

# Humanitarian emergencies, armed conflict and the HIV response



## KEY POINTS:

- People affected by humanitarian emergencies and armed conflict are often at increased risk of HIV – though these crises do not always translate into an increase in infections.
- Refugees and displaced people are not usually included in national HIV strategies meaning prevention and treatment services may not reach them.
- Humanitarian emergencies and armed conflict exacerbate existing vulnerabilities and inequalities increasing the risk of HIV for key affected populations.
- People living with, and affected by, HIV and AIDS are particularly vulnerable to the effects of instability associated with humanitarian emergencies and armed conflict.
- HIV interventions should be included in planning for emergency to ensure that the growing number of people living with HIV and affected by humanitarian emergencies can access treatment and that prevention services are in place.

Read this page to find out more about the [spread of HIV during humanitarian emergencies, armed conflict and HIV](#), [refugees and HIV](#), [humanitarian emergencies and key affected populations](#), the [impact on people living with HIV](#) and a look at [the way forward](#).

Prolonged emergencies and armed conflict constitute major challenges to HIV programming and are in turn a major barrier to stopping the spread of HIV.

---

Humanitarian emergencies present contexts of fragility, vulnerability and uncertainties. These are fertile contexts for HIV transmission. Addressing HIV in emergencies is not a matter of

choice but rather a human rights issue. Populations affected by humanitarian emergencies must be central to the goal of ending AIDS. Innovation is key to achieving this outcome.

---

*Luiz Loures, UNAIDS Deputy Executive Director* [1](#)

The relationship between HIV, humanitarian emergencies and prolonged conflict is multifaceted and complex. Crises and conflict tend to exacerbate existing vulnerabilities and inequalities, contributing to the spread of HIV. Conversely, people living with and affected by HIV and AIDS are particularly susceptible to the effects of instability.

---

We are now looking at people who are affected for 17 to 20 years by a crisis. We can no longer operate a business as usual approach. We need to change to a comprehensive health response that includes sexual and reproductive health and rights that leaves no one behind.

---

*Rajat Khosla, Human Rights Advisor Reproductive Health, World Health Organization* [2](#)

### **What is a humanitarian emergency?**

There are different types of humanitarian emergencies:

**Natural disasters** can occur rapidly (for example earthquakes, tsunamis and hurricanes) or more gradually (for example drought) and also include outbreaks of disease (for example Ebola).

**Man-made emergencies** include armed conflict, environmental degradation and large-scale industrial accidents.

When these factors combine they result in **complex emergencies**. These generally involve violence and loss of life, the displacement of populations and extensive damage to societies and economies. Unplanned urbanisation, lack of infrastructure, poverty and climate change all contribute to making humanitarian emergencies more complex.[3](#)

Complex humanitarian emergencies have become more frequent and affect more people than ever before: [4](#)

- In 2013, 314 million people worldwide were affected by emergencies.[5](#)
- At the end of 2015, more than 65.3 million people were displaced from their homes.
- The majority of them (40.8 million) were **internally displaced** meaning they had not crossed a border to find safety.[6](#)

Displacement not only affects people forced from their homes but also host communities – those living in areas accommodating people who have been displaced. Many others facing humanitarian disasters remain at home but find themselves living in fragile states.

Crises are also lasting longer. Of the 58 countries that received humanitarian assistance in 2014, 49 (84%) had done so for the last five years, and 40 (69%) were on their tenth straight year of receiving humanitarian aid.<sup>7</sup>

## Emergencies, conflict and the spread of HIV

Humanitarian emergencies and conflict disrupt normal social and economic structures and activities and often involve mass displacement. The breakdown of social cohesion, lack of income, shortage of food, sexual violence, increased drug use and the disruption of health, education and infrastructure that characterise complex emergencies all contribute to putting populations affected by these crises at greater risk of HIV and present challenges for those already living with the virus.

