENTION	IP	CURRENT SITUATION	GAPS	NEEDS/ACTIVITIES	RESOURCES	TIME
Universal precautions	ALL	Disinfecting/sterilisation is done in all the health facilities in Uganda. There is adequate water supply in all the health facilities Safe disposal of sharps and medical waste is adequate. Protective gears are available though some times not enough.	None Not enough Aprons, Gumboots, Mackintoshes	Continue to maintain the precautions. Staff should have continuos refresher training's on universal precaution. Purchase protective gears	UNHCR-BOK, IPS and MOH HQ-VAR	Feb-Dec 03
Blood for transfusion is centralised.	ALL	All blood is screened for HIV and Hepatitis .B.	None	Maintain the same.	MOH	Feb-Dec 03
Condom distribution and usage		Supply is constant for both male condoms and Femidom. Distribution is done through the health facilities, community health workers, volunteers, drug shops and groceries. There is inadequate knowledge by distributors especially shopkeepers. Many men complain about the size of free condoms distributed by ministry of health.	Facilitation of community health educators and volunteers, to sensitise communities on condom use. Lack of training's provided for the shopkeepers and other volunteer distributors. Fin other alternative brands of condoms.	Continue to access supplies from ministry of Health. Purchase bicycles for community volunteers for easy movement.	UNHCR-BOK,CMS,MOH HQ-VAR	Feb-Dec 03
BCC	ALL	Dance and Drama groups, Radio msgs, Games and sports, School health visits programs, Video shows, Leaflets, T-shirts, Teaching Aids, Workshops and Meetings, Debates, Peer Educators, Newspaper prints e.g. Straight Talk (referred to as social vaccine).	Inadequate supply of materials.	Continuity of BCC activities. Purchase materials.	HQ =VAR	Feb-Dec 03

PREVENTION	IP	CURRENT SITUATION	GAPS	NEEDS/ACTIVITIES	RESOURCES	TIME
Youth centre	ALL	None.	Lack of provision of youth services.	Establish and incorporate with other sectors. Provide youth friendly health services	HQ=VAR	Feb-Dec 03
VCT	ALL	Kyangwali (Hoima district). It is available and functioning.	Uptake is very low. Lack of trained counsellors at the health facility. Kyangwali health centre is distance from other refugee populations	Strengthen existing facilities, possibly with AVSI. Train counsellors and community counselling aids. Establish another standing site in one of the health units in the refugee settlements.	HQ=VAR and AVSI	Feb-May 03
		Adjumani refugee settlements [Adjumani]. The site is established in Adjumani Hospital, but not functioning well.	No static VCT site in the refugee camp. There are no HIV testing Kits. There is no standardised VCT Protocol established by the MOH. Lack of electricity and solar energy/panels in refugee health units. No Staff trained on provision of VCT. .	Establish two more new sites in a refugee settlement. in Alere and Mongola. Purchase HIV testing kits for new sites. Follow up with MOH on the standardised protocols and provide to health centres. Purchase solar energy/panels for health units in the refugee settlements Train VCT counsellors.	HQ = VAR , AIC	Apr-June 03

PREVENTION	IP	CURRENT SITUATION	GAPS	NEEDS/ACTIVITIES	RESOURCES	TIME
		Rhino camp and Mvepi refugee settlements [Arua. District]. There are VCT sites established in Arua regional Hospital and AIC, all are function well. AIC has established site in Omugo health centre. AIC also carries out outreach services in Omugo health centre and Mvepi health centre.	Arua regional hospital is very far from the refugee settlements. Omugo health centre VCT services not strengthened. Irregular outreach.	Establish one new sites in a refugee settlement Strengthen HC4 Omugo and Rhino refugee camp.	HQ=VAR and AIC	Feb-Dec 03
		Moyo District. The VCT site is established in Moyo Hospital , but not function well.	No static VCT site in the refugee camp. There are no HIV testing Kits. There is no standardised VCT Protocol established by the MOH. Lack of electricity and solar energy/panels in refugee health units. No Staff trained on provision of VCT.	Establish one new site in a settlement. in Kali HC III Purchase HIV testing kits for new sites. Follow up with MOH on standardised protocols and provide to health centres. Purchase solar energy/panels for health units in the settlements. Train VCT counsellors	HQ=VAR and AIC	Apr-June 03
		Kyaka refugee settlement [Kyenjojo district].	No static sites in the settlements	Start up static site at Bujubuli HC3.	HQ = VAR	Oct-Dec 03

PREVENTION	IP	CURRENT SITUATION	GAPS	NEEDS/ACTIVITIES	RESOURCES	TIME
		Nakivale and Oruching [Mbarara district]. There are VCT sites established in Mbarara University Hospital and AIC function well. AIC has an outreach VCT service to health unit of Oruchinga Health unit once month.	No static VCT site in the camps. Outreach VCT service to Oruchinga settlements once month is not adequate. AIC charges a user fee of 1000 shillings which is quite expensive. No outreach for Nakivale refugee settlement. No standing VCT site in the refugee camp. There is no standardised VCT Protocol established by the MOH. Lack of electricity/solar energy/panels in health units. No Staff trained on VCT	Establish one new sites in a refugee settlement in Nakivale HC . Purchase HIV testing kits for new sites if established. Payment for VCT services on behalf of clients. Liase with AIC to have their out reach services re-start in Nakivale Follow up with MOH on the standardised protocols and provide to health centres. Train VCT counsellors.	HQ=VAR and MOH	Feb-Dec 03
		Kiryandogo refugee settlement[Masindi district] There are VCT site is in Kiryadongo Hospital and it is functioning.	Kiryadongo hospital is far from the settlement and there are no outreach services carried out in the refugee settlements No static sites in the settlements	Co-ordinate with the Kiryadongo Hospital to have outreach services in Kiryadongo refugee settlements. Start up static site at Panyadoli HC.	HQ=VAR and MOH	Jun-Aug 03
Post exposure Prophylaxis	ALL	SGBV incidence is high for refugees but PEP not available. [Non existence.]	No PEP. Health workers at constant risk.	Purchase PEP starter kits.	HQ = VAR	Mar-Apr 03

PREVENTION	IP	CURRENT SITUATION	GAPS	NEEDS/ACTIVITIES	RESOURCES	TIME
PMTCT	ALL	Only available in Mbarara. University Hospital. Some of the refugee pregnant mothers have benefited from this service. Some regional hospitals in the districts which host refugees have this service too, e.g. Arua and Hoima district.	The regional hospitals which the MOH has PMTC services are distance from the refugee settlements. Not existing in other refugee settlements.	Strengthen existing services with MOH. Conduct Needs Assessment to all other remaining camps.	HQ = VAR	Feb-Dec 03
Prophylaxis of OIs	ALL	Availability of Septrin and INH.	Lack of fluconazole which is potent. Lack of additional food nutrients. Lack of guidelines	Purchase fluconazole drugs. Liase with WFP. Provide guidelines.	MOH TB program, / BOK/ WFP	Feb-Dec 03

CARE AND TREATMENT	IP	CURRENT SITUATION	GAPS	NEEDS/ACTIVITIES	RESOURCES	TIME
STIs	ALL	Integrated national STI program in all the sites.	Inadequate knowledge on STI management. Irregular and inadequate supply RPR kits.	Refresher training for all the health staff. Increase supply of RPR kits.	MOH,UNHCR- BOK	Feb-Dec 03
OIs	ALL		Lack of Fluconazole.	Purchase and Provide to all the health units in the refugee settlements.	? HQ- identify donor	Feb-Dec 03
ARVs	ALL	Not available for free .	No funds to purchase ARVS .	Co-ordination with MOH/ NGO facilities in the vicinity.	MOH, NGOs	Feb-Dec 03
Nutrition	ALL	Very minimal in Mbarara (Nakivale) and Kyangwali.	No nutritional support in other refugee settlements.	List all the vulnerable (PWHI) and liase with WFP. Support PLWA with IGA.	UNHCR -BOK /WFP	Feb-Dec 03
Home-Based Care	ALL	Not formalised and lack of co-ordination in all the camps.	Lack of community teams. Lack of co-ordinations. Inadequate support to PLWA.	Integration of home based care in all sectors. Family support for the PLWHA. Community teams./Peer support. Facilitation of logistics and sundries. Provision of drugs. Training in home based care skills.	HQ = VAR	Feb-Dec 03

CARE AND TREATMENT	IP	CURRENT SITUATION	GAPS	NEEDS/ACTIVITIES	RESOURCES	TIME
PLWHAs	ALL	PLWA groups available in some settlements, e.g. MAHA, MACI, AIC and meeting point.	There is stigma and lack of support among refugee populations. There no organised refugee groups as PLWA's in the refugee settlements.	Advocacy. Form support groups. Empower them with skills e.g. tailoring etc. Employment. ARVs-link with e.g. referral hosp. Contact Local available CBOs.	HQ=VAR,BOK	Feb-Dec 03
Palliative care	ALL	Not available in all the refugee settlements .	Lack of drugs and training on palliative care.	need for strong painkillers centralised for drugs within the districts from Training e.g. TASO, Mildmay, and hospice	NGOs	Feb-Dec 03
Orphans	ALL	Cared for by community service programs [EVI].	Lack of co-ordinations among sectors. Stigma and lack of support.	Adoption, distance fostering need for collaboration among sectors. Material support. Training of stakeholders.	UNHCR. BOK	Feb-Dec 03

