

HIV, refugees and conflict-affected populations in Asia

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Evidence-based experience, good assessment and a readiness to adapt programmes to local realities have been key to tackling HIV in Asia.

UNHCR's HIV activities in Asia – which began in earnest in 2005 – were based on approaches outlined in its 2005-2007 and 2008-2012 Strategic Plans but adapted to accommodate factors specific to the Asia region. These included the low-level and concentrated nature of epidemics in most countries (with HIV infection concentrated around unprotected paid sex, the sharing of contaminated injecting equipment and unprotected sex between men); the fact that most Asian countries are not signatories to the 1951 Refugee Convention or its 1967 protocol¹; and the significant population movements within the region (both conflict and non-conflict related).

Achievements over the last five years include:

- expanded access to prevention services² for most-at-risk populations with 55% of sites in 2009 addressing at least one key population – an increase from no sites in 2005
- increased access to key HIV services for refugee populations in 66% of sites
- considerable progress in the availability of antiretroviral treatment (ART): of those countries hosting more than 10,000 refugees in the region, 100% of them offer refugee populations access to ART where it exists for local populations
- increased availability of HIV-related information with 66% of refugee sites at the end of 2009 having standard HIV information systems in place
- expanded evidence base on HIV vulnerability and risk amongst conflict-generated internally displaced persons (IDPs).

While progress has been made, experience in the region has highlighted a number of challenges at different stages.

Emergency phase

It is now widely recognised that for HIV to be adequately addressed in humanitarian settings interventions need to begin early on in the response and expand as the situation stabilises. However, there is inadequate attention given to the need to prioritise interventions based on what is feasible and what will have the most impact in the early phase – given competing priorities. Furthermore, there is still inadequate understanding of the multisectoral response to HIV in the region and the role that key sectors such as shelter, protection, water and sanitation have in reducing HIV vulnerability and risk.

In addition, existing national HIV programmes in countries affected by conflict and displacement are often slow to adapt to the changes associated with displacement and the need for prioritisation. This is compounded by the fact that those UN agencies with a development focus are often unwilling to adapt their long-term strategies to meet the more immediate and rapidly evolving needs. Finally, but crucially, in conflict situations insecurity invariably hampers response. In 2008 in Sri Lanka the national HIV quality assurance scheme for HIV testing had still not extended to the conflict-affected North-East although all other regions of the country were included.

Post-emergency phase

In the post-emergency phase there are other challenges. Refugees and IDPs are often not included in National HIV Strategic Plans (NSPs). In relevant countries in Asia in 2006 45% of NSPs mentioned

refugees but only 18% mentioned activities for refugees; and only two of the nine countries with more than 10,000 IDPs acknowledged them in their plans – and none had activities directed towards IDPs. Displaced populations, especially refugees, often lack advocates during strategic plan development processes and development of other national HIV initiatives, such as Global Fund Proposals, as they are viewed as politically sensitive. However, some progress is being made, with both Sri Lanka and Thailand acknowledging displaced people in their more recent NSPs.

Considerable experience has been accrued globally and in the region on addressing HIV in camp-based refugee settings. In Asia there are large numbers of refugees who are living in non-camp settings including in urban areas – such as in Iran and Malaysia. Refugees in such settings present many challenges in the delivery of services, including HIV services. They are often scattered geographically, have minimal contact with UNHCR or its partners, and receive health and HIV-related services from a number of providers, including private providers. Information about the services they access and their specific HIV and health-related needs is often scarce. As a result a variety of interventions is needed to reach non-camp, including urban, refugees.

Improving access to sexual violence services has been challenging. Access to specialised centres may be limited for refugees and other forced migrants and where national laws oblige health providers to report survivors of sexual violence to the police, health providers are unable to offer confidential services. Furthermore, national gender-based violence programmes are often very poorly developed. Post-exposure prophylaxis for HIV is not part of many countries' responses to sexual violence.