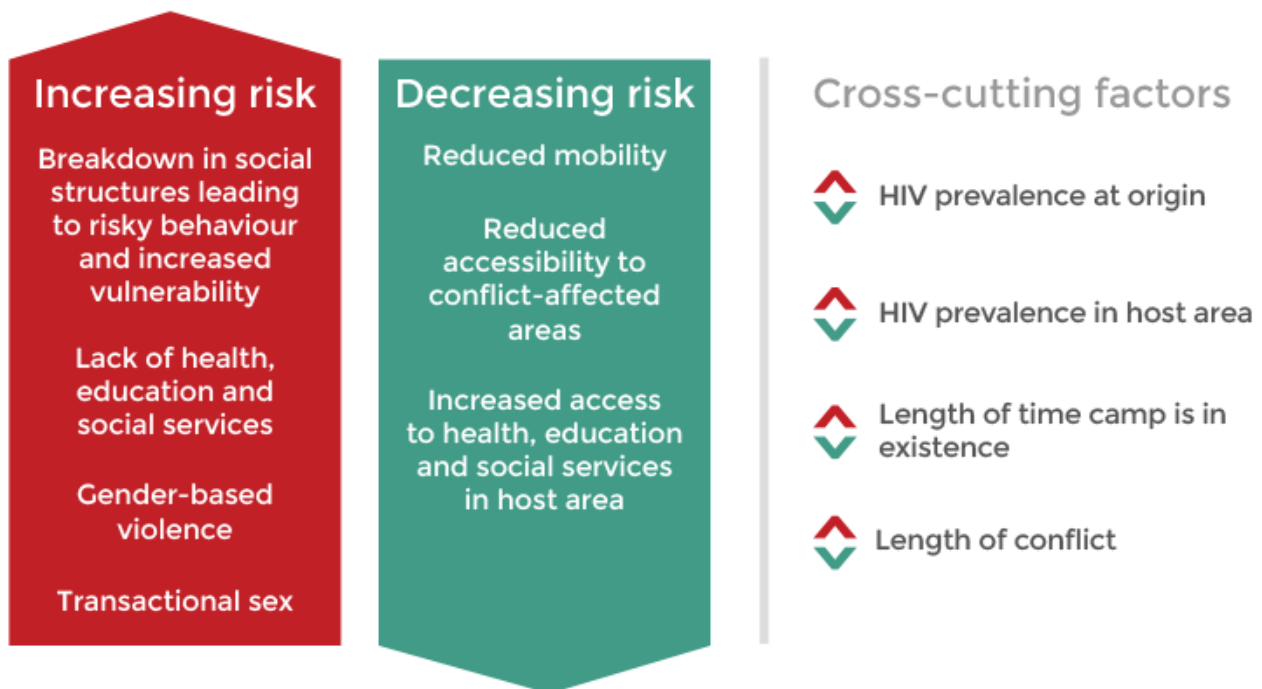
Moreover, populations most at risk of HIV in times of stability (such as women, sex workers and men who have sex with men) may become more vulnerable during humanitarian crises as existing forces of marginalisation intensify and their needs are deprioritised.

Health systems are also put under strain in emergencies and during outbreaks of conflict. This can hamper the treatment and prevention of HIV. Healthcare staff may find it harder to do their jobs and access facilities – this could be due to a range of factors including safety, access to facilities and non-payment of wages. Similarly, patients may not be able to access healthcare facilities. Emergencies can also cause problems with the supply of medication, including antiretroviral drugs, and prevention items such as condoms and testing kits.<sup>8</sup>

However, the challenges presented by emergencies do not always translate into increased infections. The spread of HIV during crises is always context-specific. Conflicting factors such as reduced mobility and access to an area, and in the case of some refugee camps improved protection, health, education and social services, may contribute to a decreased spread of HIV.<sup>9</sup> This suggests that HIV vulnerability and risk can be managed and mitigated in some contexts during emergencies. Overcoming barriers to treatment, targeted prevention services and the protection of rights are key in this. Mitigation is not always possible and will depend on factors such as existing infrastructure and how long an emergency or conflict continues.