SURVEILLANCE M&E	IP's	CURRENT SITUATION	GAPS	NEEDS/ACTIVITIES	RESOURCES	TIME
AIDS clinical case and mortality reporting	ALL	Under reporting of both clinical cases and mortality cases.	Poor reporting of clinical and deaths cases.	Training on clinical definitions and diagnosis. Standardisation of reporting formats. Develop data bases at different levels i.e. HC/facility level and national level.	UNHCR BOK	Feb-Dec 03
Blood Donors		Centralised. By MOH			MOH	
Sentinel Surveillance	ALL	Not available in all the refugee settlements.	None in all the refugee settlements.	Needs assessment to be done by MOH and establish sites in Kali, Kyangwali, Adjumani, Arua, Masindi, Nakivale.	HQ-VAR and MOH,	Feb-Dec 03
VCT	ALL	Data only from Kyangwali and few from Arua.	Data lacking.	Proper records and link with MOH forms.	UNHCR BOK ,MOH/IP's	Feb-Dec 03
PMTCTC	ALL	Available scanty data from Mbarara.	No data collection methodologies .	Develop proper data collection and link up with other NGOs working for refugees.		
Behaviour Change		Baseline surveys done in other settlements , except in Adjumani and Kiryandogo.	No standardised methodologies.	Do for Adjumani and Kiryandogo using FHI format	HQ = VAR	Feb-Dec 03
SGBV	ALL	No baseline survey done. Sensitisation and awareness raising ongoing	There is no data collection and most cases are not reported.	Link with Community services. Sensitisation and training in all the settlements. Do survey in Kiryandogo.	HQ =VAR	Feb-Dec 03

SURVEILLANCE M&E	IP's	CURRENT SITUATION	GAPS	NEEDS/ACTIVITIES	RESOURCES	TIME
Evaluation	ALL	No evaluation has been done.	External evaluation of HIV/AIDS programs lacking.	Will be organised for all areas i.e. centrally organised by branch office.	HQ = VAR	Oct-Nov 03
Training	ALL	Need for continuous training in various skills to communities and health providers	Lack of technical skills. High turnover of staff	Hospice/Palliative care training. TOT Supervision skills. Data management	HQ = VAR	Feb-Dec 03

WORKSHOP EVALUATION

Summary and Interpretation of Data from Workshop Evaluation (respondents N=23):

Indicator	N	Mean	Median
Objectives Clear	23	3.3	3.0
Meeting Organised	22	3.0	3.0
Resource Materials	21	3.2	3.0
Presentations			
BSS	21	2.6	3.0
Youth	22	3.0	3.0
Multi sectoral	22	3.0	3.0
VCT	22	3.1	3.0
PMTCT	22	2.9	3.0
HBC	22	2.7	3.0
More Information (allowed more than 1 answer)	21		
BSS		7	
Youth		1	
Multi sectoral		4	
PMTCT		13	
HBC		6	
Other Topics (allowed more than 1 answer)	12		
More about Host Gov rules		3	
PLWAs		3	
Orphans		1	
SGBV		1	
ARVs		2	
M&E		2	
Workplace Issues		3	
Community Participation		2	
Operational Issues		1	
Regional Issues		2	
Local NGO involvement		1	
Discussion Time	23	3.0	3.0
2003 Planning	22	3.1	3.0
Objectives Achieved	22	3.3	3.0
Meet Expectations	23	3.0	3.0
Additional Comments (allowed more than 1 answer)	8		
Well organised workshop	3		
Equal time for all Presenters	1		
Look forward to future Funding	1		
Admin issues for participants poor	2		
Ban cell phones	1		
Want annual workshop	1		

Interpretation of Data

Overall, workshop was well planned and received.
Participants found presentations useful.
Participants wanted more information on all topics presented (especially PMTCT) except for youth centres; despite discussion time being sufficient for each topic.
Participants would like to have had information on various other topics (see above).

See Appendix 11 for questionnaire and forms in EpiInfo.

Appendix 1
Signatories of Consensus Statement

HIV/AIDS WORKSHOP, ENTEBBE 10 - 13 DECEMBER, 2002

Signatories to HIV/AIDS Entebbe consensus statement.

NOS.	NAMES	AGENCY	Signature
1	TIBAHWA LOEKADIA	AAH, KYANGWALI	
2	TEZRA MASINI	UNICEF, TANZANIA	
3	NJOGU PETTERSON	UNHCR, PESHAWAR	
4	DR. KUBOKA HARISON	ADEO, ~~KAMPALA~~ Moyo	
5	MARWA MTALAI	TRCS, TANZANIA	
6	MSAFIRI SWAI	TRCS, TANZANIA	
7	BERYL HUTCHCHSON	CORD, TANZANIA	
8	MARIAN SCHILPEROORD	UNHCR, TANZANIA	
9	JOHN TABAYI	UNHCR, TANZANIA	
10	ABEL NGWALLE	NPA, TANZANIA	
11	ATHANAS NGAMBAKUBI	UMATI, TANZANIA	
12	AZZIMONTI GAETANO	AVSI, HOIMA	absent
13	STEPHEN KAJIRWA K.	UNHCR, KAKUMA	absent
14	JOYCE RIUNGU	NCCK, KENYA	
15	MICHEAL KWENA OSALA	MSF - B, KENYA	
16	GACHUCHA DANSON	CARE, KENYA	
17	ESTHER MWANYIKA	IRC, KAKUMA	
18	MOHAMMED QASSIM	UNHCR, KENYA	
19	CHRIS OMARA	AHA, ADJUMANI	
20	LINNIE KESSELLY	UNHCR, UGANDA	absent
21	PIWANG ALPHONSE	DED, RHINO CAMP	
22	DOMINICK TIBYAMPANSHA	UNHCR, UGANDA	
23	PAUL SPIEGEL	UNHCR, GENEVA	
24	STEPHEN MACHARIA	IRC, TANZANIA	
25	VUZZA CHRISTOPHER MAEKO	MOH, UGANDA	
26	PAUL BISHOP	IRC, UGANDA	
27	ROSELIDAH ONDEKO	IRC, UGANDA	
28	AGUTI EVELYN	UNHCR, UGANDA	
29	EDITH MUDHIRI	DDHS, ARUA	
30	DOMINICA LIRI	URCS, UGANDA	
31	JAMES OKWENY	AIC, UGANDA	absent
32	ANDREA MULLER	MACI, UGANDA	absent
33	DOROTHY JOBOLINGO	UNHCR, UGANDA	absent
34	SARAH SEMAFUMU	UNHCR, UGANDA	

Appendix 2
List of Participants

NAMES	AGENCY	E-MAIL ADDRESS
TEZRA MASINI	UNICEF, TANZANIA	tmasini@unicef.org
NJOGU PATTERSON	UNHCR, PESHAWAR, PAK	njogup@unhcr.ch
DR. KUBOKA HARISON	ADEO, KAMPALA, UG	adeo@africaonline.co.ug
MARWA MTALAI	TRCS, TANZANIA	ifrctz05@ifrc.org
MSAFIRI SWAI	TRCS, TANZANIA	moisaf@hotmail.com
BERYL HUTCHCHSON	CORD, TANZANIA	dwafricaonline.co.tz
MARIAN SCHILPEROORD	UNHCR, TANZANIA	schilper@unhcr.ch
JOHN TABAYI	UNHCR, TANZANIA	tabayi@unhcr.ch
ABEL NGWALLE	NPA, TANZANIA	angwalle@bushlink.co.tz
ATHANAS NGAMBAKUBI	UMATI, TANZANIA	umatikib@africaonline.co.tz
AZZIMONTI GAETANO	AVSI, HOIMA, UG	hoima.uganda@avsi.org
STEPHEN KAJIRWA K.	UNHCR, KAKUMA, KENYA	kenka@unhcr.ch
JOYCE RIUNGU	NCCK, KENYA	joyriungu3@yahoo.com
MICHEAL KWENA OSALA	MSF - B, KENYA	Drkwena@yahoo.com
GACHUCHA DANSON	CARE, KENYA	gachu@ddb.care.or.ke
ESTHER MWANYIKA	IRC, KAKUMA, KENYA	emwanyika@yahoo.com
MOHAMMED QASSIM	UNHCR, KENYA	qassimm@unhcr.ch
CHRIS OMARA	AHA, ADJUMANI, UG	ahaadjumani@infocom.co.ug
LINNIE KESSELLY	UNHCR, UGANDA	kesselly@unhcr.ch
PIWANG ALPHONSE	DED, RHINO CAMP, UG	c/o aguti@unhcr.ch
DOMINICK TIBYAMPANSHA	UNHCR, UGANDA	tibyampas@unhcr.ch
PAUL SPIEGEL	UNHCR, GENEVA, SUISSE	spiegel@unhcr.ch
STEPHEN MACHARIA	IRC, TANZANIA	smacharia@avu.org / irckb@africaonline.co.tz
VUZZA CHRISTOPHER MAEKO	MOH, UGANDA	machrishik@yahoo.co.uk
PAUL BISHOP	IRC, UGANDA	programs@ircuganda.co.ug
ROSELIDAH ONDEKO	IRC, UGANDA	roselidah@ircuganda.co.ug
AGUTI EVELYN	UNHCR, UGANDA	aguti@unhcr.ch
EDITH MUDHIRI	DDHS, ARUA, UG	c/o aguti@unhcr.ch
DOMINICA LIRI	URCS, UGANDA	mabusiadominica@yahoo.com.ug
JAMES OKWENY	AIC, UGANDA	c/o aguti@unhcr.ch
ANDREA MULLER	MACI, UGANDA	sudanuganda@gmx.de
DOROTHY JOBOLINGO	UNHCR, UGANDA	jobolingo@unhcr.ch
SARAH SEMAFUMU	UNHCR, UGANDA	semafumu@unhcr.ch