While significant progress has been made in programming this has not been matched by progress in behavioural or biological surveillance in those most-at-risk amongst conflict-affected populations in the region. In refugee and related settings it has been difficult starting HIV interventions for most-at-risk groups because of factors such as the closed nature of many settings and the considerable stigma and discrimination these populations face over and above their displacement status. Other challenges include small sample sizes and ethical considerations. Furthermore, there is a dearth of both biological and behavioural data amongst urban refugees. Progress has been made, however, in qualitative approaches such as participatory learning and action which has been used to identify risks and vulnerabilities associated with sex work amongst urban refugees in Delhi. Rapid assessments have been done in relation to substance use in Thailand and Pakistan, resulting in improved programming.

Lessons

Inclusion of refugees and displaced populations in national HIV initiatives is a necessary first step but as an isolated measure will not guarantee access to services. Advocacy for the inclusion of refugees and related populations in national HIV initiatives is a key component of UNHCR's HIV

A refugee visits community health worker Zafar Ullah (right) in his home for a fresh supply of condoms, Nayapara camp for Rohingya refugees, Bangladesh.



programming at country level. However, while a national policy may be supportive of refugee access, refugees often have special needs which may hinder uptake of services. These include different language and cultural backgrounds from those of the host community, lower literacy levels than the host community, fear of harassment and arrest, and uncertainty about their rights. All of these need to be taken into consideration.

HIV prevention activities amongst refugees and other persons of concern in the region must target those most at risk of infection. Refugees and IDPs are often seen as homogeneous populations whereas, like all populations, they contain persons with varying degrees of risk. In keeping with regional guidance on addressing HIV in low prevalence/concentrated epidemic settings, HIV interventions for persons of concern

in Asia need to target those most at risk of infection, such as sex workers and their clients, men who have sex with men and injecting drug users. General population interventions such as mass awareness activities, though appearing to reach more people, will have less impact.

It is possible to reach marginalised and highly stigmatised populations with HIV-related services in a closed setting, even in the presence of strong socio-cultural constraints. Building trust with the concerned community may take time but is necessary to facilitate uptake of services - and it is essential that this trust be maintained. Working with peers and trusted community gatekeepers will assist in reaching most-at-risk persons.

Proper assessment of HIV risk and vulnerabilities and the operating environment in each population of concern is necessary to design appropriate interventions. Each context is different and a 'one size fits all' approach is not appropriate. Local assessment is needed to determine which interventions are most appropriate and why, and to identify possible barriers to planned activities and potential solutions.

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1. Signatories to the 1951 Refugee Convention in Asia include Cambodia, China, the Philippines and Iran.
2. Including STI management, male and female condom provision, clean needles and syringes, peer outreach, peer support groups and behaviour change communication.

Innovative approaches in Malaysia

Malaysia hosts over 70,000 refugees, mostly from Myanmar/Burma, who are mainly scattered throughout the Klang Valley area (incorporating Kuala Lumpur). At the end of 2009, there were 124 refugees receiving ART supported by the Ministry of Health and UNHCR. Following expressions of concern regarding adherence to ART amongst refugees, a number of measures to support refugees on ART and to facilitate their adherence to treatment programmes were introduced, with considerable success.

A multi-level approach at home, community and facility level was adopted. Home interventions included dosage boxes, mobile phone alarms and support for adequate nutritional intake. Community activities included assigning people living with HIV to a community counsellor, mobile phone 'hotlines' and treatment support groups. All refugees access services at one hospital, Sungoh Bulai, in Kuala Lumpur, which has structured its services to meet the needs of refugees. All new and follow-up appointments for refugees, for example, are scheduled on the same day of the week to facilitate access to interpreters in appropriate languages and trained counsellors.

Following these interventions, medical providers reported that average viral load suppression in refugees had improved significantly and was comparable to nationals. Refugee satisfaction with the support received was high.