It should also be recognised that in some cases the end of conflict may also bring the risk of increased infections as areas open up, people return, and transport and travel to the area increase. Increased focus on HIV prevention may be particularly important at this time.

## Factors affecting HIV transmission among displaced populations



AVERT.org Source: Paul B. Spiegel (2004) 'HIV/AIDS among Conflict-affected and Displaced Populations: Dispelling Myths and Taking Action', Disasters

### Case study: HIV in the aftermath of the 2010 Haiti earthquake

In 2010 a massive earthquake struck Haiti, affecting 3.5 million people. Death and destruction on a massive scale severely disrupted healthcare services, in an already fragile and impoverished state.

In the immediate aftermath of the earthquake, treating acute injuries and preventing the outbreak of communicable diseases were prioritised over other needs leading to enormous gaps in the HIV response.

HIV treatment interruption in the period immediately following the earthquake was widespread. The Haitian government estimated that 24,000 Haitians were accessing ART before the earthquake; by the summer of 2010, according to UNAIDS, less than 40% of these people still had access.<sup>10</sup>

Meanwhile, vulnerability to HIV and risk increased for many people. For example, more than 1.5 million people were made homeless and a huge number of people were forced to move into camps where many women turned to formal and informal sex work to survive. Two years after the earthquake, HIV prevalence in camps was found to be double the rate of surrounding areas.

As money was channelled through large international organisations the expertise of local organisations in working with populations most at risk went under used. This meant that even when HIV prevention and treatment services were available, hard to reach populations such as sex workers were not effectively targeted.<sup>11</sup>

## Armed conflict and HIV

Studies examining how conflict affects the spread of HIV have produced mixed, and even contradicting, results. Research by the US Centers for Disease Control and Prevention found lower than expected HIV prevalence rates in Sierra Leone in 2002 at the end of its prolonged civil war. Similarly, low prevalence rates were found in civil-war affected southern Sudan (now South Sudan) in 2003.

These HIV prevalence rates were lower than those in many surrounding countries which had not suffered from conflict. Both Sierra Leone and southern Sudan had suffered protracted conflicts over decades which severely limited access to and mobility of much of the country and population.<sup>12</sup>

In 2015, a study tracking HIV incidence in 36 sub-Saharan countries over 22 years found that the spread of HIV was fastest in the five-year period before the break out of hostilities. These findings suggest that waiting to intervene until conflict is already underway may miss a decisive opportunity to prevent new infections.<sup>13</sup>

It is important to note that findings of a decline in HIV incidence during intense conflict may in some cases reflect the fact that violence undermines accurate data collection rather than indicating a real decline. In these circumstances many new infections may remain undetected.<sup>14</sup>

### Case study: Conflict in Ukraine halts harm reduction for HIV prevention

In 2014, Russia began making incursions into Ukrainian territory. It is estimated that 40% of people living with HIV who have been receiving HIV-related harm reduction services now live in territory controlled by Russia or pro-Russian separatists.<sup>15</sup>

As Russia does not permit the use of OST, many OST services in these annexed territories have been closed down.

## Refugees and HIV

A common misconception is that refugees carry HIV and spread the infection in their new host countries. There is, however, no evidence to support this. Studies have repeatedly found that in many contexts the prevalence of HIV among refugee populations is lower than in host communities.