Appendix 3
Workshop Agenda

Session	Tuesday 10 December	Wednesday 11 December	Thursday 12 December	Friday 13 December
8:30-10:30	**Opening/Introductions** *-UNHCR* General Overview *-Spiegel* Keynote Address *-Kirungi* Strategic Plan *-Spiegel* Discussion	Previous day summary **Youth Centres and HIV** *-Macharia* Discussion	Previous day summary **Prevention of Mother-to-Child Prevention** *-Ngwalle and Mazini* Discussion	Previous day summary **Planning for 2003**
10:30-11:00	BREAK			
11:00-12:30	**Behavioural surveillance surveys** *-Okiror* Discussion	**Multi-sectoral approach** Comm. Serv. –Kesselly Education -Jobolingo Discussion	**Home-based care** -*Ngwalle* Discussion	**Planning for 2003**
1230–1330	LUNCH			
13:30-15:30	**Sharing of Materials** -Info-Ed.-Comm.(IEC) -BSS surveys -HIV/AIDS CD Discussion on Prevention	**Break out groups**	**Planning for 2003**	**Presentations of Plans by Country**
15:30-16:00	BREAK			
16:00-17:30	**Break out groups**	**Voluntary testing and counselling** *-Mwanyika* Discussion	**Planning for 2003**	

Appendix 4
HIV/AIDS/STI Surveillance in Uganda (Presentation)

HIV/AIDS/STI Surveillance in Uganda:

STD/AIDS Control Programme,
Ministry of Health, Uganda

Presenter: Dr. Wilford L Kirungi

1

Spread of HIV over time in sub-Saharan Africa, 1984 to 1999

Estimated percentage of adults (15–49) infected with HIV

20.0% – 36.0%
10.0% – 20.0%
5.0% – 10.0%
1.0% – 5.0%
0.0% – 1.0%
trend data unavailable
outside region

2

Background:

- Accurate eepidemiological data is essential to guide designing, targeting, monitoring and evaluation of Public health Programmes.
- HIV/AIDS surveillance in Uganda was designed in 1987 to provide data for this purpose
- The surveillance system has evolved over time to embrace new development and evolving challenges
- Data obtained has been very useful for advocacy, designing and targeting intervention, public education, M/E etc.

3

Public Health Surveillance of HIV/AIDS

The systematic collection, compilation, analysis, interpretation and dissemination of epidemiological information of sufficient accuracy and completeness regarding the distribution and spread of disease or infection in populations, to be relevant to the planning, implementation and monitoring of HIV/AIDS prevention and control programmes.

4

Surveillance:

- Disease surveillance is systematic and ongoing
- Dissemination is a critical component,
- Surveillance data only useful if followed by action.
- Often surveillance uses data that is already being collected routinely or available somewhere.
- Surveillance is not a controlled study for which special high quality data is collected
- Surveillance differs from surveys which are one off events, although repeated systematic surveys can give surveillance information

5

HIV/AIDS/STI surveillance

This surveillance takes several forms:

- Active surveillance of HIV infection (just like Ebola, Cholera)
- Passive surveillance as in the case of AIDS
- Sentinel surveillance of HIV and STIs using few sentinel sites and population.
- Universal case reports by health units (AIDS & STIs)
- Laboratory based surveillance e.g. emergence of drug resistant TB or *Neisseria gonorrhoea*, ARVs
- Repeated cross sectional surveys as is the case with behavioural surveillance.

6

HIV/AIDS/STI Surveillance in Uganda

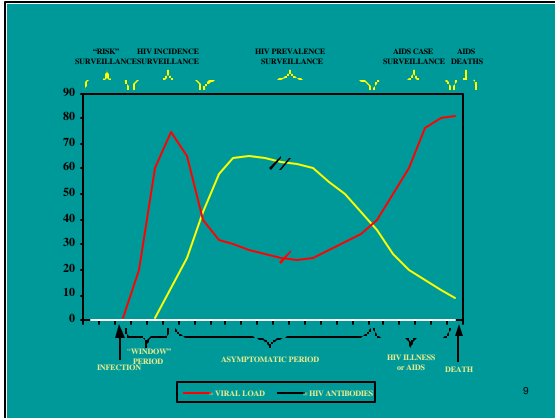
- HIV/AIDS surveillance consists of:
  - AIDS case surveillance
  - HIV sero-surveillance
  - Behavioural surveillance
  - STI surveillance
  - Statistical projections and modelling
- Augumented by data from other sources e.g.
  - Programme data such as VCT, PMTCT, BT, ARTs
  - Research e.g longitudinal cohorts in Masaka and Rakai
  - Programme M/E data.
  - Mortality surveys / vital registration
  - National health surveys such as the UDHS

7

2nd generation HIV surveillance

HIV surveillance
STI surveillance
AIDS reporting
behavioural surveillance
Data management
Data analysis
HIV estimates and projections
Use of data for action

8



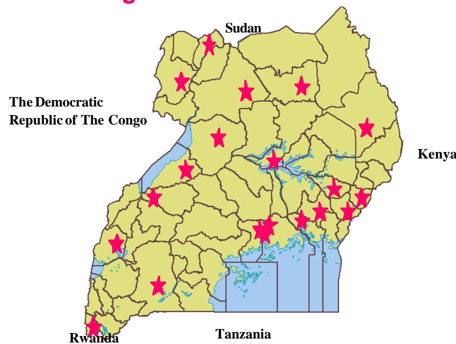
9

HIV Surveillance ....

- Main Objective is to monitor trends in HIV infection
- Active sero-surveillance of sentinel populations (prenatal mothers, STD patients , TB patients at sentinel sites)
- 20 sentinel sites with scale up plan for rural areas
- Based WHO guidelines on sentinel surveillance
- 250 - 500 Samples collected in 6-8 weeks quarterly from prenatal women at their first ANC attendance.
- Anonymous unlinked procedures are used. Blood collected for syphilis screening, & residual blood tested for HIV.
- Data available on age, sex, address, parity & year
- Serological testing conducted centrally at UVRI, using a standard surveillance testing protocol and QA
- System was evaluated in 1996 by WHO and found robust

10

Location of HIV Sentinel Surveillance sites in Uganda



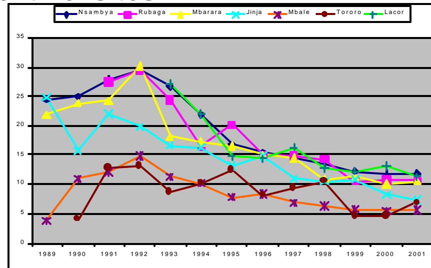
11

Antenatal HIV-1 sero-prevalence 2001

Site	Prevalence (%)	95% CI:
Urban sentinel sites (Cities / municipalities)		
Lacor Hospital	11.3	9.8 - 13.7
Mbarara Hospital	10.6	7.1 - 13.9
Rubaga Hospital	10.4	8.1 - 14.0
Nsambya Hospital	9.5	9.0 - 15.0
Jinja Hospital	**7.4**	**5.6 - 11.1**
Tororo Hospital	**7.0**	**5.8 - 9.7**
Mbale Hospital	5.6	3.2 - 8.3
Hoima	5.2	3.1 - 7.8
Soroti Hospital	5.1	2.8 - 6.7
Arua hospital	4.8	2.3 - 7.4
Semi urban / Rural sentinel sites (small towns and villages)		
Kagadi Hospital	7.4	7.4 - 14.7
Mutolere Hospital	4.1	0.7 - 5.1
Pallisa Hospital	**3.7**	**2.2 - 6.5**
Moyo Hospital	2.7	1.2 - 5.7
Matany Hospital	1.7	0.7 - 4.6

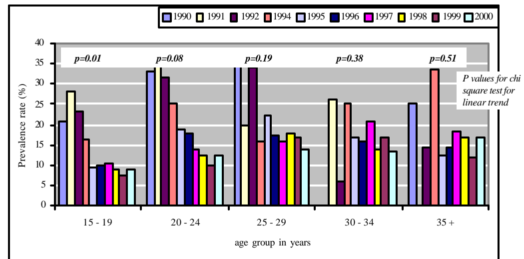
12

Trends in Antenatal HIV-1 prevalence 1989 – 2001 at selected sentinel sites



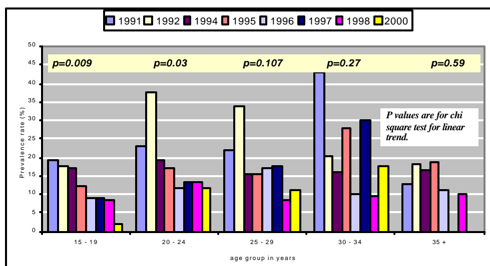
13

Trends in antenatal HIV-1 prevalence by age-group at Nsambya Hospital, Kampala.