One study in sub-Saharan Africa found that in three of the four countries examined, refugee populations had lower HIV prevalence rates than in the surrounding host communities. Only in one country did the displaced and host populations have comparable rates.<sup>16</sup> A 2013 study reconfirmed that displaced populations, including refugees, do not have a higher HIV prevalence than host communities.<sup>17</sup>

Despite international laws protecting the universal right to health, many refugees and displaced people face barriers to HIV treatment which include exclusionary health policies and uncertain legal status which deters refugees from accessing services for fear of identification by authorities.<sup>18</sup>

Refugees and internally displaced people are not usually included in national HIV strategic plans. This means they can often fall through the gaps of prevention and treatment services as they are not specifically targeted.<sup>19</sup> Research carried out in 2010 found that a majority of countries in sub-Saharan Africa hosting more than 10,000 refugees and internally displaced people did not include

these groups in their Global Fund proposals.[20](#)

Beyond legal obligations, it is a public health imperative to include these groups in national strategic plans. This will help ensure they are able to access HIV services along with members of the host community with whom they interact on a daily basis. Providing prevention and treatment to only part of a population in a geographical area will not effectively protect public health. [21](#)

In humanitarian settings, as elsewhere, involving communities and empowering those people most affected by HIV is critical to an effective response. In the context of mass displacement, an effective HIV response must include both the displaced community and the host community.

---

I faced a lot of discrimination, but I broke my silence on HIV to try to make working on HIV a community issue and to show that we can intervene as refugees because we have a true understanding of the challenges and realities.

---

*Former refugee Mr Noé Seisaba from Burundi, who founded the Stop SIDA organisation which works on HIV initiatives in refugee camps* [22](#)

### **Case study: Providing ART in conflict zones**

In 2005, Medecins Sans Frontieres (MSF) began an HIV treatment programme in the Pool region of the Democratic Republic of Congo, an area heavily affected by violent unrest, focusing on ensuring continuity of antiretroviral treatment, the programme centred on provider-initiated testing and counselling for high-risk patients or patients with possible medical indicators of HIV at all MSF facilities (not just HIV clinics), and on the integration of HIV care and treatment with other MSF activities.

MSF implemented similar programmes in a total of 12 countries. Data collected in these programmes show patient outcomes in these post-conflict regions were comparable to those in other more stable but resource-limited settings.

MSF's recommendations for ensuring these programmes succeed include contingency planning for both staff and patients, focusing on patient adherence through education and motivation, establishing secure emergency stocks of medication, and educating patients on strategies for managing forced treatment interruptions. [23](#)

## **Emergencies, conflict and key affected populations**

Humanitarian emergencies and prolonged conflict tend to exacerbate existing vulnerabilities and inequalities. Including HIV prevention and treatment in humanitarian responses and tailoring HIV and other services to meet the needs of affected populations can radically reduce the spread of HIV.



## Women and girls

Incidence of rape and gender-based violence increases during humanitarian crises and periods of instability. Research suggests that seven out of 10 women are exposed to gender-based violence in crisis situations. In one example, after the 2011 cyclones in Vanuatu, a counselling centre recorded a 300% increase in referrals for gender-based violence.<sup>24</sup>

Research has shown that victims of gender-based violence are at a higher risk of infection as violent men are more likely to be living with HIV, to impose risky sexual practices on their partners and have multiple partners. The psychological impact of sexual abuse can also mean women become more susceptible to risky behaviours that can lead to HIV infection.<sup>25</sup>

The destruction of community structures and the splitting of families during crises mean women might be left to fend for themselves or their families alone. These circumstances mean women are more likely to trade sex for basic necessities such as food, water and shelter, increasing the risk of HIV transmission.<sup>26</sup> A 2010 HIV behavioural surveillance survey conducted in Dadaab (Kenya), the world's biggest refugee camp, found that 3% of sexually active respondents reported having transactional sex for money, gifts or favours. <sup>27</sup>

Targeted HIV interventions that protect, train and educate women are essential to halting the spread of HIV in humanitarian settings.

## Children and young people

Like women, children and young people are vulnerable to violence, abuse and coercion, including sexual violence and transactional sex which increase during crises. Forced sex in childhood or adolescence increases the risk of contracting HIV as it adds to the likelihood of engaging in unprotected sex, participating in transactional sex, having first consensual sex at a younger age and having multiple partners. <sup>28</sup>

The abusive use of children as soldiers can mean they become sexually active at a young age and may commit sexual violence which puts them at an increased risk of contracting HIV. <sup>29</sup>

Traumatic events that take place in humanitarian contexts can harm young people's mental health and increase the incidence of higher-risk behaviour such as drug and alcohol abuse and unsafe sex.<sup>30</sup>

Beyond the risk of violence and coercion, humanitarian crises limit educational opportunities as schools often close and education is disrupted, meaning other channels to deliver basic HIV prevention messages to young people must be found.<sup>31</sup> Tailored programmes to ensure young people can access HIV prevention and treatment during emergencies are integral to an effective HIV strategy.

### Case study: Youth-friendly mobile health and outreach clinics

On the Cameroon and Central African Republic border, Plan Cameroon and UNFPA are delivering youth-friendly, integrated sexual and reproductive healthcare (SRH) and education to adolescent refugees through mobile health clinics, community education and outreach.

Assessing adolescents who come to the service for protection and SRH issues, the project targets both adolescent refugees living in camps and the urban displaced population, aiming to engage the most marginalised and difficult to reach communities.

The mobile health clinics work closely with young refugees to ensure that services are

accessible, acceptable and appropriate and the clinics provide an out-of-hours service in line with their needs. At the clinics, young people have access to comprehensive SRH services including HIV testing, counselling, provision of antiretroviral treatment (ART) and clinical management of rape.<sup>32</sup>

## Sex workers

High levels of poverty, lack of livelihood opportunities, separation of families, breakdown of communities and social norms that often accompany humanitarian crises can lead to sex being sold or exchanged for shelter, food and protection.<sup>33</sup> The presence of armed groups, armies, other uniformed services and aid workers can also lead to an increase in sex work.

In these circumstances sex is frequently unprotected, exposing sex workers and their clients to sexually transmitted infections (STIs), including HIV.<sup>34</sup> Many women who take up sex work during emergencies may not have been sex workers before. They may, therefore, find it more difficult to network with other sex workers and negotiate safer sex, which puts them at higher risk of HIV infection. Fear of violence and stigma may also prevent sex workers from seeking health services.<sup>35</sup>

---

The needs of sex workers are often not met in emergencies. Sex workers are left out at all stages of planning... They need access to sex worker friendly comprehensive reproductive health services including counselling services at locations of their choice... During emergencies sex workers need consistent access to condoms... Barriers to access condoms increase their risks of pregnancy, STIs and HIV.

---

*Sathya Doraiswamy, senior regional HIV officer for the UN Refugee Agency (UNHCR)*<sup>36</sup>

In 2010, UNHCR launched guidelines on HIV and sex work in refugee situations. The guidelines include calls to involve sex workers and the wider community, identify 'hotspots' where sex work takes place, protect sex workers and provide health services and sex worker peer-led systems. <sup>37</sup>

## Men who have sex with men

During crises a breakdown in targeted prevention services means that men who have sex with men may become harder to reach and more vulnerable to HIV infection. In times of stability, targeted, locally tailored services, such as safe spaces provided by community centres or established social networks, help to mitigate the risk of HIV to marginalised groups. These, however, may cease to function during emergencies.

During non-emergency times, for example, 85% of men who have sex with men in Kathmandu, Nepal, access condoms principally through drop-in centres that cater specifically to their community. Such places were not able to operate in the wake of the earthquake that hit Nepal in 2015. This left men who have sex with men and other sexual minorities with no access to HIV treatment and prevention services.<sup>38</sup>