14

Trends in antenatal HIV-1 prevalence by age-group at Mbarara Hospital:



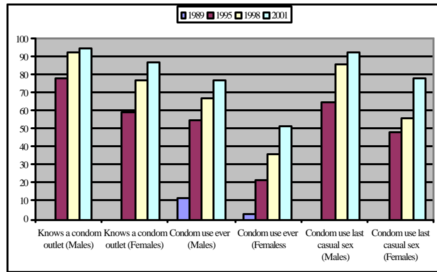
15

Behavioural Surveillance

- Based on repeated X-sectional sub national KABP surveys every 2 – 3 yrs to obtain prevention outcome indicators.
- Approx. 1500 adults (15 – 49 yrs) obtained through multistage clustered sampling designs.
- Sampling and interviewing methods are similar between places and over time
- Data obtained on sexual behaviour, knowledge and attitudes and symptoms of STDs by face to face interviews
- Responses to identical questions are compared between places and trends over time
- Data on behavioural indicators contrasted with AN prevalence data from hospitals serving the pop'n.
- We present some of the behavioural data.

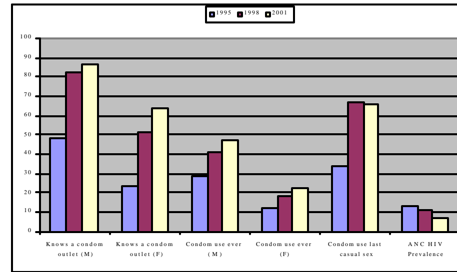
16

Kampala: Condom use by sexually active adults:



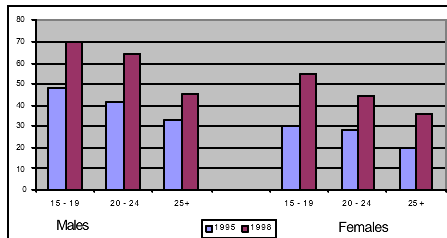
17

Jinja: Condom use by sexually active adults:



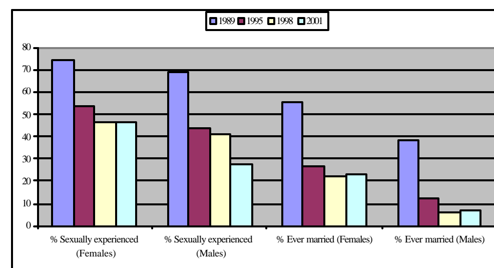
18

Proportion of adults who had ever used a condom by age-group: Jinja, 1995 Vs 1998



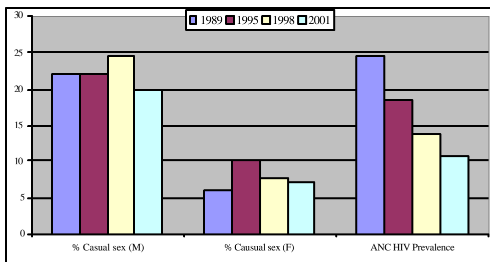
19

Kampala: Proportion of Youth (15-19 yrs) who are sexually active & proportion ever married



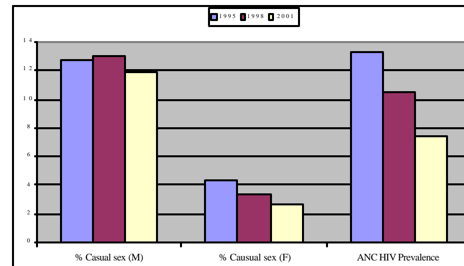
20

Kampala: Reported non regular sexual partnerships among sexually active adults:



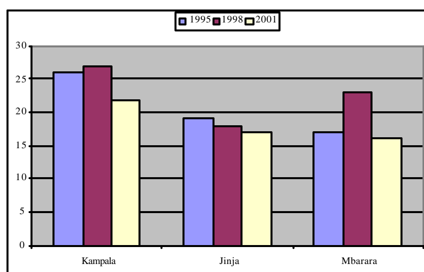
21

Jinja: Reported non regular sexual partnerships among sexually active adults:



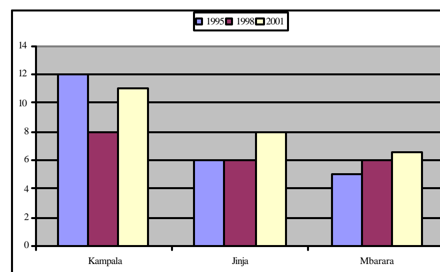
22

Men: Multiple partnerships (> 1) among men with a non regular sexual partner in the past year



23

Women: Multiple sexual partnerships (<1) among women with non regular sex partner in the past year



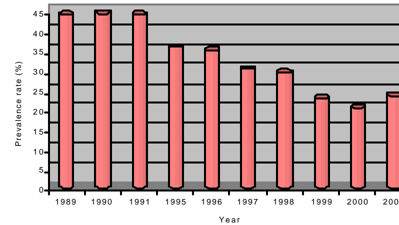
24

STI Surveillance ....

- STI surveillance is now a component of 2nd generation HIV surveillance,
- Main objective is monitoring STI disease burden and trends as an an early system for HIV dynamics
- Started in early 1990s
- Based on syndromic case reports through:
  - Twenty sentinel sites
  - Universal case reports through HMIS
- Data from sentinel surveillance should complement HIV surveillance
- Complemented by special studies and monitoring of antimicrobial susceptibilities of STI pathogens

25

HIV infection among STD patients, Mulago hospital STD clinic



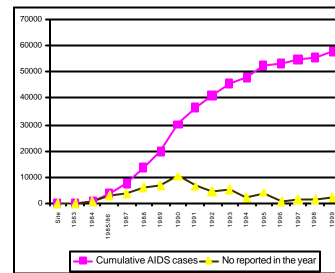
26

AIDS case surveillance

- Main objective is to monitor magnitude and trends in the health facility burden of AIDS.
- Disadvantage that this is a late warning system and affected by under-reporting, ARVs, HBM, etc
- Passive reporting of clinical AIDS to ACP using standardised formats and also through HMIS and IDSR
- Uses clinical AIDS case definitions, based on the Bangui clinical AIDS case definition
- Paediatic and Adult case definitions are used.
- The system is however largely incomplete.
- Proposal to introduce sentinel reporting being considered.

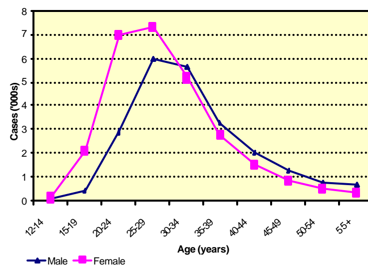
27

Cumulative AIDS cases in Uganda



28

Distribution of adult AIDS cases by age and sex



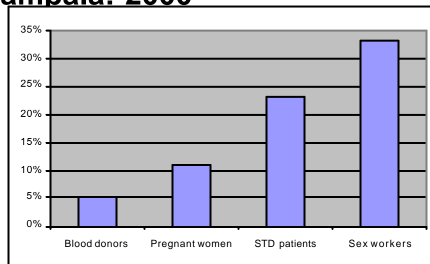
29

HIV Seroprevalence data from other sources:

- Routine data sets also available from other sources that can augument the picture from routine surveillance:
  - Include VCT / PMTCT services
  - Blood transfusion services
  - Clinical service delivery e.g. lacor
  - Longitudinal studies
  - etc

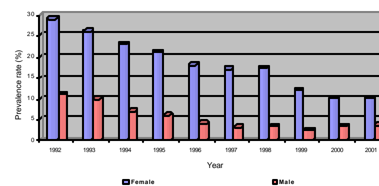
30

HIV Prevalence among population subgroups in Kampala: 2000



31

HIV rates for 15-24 year olds by sex among 1st time testers AIC, Kampala



32

Statistical modelling:

- Main objectives is to obtained National estimates of HIV/AIDS
- Based on computer simulations using mathematical models with input of surveillance and the national socio-demographic data
- Originally used Epi model developed by GPA
- Now using EPP developed by WHO/AUNAID

33

Estimates of HIV Epidemic in Uganda as of December 2001

Number of people living with HIV/AIDS	Total Adults Women Men Children	1,050,555 945,500 531,909 413,591 105,055
New AIDS cases in 2000	Total Adults Women Men Children	99,031 89,128 49,092 40,036 9,903
Cumulative AIDS death since the beginning of the epidemic	Total Adults Women Men Children	947,552 852,797 427,153 425,644 94,755

34

Dissemination:

- Dissemination is critical in any surveillance system if the data is to be used for action, and to maintain the morale of individuals proving it.
- Traditionally disseminated via annual HIV surveillance reports
- Other avenues include press releases, scientific conferences, journals articles, fact sheets etc.
- Other dissemination outlets such as conferences and meetings will be considered
- In future, report should on a web enabled interface WWW

35

Way forward

- Strengthen 2nd generation HIV surveillance esp. over-sampling young age (15 – 24) groups, so that data can be presented by single year, and elements of STI and Behavioural surveillance
- Expand sentinel surveillance rural areas
- National sero survey in the pipeline: to calibrate sentinel surveillance systems and to obtain direct estimates including obtaining data on men
- Validate incidence assays, consider applying them
- Consider period population sero surveys including target groups such as FSW
- Innovative ways to improve AIDS and STI case surveillance

36

Conclusions

- Both sentinel sero surveillance and behavioural surveillance have serious limitations
- When done consistently, they can provide useful data for planning and evaluation of programmes
- Should be cautiously interpreted and generalised
- Value added by augumenting it with data from other sources
- Both biological and behavioural surveillance are important and should consistently explain one another

37

Acknowledgements ....

- The surveillance activity in Uganda has been supported by:
  - The Government of Uganda MOH,
  - The WHO / GPA and WHO office Uganda
  - The World Bank / GOU STI Project
  - US Centers for Disease Control and Prevention (CDC)
- Other institutions involved in HIV surveillance
  - Uganda Virus Research Institute
- More surveillance data in Uganda is obtained from:
  - Research institutions – MRC, Rakai Project etc
  - Programme data from VCT, BT, NTLP etc
  - National surveys e.g UDHS+, etc

38

Appendix 5
Karago Youth Centre in Tanzania (Presentation)

YOUTH CENTER

Karago

Refugee camp

Kibondo District, Tanzania

TANZANIA

- Population 34,000,000 peoples
- Plus 510,000 refuges (Burundi, DRC & Rwanda)
- 160,000 live in five camps in Kibondo District (99% are from Burundi)
- 34,000 live in Karago camp (from Burundi)

HIV prevalence

- Burundi: HIV prevalence in Burundi: 20% in cities and 6% in rural areas (from WHO Burundi)
- Tanzania: HIV prevalence in host population (Tanzanians): 10 - 13% (from WHO Tanzania)
- Refugee camps: HIV prevalence in refugee camps: average of 7% (blood donors)

IRC Tanzania Refugee program

- *Services:* Comprehensive Primary Health care services including HIV/AIDS and ASRH program
- *Sites*: Mtendeli camp (48,000)
  Nduta camp (49,000)
  Karago camp (32,000)
- *Origin:* From Burundi

IRC Tanzania HIV program background

- Since the establishment of the camps (Mtendeli and Nduta camp in July 1996 and Karago camp in December 1999)
  - Awareness raising on HIV/AIDS through Health Education (By Medical staff in the Health facilities and CHWs in the community and schools
  - Universal precautions including blood screening
  - Condom promotion and distribution (Condoms from UNFPA)
  - Management of AIDS patients
- From May 2000: VCT program in the hospital
- KYC ASRH activities started in January 2001

KARAGO YOUTH CENTER Background

- Initial assessment (WHO) in 2000: RH Services not accessible to youths – Difficult share the same services with parents and lack of privacy.
- IRC under WHO grant
- From October 2000 (preparation)
- Social and RH services

IRC and Karago Youth Center

- October 2000. (construction, community sensitization and youth mobilization)
- Activities started in January 2001
- Social services: Skills training and recreation activities. (October 1, 2002: UMATI)
- ASRH services: STI clinics services, VTC, FP services, and Health Education

Objectives

- To reduce adolescent’s sexual and reproductive health problems in refugee camp through accessible and acceptable youth friendly RH services

SPECIFIC SERVICES

- Life skill training (handcraft, language classes, tailoring)
- IEC and BCC on health in general with emphasis on ASRH issues
- Family planning services
- STI clinic services
- VCT services
- Referral
- Condoms promotion and distribution

Strategy of Implementation

- Provision of adolescent friendly services
- Availability of social services (Reduce the stigma)
- Young services providers (both sex)
- Youths and parents involvement
- Use of existing Youth groups for awareness raising on RH problems

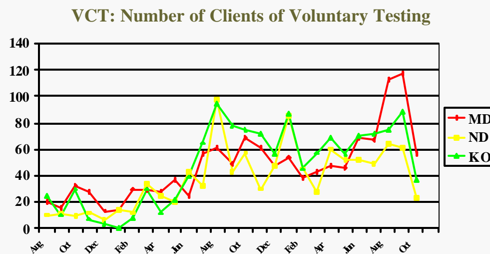
Beneficiaries

- Youths refugee population from 12 to 24 years old both sex living in Karago (approximately 5,500 youths)

DONORS FOR IRC

- United Nations High Commissioner for Refugees [UNHCR] (staff and medical supplies)
- Stichting Vlucteling (SV) (Social activities and structures)
- United States Department of state 's Bureau for Population Refugees and Migration [PRM] (Staff benefit and program supplies)
- UNICEF (teaching structures)
- ECHO from January 2003 to December 2004

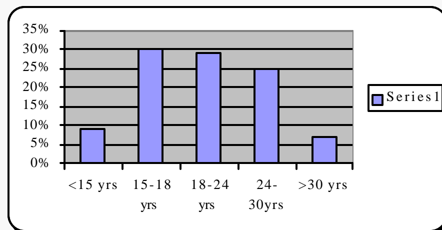
STATISTICS



3,571 clients

- Gender: 1,581 females (44.1%) out of 3,581 clients
- Age: - < 15 yrs: 322 (9%)
  - 15 to 18 yrs: 1,074 (30%)
  - 18 to 24 yrs: 1,039 (29%)
  - 24 to 30 yrs: 895 (25%)
  - > 30 yrs: 251 (7%)

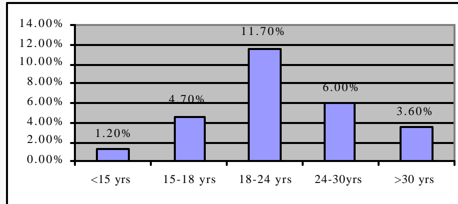
3,571 clients



Clients per camp and prevalence

Camps	# tested	Positive	Prevalence
Karago	1,298	59	4.50%
Mtendeli	1,263	96	7.60%
Nduta	1,020	70	6.90%

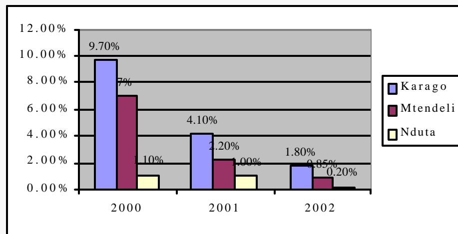
HIV prevalence (confirmatory testing) per age groups



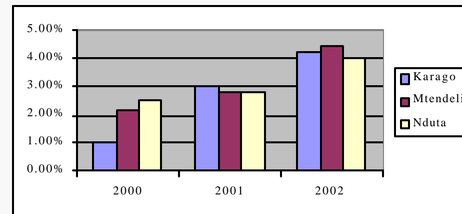
STI Clinics

- OPD, MCH Unit and youth centers
- From January 2002
  - – 489 STI case treated in Karago camp
  - – 311 cases in Mtendeli camp
  - – 216 cases in Nduta camp

Syphilis prevalence among PW



Family Planning – Contraceptive prevalence



Achievements

- Availability and acceptability of adolescent friendly services
- Increased use of RH services by the adolescents
- Awareness increased among youths on RH issues
- Acquire of basic skills in handcraft and tailoring.
- Reduction of idleness among adolescents through recreation activities.

Constraints and lessons learned

- Low attendance of girls (Cultural practice
- Low level of education of the population
- Limited social activities (limited fund)

Appendix 6
Integrated Multi-Sectoral Community Development Approach (Presentation)

- **INTEGRATED MULTI-SECTOR COMMUNITY DEVELOPMENT APPROACH:**

- **“Integral”** defined as **“necessary for completeness”** as in **“soul and spirit are integral parts of a human being”. “Integrate”:** to join parts into a whole.
- Multi-sector Approach: Method involving several sectors with a common objective.

- To achieve this essential “completeness /wholeness”, various sectors join their efforts in order to contribute to and reinforce support to refugee community capacity building with the aim of achieving maximum self reliance.
- The community development or community based approach focuses on improving communities’ capacity to meet their own needs and to solve their own problems.

2. WHY USE IT?

- Overall aim within refugee programme is achievement of self-reliance by participation of refugees themselves in problem solving.
  - Emphasis on inter-sector community based approach as part of overall programme of refugee protection and assistance.
- Integrated approach recognises that participation is more than technique but is reflected in collaborative interaction between sectors and community.

UNHCR POLICY:

- Broad policy outlines for promoting (integrated multi-sector) community development approach in all UNHCR activities:
  - **Planning**: above needs to be applied from emergency state to durable solution.
  - **Implementation**: Capacity building is integral part of all assistance programmes to increase refugee capacity.
  - **Partnership**: Intersectoral and Interagency coordination and cooperation are key elements to achieving unified approach which require active management support and shared commitment of actors in various sectors.
  - **Training:** Training at various levels of organisation and IPs /Ops will assist in operationalising this approach.
  - **Monitoring and Evaluation:** mechanisms are required for systemic analysis and should facilitate adjustment of activities required at various operational phases.
  - **Staff:** To reinforce cross sectoral community development approach, community services staff and partners are to work directly with refugee communities.

EXAMPLE:

- Active participation of refugee community is fostered through specific techniques such as awareness raising and community mobilisation.
  - i.e. training in life skills and AIDS awareness raising among refugee youth.

3. BENEFITS AND COSTS:

» Active involvement of refugees and their communities = search for own solutions.
» More effective use of limited resources.
» Needs based and situation appropriate: services address real needs.
» Sustainability: increase community participation= higher commitment to goal achievement + longer lasting effects.
» Intersectoral collaboration = greater programme effectiveness.
» Enterprise stimulation = Dependency minimised.

COSTS:

» Requires investment of time: more time for dialogue with refugees/all sectors: ensures shared understanding and commitment.
» Efficiency initially compromised: various trainings needed to overcome lacks in skills and knowledge and sectoral adjustments for increased collaborations.
» More staff/organisational time input: required for initial support to community and involvement with other sectors.