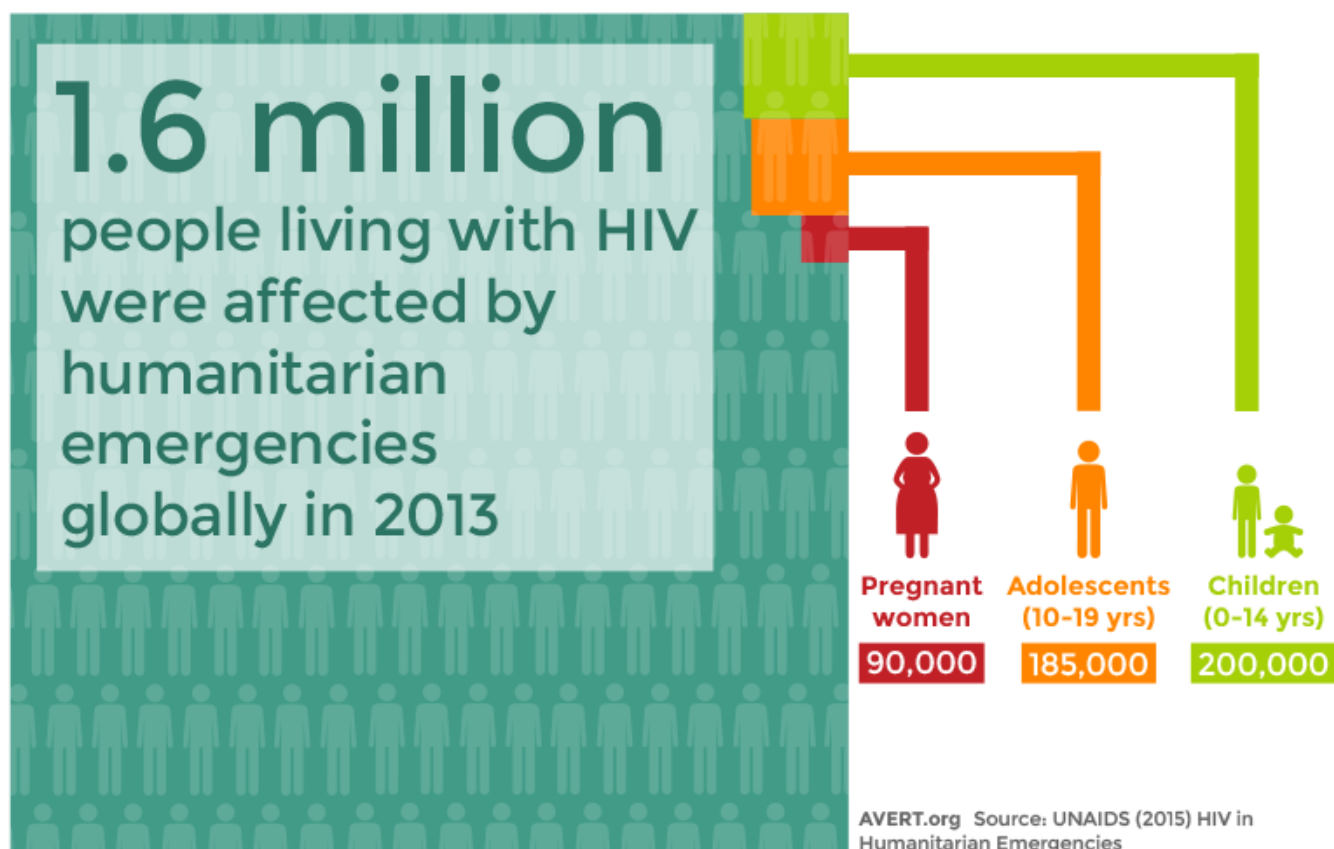
The loss of support networks during periods of increased violence can also lead men who have sex with men, who are often seen as an easy target, to go into hiding and not prioritise their health. They may also have difficulty accessing aid and assistance during crises, when women and children are typically considered most vulnerable and prioritised in the humanitarian response.