4. EXAMPLES IN THE UNHCR UGANDA PROGRAMME:

PREVENTION:

- Several interactive and intersectoral activities aimed at increased professional capability and behaviour change.

Training: (workshops/seminars/IEC material/films & videos/drama groups)

Trainees: Health workers/Peer educators/Lab techs / Community services workers/ Community leaders/ Teachers/Refugee women's groups/other IP staff /TOT (in Kyangwali included sensitisation of UPDF located with in the settlement)

RESPONSE: CARE & TREATMENT

» **Sex and Gender based Violence (SGBV):** Reports indicate high incidences in some settlements and districts.

» SGBV (may result in STIs/HIV-AIDS) requires well coordinated multi-sector community based strategies for both prevention and response while quality of timely service delivery depends on agreed standards.

» **Community support reported:**

» Awareness raising/sensitisation on regular basis

» Formation of SGBV committees to follow-up cases

» Community counselors trained in each zone

» Creation of drama groups as well as campaign network involving health, community services, OPM, Police, Refugee leaders to campaign against SGBV.

» **Nutrition:**

» In settlements of Central and Southwest, it is reported that there are certain food supplements provided to all HIV/AIDS patients including fresh milk, vitamins and iron.

» Other measures taken include IGA projects such as poultry keeping as well as food security campaign.

» No special nutritional programme is being implemented in Northern settlements except for TB cases.

» **People Living with HIV/AIDS (PLWHAs)**

» Care and treatment depend on the patient's condition whether services under Nutrition, Home Based and/or Palliative Care are offered.

» For those PLWHAs still physically active, there are a range of activities reported i.e. involvement in AIDS campaigns, formation of support groups and CBOs, IGA, skills training and employment opportunities.

5. CHALLENGES & RECOMMENDATION :

» Intersectoral collaboration and commitment

» Training

» Standards of service delivery: HIV/AIDS prevention and response.

» Reporting: Impact and performance indicators

» Surveillance: Statistics

» Surveys: KAP

» **EC.51.SC.CRP.6 (15/02/01): Acknowledgement of use of policy material from the Executive Committee Standing Committee 20th Meeting, a document entitled: "**REINFORCING A COMMUNITYDEVELOPMENT APPROACH".**

Appendix 7
Integrating Multi-sectoral Education (Presentation)

UNHCR HIV/AIDS WORKSHOP: ENTEBBE, UGANDA
EDUCATION PAPER PRESENTED BY DOROTHY JOBOLINGO

Goals of refugee education in Uganda:

– Increase access of refugees, girls and boys, in refugee hosting communities to formal education with good quality standards.
– Increase opportunities for refugees to access non formal education; life skills education and vocational skills training.

Goals of refugee education in Uganda cont:

– **Increase capacity of refugee and hosting community to co-exist peacefully; become aware of environmental concerns; become self-supporting and responsible for its members with special needs, including women, adolescents and children.**

Enrolment

- Refugees supported by UNHCR through the formal education system, by end of June 2002 were: 9,223 children enrolled in nursery/pre-school education (50.2% females and 49.8% males), 52,620 children enrolled in primary education (44% females and 56% males), 5,380 enrolled in secondary education (21% females and 79% males), 377 in formal vocational skills training (33.2% females, 66.8% males), 314 in teacher training (78% males, 22% females) and 71 in university education (38% females and 62% males). UNHCR also assisted 1074 in literacy programmes (43% males, 57% females).

Education:

– Academic performance is very good in primary refugee schools and good pass rates were noted (85 - 90%) for the Sudanese case load in Arua , Mbarara, Hoima, Acholi Pii, Adjumani and Moyo. UNHCR continued to focus on quality of education and to provide teacher training (in service and through national institutions and systems). Efforts are underway to send more female teachers for training so that girls can have role models.

Education cont:

- **NGO s and Government departments**
- **Life skills education**
- The life skills promotion in education programmes aims at addressing issues of social mobilisation, both for in-school youth and out-of-school youth, in relation to Peace education, Reproductive health (including HIV/AIDS), Action for Children/s rights, Environment conservation and Sanitation, in order to demonstrate the link between a good environment (a good social and physical environment free from diseases, abuse and conflict) and good quality of life.

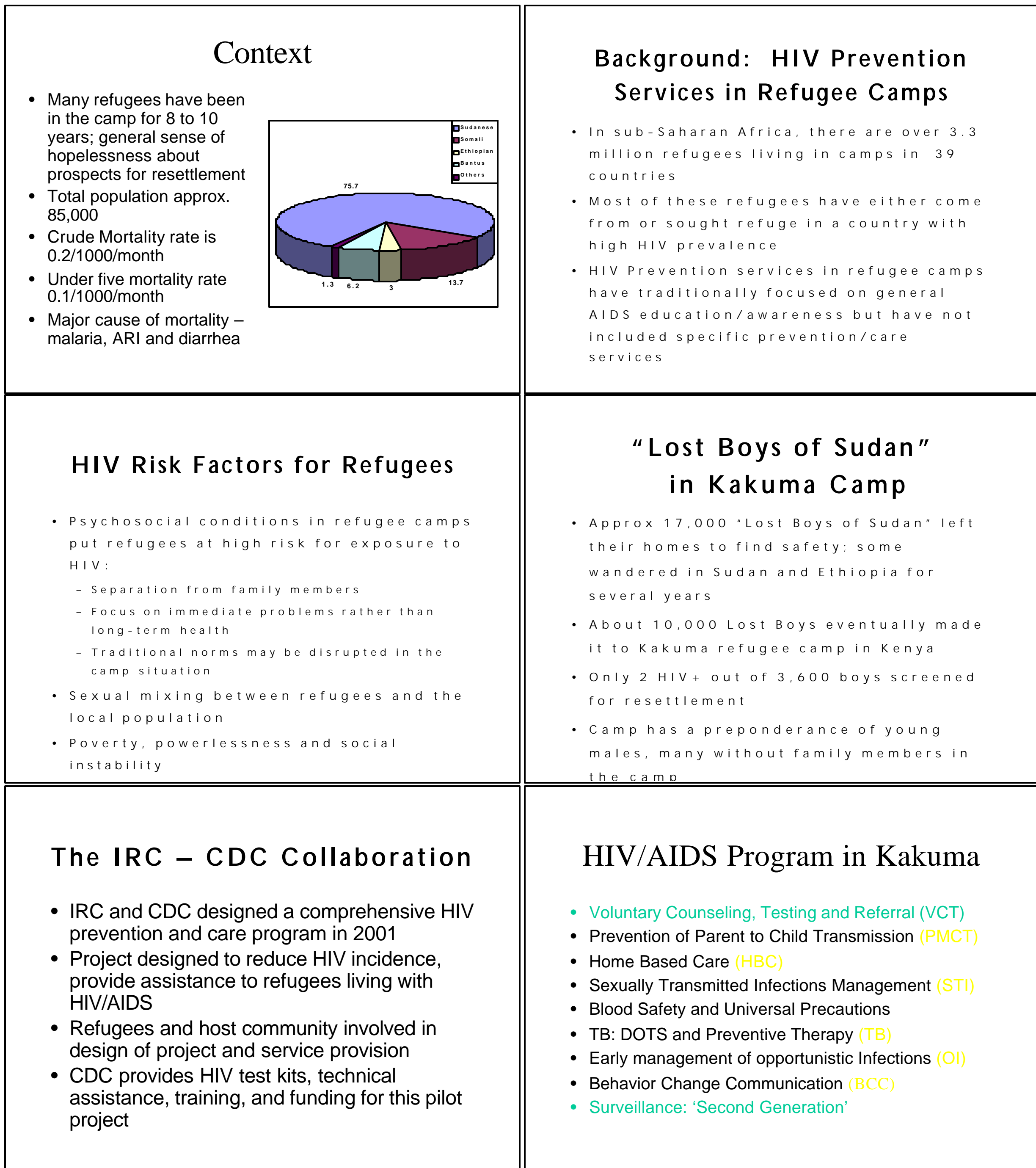
Use of multi-media and multiple channels

- The UNHCR guidelines recommend that important messages regarding these issues should be conveyed through the following multiple channels, to school pupils as well as adults (mostly attending adult literacy programmes) and out-of-school youth:

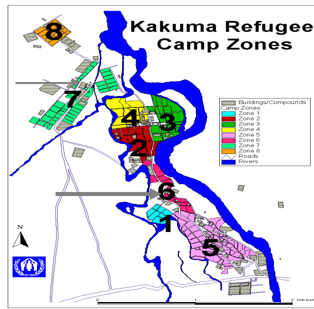
EXAMPLES OF ACTIVITIES DONE FOR YOUTH IN SCHOOL AND FOR THOSE OUT OF SCHOOL

- **DED Activities in Arua**
- **Uganda Red Cross Society (URCS)**
- **AHA through Health of Adolescents Project (HAP)- Adjumani**
- **AHA through Madi Aids Control Initiative (MACI)- Adjumani**

Appendix 8
Voluntary Testing and Counselling, Kakuma, Kenya (Presentation)



VCT Location



VCT: To reduce the incidence and impact of HIV

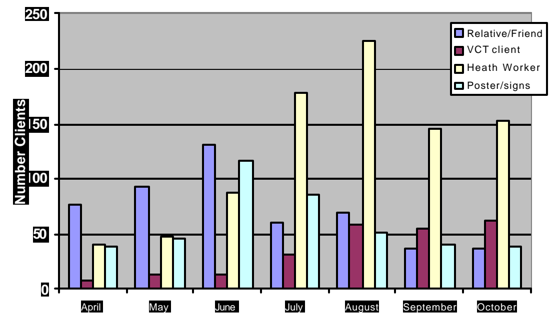
Free Services

- Pre and post test counseling
- Daily anonymous HIV testing services with two parallel rapid test, and same day results.
- Training on Counseling and other related issues
- Drop in center for recreation, information & education
- Ongoing support counseling regardless of HIV status
- Post test club activities: meetings, health talks, community activities, drama, indoor doors etc
- Community mobilization and motivation

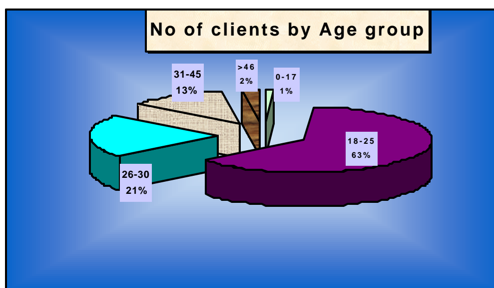
Counseling and Testing is done on site by a trained counselor, supervised by a laboratory technician

- Two different, rapid, simple whole blood tests are used for every client
- Confirmed results in 15 to 20 minutes
- Tests used at present:
  - Abbott Determine
  - Trinity Biotech Unigold

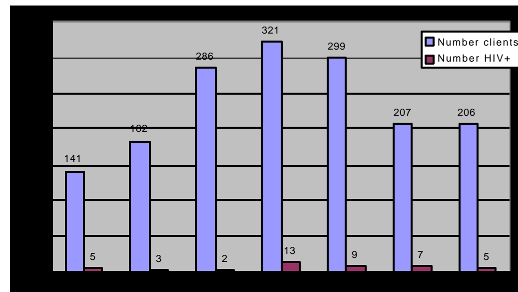
How we reach clients



The majority of the clients are the youth



Demand for VCT Services

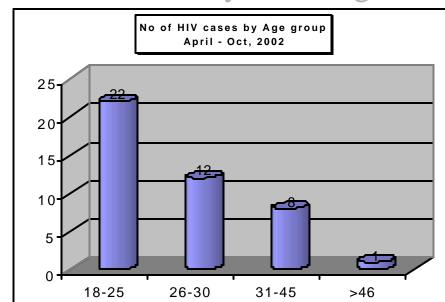


"Planning for the future" is the main reason given by VCT clients

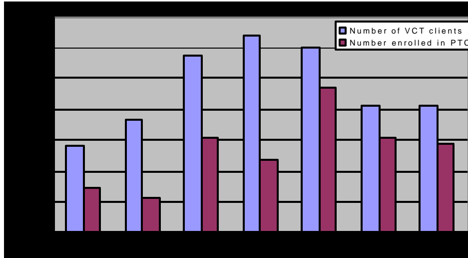
The female attending the center are 3 times more likely to be infected by HIV

	Negative	Positive	Total	'Risk' (%)
Males	1229	21	1250	1.7
Female	373	22	395	5.6
Total	1602	43	1645	

75% of the HIV positive clients are less than 30 years of age



Number of Clients Counseled and Tested registered in the PTC



The clubs are very popular with young people in the camp and provide a setting for on-going prevention interventions

Strengths

- Capacity for training: Experienced national Counsellor part of the VCT Team
- Mechanisms for quality assurance: Laboratory back up
- Accessibility to quality HIV counseling and testing
- Same day, same hour results
- Voluntarism and confidentiality: no written results and maintaining anonymous records
- Mechanism for continuous community mobilization: RH workers, COR team, PTC members, Community
- Data management: User-friendly free software EPI info 2000 with uniform formats

Lessons: Specific

- The Rapid acceptance of VCT services in Kakuma suggests that:
  - VCT should be offered to refugees in Sub-Saharan Africa
  - VCT is an important entry point for HIV/AIDS prevention and care programs in refugee settings
  - It is important to offer VCT services to refugee populations, especially those who have sought refugee to or from high prevalence regions
- Special services are needed for HIV+ clients, especially those separated from their families

Lessons: Specific …..

- Health workers report that social support systems in the camp are inadequate for the youth who are HIV+ and are separated from their families
- Infection in the youth suggest recent and possible on-going transmission
- Quality training of staff is very important for implementation of VCT
- Community sensitization/mobilization is crucial for VCT uptake

Appendix 9
Prevention of Mother to Child Transmission, Ngara, Tanzania (Presentation)

UNICEF Presentation on PMTCT
Activities linked to PMTCT

- STD clinic
- Screening blood donors
- Condom promotion
- VCT services
- Health education
- Infant feeding activities
- Obstetric care
- Counseling services e.g. family planning
- Reproductive health M&E
- Therapeutic and supplementary feeding

RECOMMENDATIONS MADE DURING THE REVIEW MEETING

- Every PMTCT implementing site should ensure availability of proper counseling room.
- Training of more counselors is needed.
- PMTCT activities should be incorporated in exiting comprehensive health plans and budget.
- Ensure regular availability of drugs, supplies and equipment.
- Training of PMTCT component should be uniform and adhere to National guidelines of Ministry of Health for quality assurance.
- Co-ordination mech. should be acc. to MOH proposed organogram.
- UNHCR representatives preferably the Reproductive Health focal person to attend these reviews meetings as they are also important in implementation of activities.
- All actors should finalize implementation of the planned activities and fund liquidation for phase one by December 2002.
- Plans for 2003 to be submitted to UNICEF offices in each district.

LESSONS LEARNT

- Success of PMTCT project requires high level commitment from all concern partners
- Existing full package of MCH services makes integration much easier.
- Technical guidance from experienced people is very necessary.
- Sensitization and awareness creation to key focus group speeds community understanding of the project.
- Improvement of counseling environment is necessary to assure confidentiality.
- Health workers must be trained adequately so as to guide mothers and partners in the project.
- In areas where most mothers are delivered by TBAs, trainingTBAs on the importance of referral of mothers and newborns to the health center is of paramount importance.

Progress Made

- Consultation meetings with UNHCR, UNAIDS, NACP, MoH and TFNC were done in 2001 and continued in 2002.
- Feasibility study in the refugee and RAA health facilities was conducted (2001).
- Development of strategic plan for the project which involved all stake holders (UN agencies, implementing partners and government (2002 Feb.)
- Development of integrated health plans for PMTCT for each NGO and districts (April 2002).
- Funding of all developed plans.
- Technical support to the pilot project and other areas.
- Training on PMTCT for trainers from all health NGOs and district focal persons (DACC and RH MCH Coordinators) was conducted.
- Sensitization seminars to focus groups.

Progress Made cont.

- Collaboration with the MoH is inevitable not only for technical support but also to be in line with the government policy on HIV/AIDS.
- For adequate counseling, more counselors need to be trained on PMTCT and this must on regular basis.
- Sensitization and training of IP leaders is important for support of the project.
- Increased knowledge on PMTCT by community increase demand for VCT, therefore, counseling and testing services must be accessible by other community groups.
- There is increased workload during the first days of VCCT, however this come down to normal after attending new mothers only.

Strategies:

- Continuous capacity building of relevant staff.
- Involve males and equip them with enough knowledge in HIV/STD, ANC/PMTCT services and family planning to enable them make an informed choice and adapt positive behavior.
- Involve other family members and the community as a whole and equip them with enough knowledge on PMTCT to reduce stigmatization of women found to be HIV positive.
- Integrate the VCCT services into the existing STD project at the ANC.
- Integrate PMTCT indicators into the existing health and nutrition information reports/system.
- Strengthen linkages with other HIV related interventions such as VCT, condom distribution, care of affected people, home based care, and adolescent and youth reproductive health.
- Resource mobilization and allocation.

CONSTRAINTS/CHALLENGES FACED

- Delayed funds to reach IPs due to Ips poor financial records (when blacklisted due to unliquidated previous funds.
- Delayed proposals from IPs
- Delayed materials e.g. HIV/AIDS kits, protective gears
- Meningitis outbreak (gatherings stopped)
- Staff turnover especially those already trained due to repatriation and moving to greener pastures. .
- Problems with data clerk trainer
- Counseling rooms posed as a challenge in some camps.
- Changes in the policies regarding ARV- AZT vs. Niverapine.

Objectives for 2003

- Document the existing practices related to reproductive health and infant feeding.
- Continue with sensitization activities both to relevant health workers, cultural groups, influential and religious leaders, family members and the community in general.
- Strengthen the reproductive health program, particularly the comprehensive MCH services (antenatal, VCCT, postnatal, family planning and child care).
- Improve the quality of service delivery.
- Strengthening breastfeeding and alternative infant feeding counseling and practices.
- Practice optimal obstetric care.
- Expand the course of ARV prophylaxis to remaining camps.
- Ensure availability of IEC materials.
- Strengthen monitoring and evaluation.