In the aftermath of the Haiti earthquake, food rations schemes in some camps targeted women only – on the assumption that women would ensure a more equitable distribution of food among their family. This meant that any man outside a traditional family setting could not access rations, inadvertently excluding any men who have sex with men and transgender people who had been rejected by their families.<sup>39</sup>

## The impacts of emergencies and conflict on people living with HIV

People living with and affected by HIV and AIDS are particularly vulnerable to the effects of instability associated with humanitarian emergencies and prolonged crises. Unfortunately, a huge number of people living with HIV are affected by crises every year.

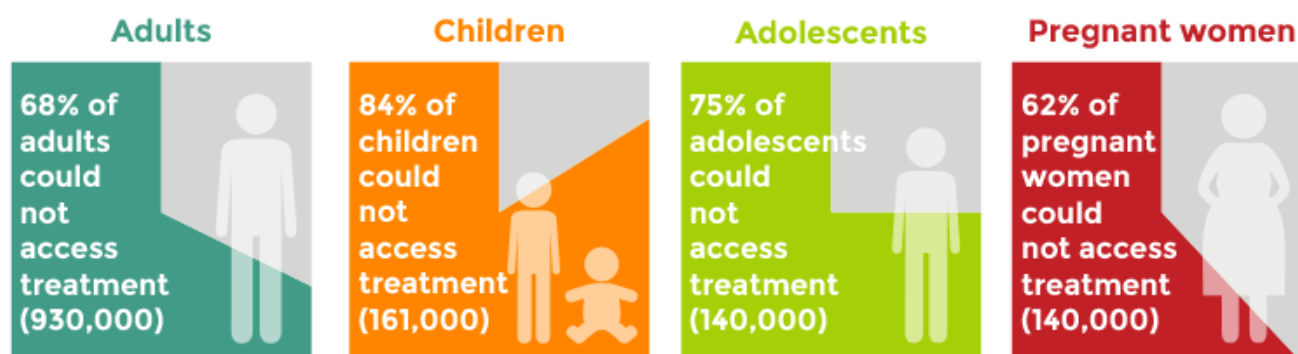
In 2013, one in every 22 people living with HIV was affected by humanitarian emergencies (a total of 1.6 million people). The vast majority of these people (1.3 million/81%) were in sub-Saharan Africa.<sup>40</sup>



Humanitarian emergencies and prolonged crises make accessing HIV treatment more difficult. This is particularly the case when large numbers of people become displaced and social infrastructure is disrupted. In 2013, more than one million people living with HIV were estimated to have been unable to access ART due to humanitarian emergencies.<sup>41</sup> People living with HIV who are unable to access treatment face an increased risk of opportunistic infections and developing AIDS-defining

illnesses. Treatment interruption may also lead to complications such as drug resistance.<sup>42</sup>

## 1.29 million people living with HIV could not access treatment because of humanitarian emergencies in 2013



AVERT.org Source: UNAIDS (2015) HIV in Humanitarian Emergencies

Lack of access to healthcare also poses the problem of patients going unmonitored. This means they may end up taking the wrong treatment or not starting treatment when they need to.<sup>43</sup>

---

We are talking about incredible numbers of people and multiple layers of vulnerability. This is too big a scale and impact to ignore. We have to ensure that HIV prevention and treatment services are systematically integrated into emergency responses.

---

*Mr Michel Sidibé, Executive Director of UNAIDS.*<sup>44</sup>

### **Case study: Ensuring access to ART for refugees in Malaysia**

In 2009, Malaysia hosted more than 70,000 refugees, mostly from Burma. At that time there were 124 refugees receiving ART supported by the Ministry of Health and UNHCR.

A number of measures to support them and facilitate their adherence were introduced. Home interventions included dosage boxes, mobile phone alarms and nutritional support. Community activities included community counsellors, mobile phone 'hotlines' and treatment support groups.

A hospital, Sungoh Bulai, in Kuala Lumpur, structured its services to meet the needs of refugees. All new and follow-up appointments were 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 viral load suppression in refugees had improved significantly and was comparable to nationals. Refugee satisfaction with the support received was high.<sup>45</sup>

# Food and nutrition for people living with HIV affected by emergencies

Emergencies often cause food shortages or hikes in food prices, resulting in food insecurity and malnutrition among affected populations.