Recommendations from assessment

- Integrate PMTCT to MCH services
- Awareness creation to community
- Capacity building
- Strengthen VCT
- Increase counselors and rooms
- Provide supplies for safety precautions
- Ensure ARV availability
- Promote exclusive breast feeding
- Revise interfering practices to PMTCT
- Ensure health promotion materials
- Establish magnitude and HIV trend

Strategies

- Promote active community participation
- Establish VCT as well as rapid and confirmatory testing
- Multifocal and integrated intervention
- Develop PMTCT training manual
- Support effective social mobilization
  - Review and document
  - Develop appropriate and acceptable messages
  - Use traditional communication methods
  - Promote good traditional beliefs
  - Discourage bad traditions
  - Develop advocacy tool
  - Encourage male partner participation
  - Establish and strengthen linkages
  - Capacity building to service providers
  - Promote, protect and support breast feeding
  - Monitoring and evaluation
  - Partnership with others
  - Service delivery

Planned activities

- Advocacy and sensitization meetings
- Camp level dialogue
- Planning with key implementers
- Capacity building
- Procurement and distribution of supplies
- Provision of technical support
- Follow up
- Support breast milk promotion
- Monitoring and evaluation

Key indicators

- Proportion of preg. women seen at antenatal clinic <16 weeks of gestation.
- Proportion of preg. women receiving info. on HIV testing during pre test counseling.
- Proportion of pregnant women accepting testing
- Proportion of pregnant women who test positive and accept ARV.
- Proportion of pregnant women who bring partners for counseling/testing.
- Proportion of pregnant women who come for results.
- Proportion of pregnant women who fully adhere to the ARV regimen.
- Proportion of preg. women who opt to breast feed and those who opt not to
- Proportion of preg. women who adhere to regimen and deliver at health facility.
- Proportion of infants of HIV positive who grow according to standard growth curves of Tanzania
- Morbidity rates among infants of HIV positive mothers.
- Prevalence of HIV infection among infants of HIV positive mothers.

PROGRESS MADE

- Consultation meetings with UNHCR, UNAIDS, NACP, MoH and TFNC were done in 2001 and continued in 2002.
- Feasibility study in the refugee and RAA health facilities was conducted (2001).
- Development of strategic plan for the project which involved all stake holders (UN agencies, implementing partners and government (2002 Feb.)
- Development of integrated health plans for PMTCT for each NGO and districts (April 2002).
- Funding of all developed plans.
- Technical support to the pilot project and other areas.
- Training on PMTCT for trainers from all health NGOs and district focal persons (DACC and RH MCH Coordinators) was conducted.

PROGRESS MADE cont.

- Sensitization seminars to focus groups.
- Training for laboratory technicians on Capillus and Determine testing methods.
- Training of Key Health staff and TBAs at camp level.
- Training on VCCT and infant feeding options for trainers and later at camp levels.
- Official launching of Lukole camps as pilot area (2002 October).
- Follow up and supervision of activities.
- Annual review meeting
- Facilitate donor visit of the project.

NPA Presentation on PMTCT
INTRODUCTION

- NPA implements the PMTCT programme in the Lukole camps.
- The launched on the 4th of October .
- Despite the low prevalence rate of HIV among pregnant women in Lukole camps 4% and 2% for Lukole A and B respectively (AMREF)
- Recommended the program to keep the prevalence low.

PROBLEM

- The presence of social, cultural and obstetrical factors which facilitates mother to child transmission of HIV

REASONS

- Lack of knowledge to the community and among Health care providers and staff. Unavailability of counseling rooms at MCH. Few counselors available at MCH.Few materials and supplies for testing. Drugs not available.Unimproved obstetrics care in terms of MTCT.
- infant feeding practices favoring MTCT

INPUTS

- Grant (Funds)
- Constructions.
- Furniture
- Trainings.
- Staffing.
- Equipments and supplies

ACTIVITIES

- Sensitization meetings to the community
- Construction and furniture
- Staffing
- Trainings to different health care providers.
- Procurement of additional materials and supplies.
- Development of IEC materials and Obstetric guidelines.
- Counseling and testing activities at MCH
- Study visit

EFFECTS

- Increased knowledge on MTCT and PMTCT among community members and health care providers (FGD).
- Availability of counseling and testing services at MCH.
- Increased number of pregnant women and their partners counseled and tested.
- Modified Obstetric care practiced in Hospital.

EFFECTS cont.

- Prophylactic ARV taken by HIV positive mothers and their babies.
- Improved infant feeding practices in line with PMTCT

Lesson learned

- Linking of the program to the National program is Vital
- Service integration to MCH makes the program cost effective
- Technical support from the Competent and already existing project is important
- High commitment to all staff is needed

Challenges

- Delaying of funds for implementation
- Third test in case of discordant (ELISA)
- Low male involvement
- Follow up for Tanzanian .
- Data management
- Repatriation

Future Plans

- Strengthening of the existing activities the male involvement
- Use of the third rapid test for discordant results

Appendix 10
Home Based Care, Ngara, Tanzania (Presentation)

Background

Pre existing home –Community based care to chronically sick patient in the camp through volunteers.

Problems.

Coordination,

administrative skills

Technical skills

formal HBC

Reasons

Increased burden to the Hospital in taking care of chronically ill patients admitted in the wards

about 30% bed occupancy .

Registration

- Identification and registration of all chronically ill patients in the camp was done by community health workers they registered 158 chronic ill cases.

Training

- Training to health workers(clinical officers and nurses) on WHO case definition of AIDS was conducted . Then among the registered chronically ill individuals, 122 AIDS cases were identified.

Facility based HBC teams

- Facility based HBC teams were formed at each OPD to serve the catchments area served by the OPD, the teams comprised of clinical officer, counselor, nutrition assistant, HIT and CSW. Later on religious leaders and family members were involved.

Referral

- Referral between home -community (volunteers), and
- Facility (hospital) based care;
- Administrative camps structures .

Re orientation of structure

Home-community-Facility

Orphan ;

- Registration of orphan in the camp has been done and we have a total of 51 orphans who lost one and / or both parents other inclusion criteria is the age below 16 years.
- Problems:
- who are the ADIS orphan ?
- Who should concert for their HIV testing ?

challenges

Stigma .

- Women vulnerability to sexual violence
- Local community
- Continuous Movement
- High demand for assistance
- AIDS ophans attention so far.
- 6.dependency among families with PLWAs
- 7.HBCprogram overwhelmed by the number of clients
- 8.incentives to volunteers

Way forward (points)

community sensitization to reduce stigma.

- Proper recording and commencing the orphan program and link to HBC.
- Establishment of positive and negative clubs.
- Encourage more of the clinically HIV diagnosed HBC clients go for testing.
- Strengthening prophylaxis for Opportunistic infections especially using co-trimoxazole and explore the possibility of starting INH prophylaxis

Appendix 11
Workshop Evaluation Form

	Poor	Average	Good	Excellent
1. Were the objectives of the workshop clear?	1	2	3	4
2. Was the workshop well organised?	1	2	3	4
3. Were the resource materials sufficient?	1	2	3	4
4. Rate the following presentations:				
a. Behavioural surveillance surveys	1	2	3	4
b. Youth centres and HIV	1	2	3	4
c. Multi-sectoral approach	1	2	3	4
d. Voluntary Counselling and Testing	1	2	3	4
e. Prevention of mother to child transmission	1	2	3	4
f. Home based care	1	2	3	4

5 Which topics covered would you have liked to have more information on?

____
____
____

6. What other topics would you have liked to see covered?

____
____
____

7. Was there enough time for discussion?	1	2	3	4
8. Were the 2003 planning sessions useful?	1	2	3	4
9. Were the objectives of the workshop achieved?	1	2	3	4
10. Did the workshop meet your expectations?	1	2	3	4

11. Any additional comments/suggestions?

____
____
____

Ques form in Epi Info 6.04b (EVAL.QES)

Poor=1 Average=2 Good=3 Excellent=4

Question	Field	Type
1. Were objectives of the workshop clear?	{obj}	#
2. Was the workshop well organised?	{org}	#
3. Were the resource materials sufficient?	{material}	#
4. Rate the following presentations:		
a. Behavioural surveillance surveys	{bss}	#
b. Youth centres and HIV	{youth}	#
c. Multi-sectoral approach	{multi}	#
d. Voluntary Counselling and Testing	{vct}	#
e. Prev'n of mother to child transmission	{pmtct}	#
f. Home based care	{hbc}	#
5. Which topics did you want more info on? (1=a, 2-=b, 3=c, 4=d, 5=e, 6=f from ques 4))	{info}	#
6. What other topics did you want to see covered?	{other}	<A>
7. Was there enough time for discussion?	{disc}	#
8. Were the 2003 planning sessions useful?	{plan}	#
9. Were objectives of workshop achieved?	{achieve}	#
10. Did the workshop meet your expectations?	{expect}	#
11. Any additional comments/suggestions?	{comment}	<A>

Pgm file for running program in Epi Info 6.04b (EVAL.PGM)

```
*Program to generate data for the questionnaire EVAL.REC that is for HIV/AIDS and Refugee workshop
in Entebbe Dec 10-13 2002
READ EVAL
MEANS OBJ
MEANS ORG
MEANS MATERIAL
MEANS BSS
MEANS YOUTH
MEANS MULTI
MEANS VCT
MEANS PMTCT
MEANS HBC
FREQ INFO
FREQ OTHER
MEANS DISC
MEANS PLAN
MEANS ACHIEVE
MEANS EXPECT
FREQ COMMENT
```

Had total of 33 participants at workshop and one moderator.
Six persons were absent at time evaluation forms were handed out = 27 persons received evaluation forms.
Of these, 23 persons (85.2%) completed the evaluation forms.