People living with HIV need more calories and nutrients to stay healthy, have lower appetites and are less able to absorb nutrients. Malnutrition is a particular risk for people living with HIV, increasing the likelihood of dying in the first six months of HIV treatment by between two and six-fold.<sup>46</sup>

Food insecurity makes it harder to adhere to treatment. It can also result in behaviour, such as transactional sex, which puts individuals at higher risk of HIV. Eleven out of 30 UNAIDS Fast Track priority countries are among the world's most food insecure.<sup>47</sup>

In many countries, national policy frameworks for HIV have started to include food and nutrition support. In emergencies and prolonged crises, food and nutrition interventions should be integrated as a key component of a minimum healthcare package.<sup>48</sup>

## The way forward: Including HIV in humanitarian responses

In the past, HIV interventions were not included in humanitarian responses as they were considered to be addressing a developmental issue. In 2003, the Inter-Agency Standing Committee (IASC) published the first comprehensive guidelines for addressing HIV in humanitarian settings to help those involved in emergency response to deliver HIV prevention, care and support to people affected by humanitarian crisis.

Since then, there has been a growing awareness that HIV interventions must be multi-sectoral, begin at the onset of a conflict or emergency, and be continued through every stage.<sup>49</sup> However, the reality on the ground has often fallen short of aspirations. In many humanitarian settings there remain substantial gaps in the provision of HIV services.

Sexual health, including HIV prevention and treatment services, has not been prioritised in humanitarian responses despite being included in the SPHERE handbook which sets out minimum standards for humanitarian response. <sup>50</sup> This means that a significant number of people living with HIV and affected by emergencies continue to lack access to treatment, yet more are put at risk of contracting HIV as they lack access to prevention services.

UNAIDS emphasises that stronger integration of HIV treatment and prevention into emergency planning (at national, international and organisational levels) is crucial to ensure HIV services can continue in humanitarian contexts. This should include:

- determining roles and responsibilities of key actors prior to any emergency
- decentralising stocks of medication and prevention supplies, such as condoms and testing kits, so that they are dispersed between a number of facilities
- improving HIV-related data management including patient follow-up plans with a unique identification number for each patient
- using tools such as health travel cards with details of treatment to help ensure treatment is not interrupted if patients are forced to move
- providing longer-term prescriptions
- ensuring that HIV services are available in camps for people who have been displaced

- providing rapid tests
- ensuring safe blood transfusions.<sup>51</sup>

However, the provision of HIV services during crises is clearly still not meeting the needs of the people affected. This remains a major hurdle in the global fight against HIV and AIDS.

---

We cannot end the AIDS epidemic by 2030 if we do not provide protection, care and treatment to people affected by emergencies. It is a matter of public health for people displaced by emergencies and those that host them. It is a basic human right.

---

*Paul Spiegel, Deputy Director, Division of Programme Support and Management at the United Nations High Commissioner for Refugees*<sup>52</sup>

**Photo credit:** ©flickr/UNHCR

### Tools and resources:

IASC (2010) [Guidelines for Addressing HIV in Humanitarian Settings](#)

- 1. UNAIDS (2015) [HIV in Humanitarian Emergencies](#) [pdf]
- 2. IPPF (2016) '[Global Call for Urgent Action on Sexual and Reproductive Health in Humanitarian settings](#)'. (Accessed on: 04/05/2017)[pdf]
- 3. Humanitarian Coalition '[What is a Humanitarian Emergency](#)' (Accessed on: 04/05/2017)
- 4. Humanitarian Policy Group (2016) '[Time to let go - Remaking Humanitarian Action for the Modern Era](#)' (Accessed on: 04/05/2017)
- 5. UNAIDS (2015) [HIV in Humanitarian Emergencies](#)[pdf]
- 6. UNHCR (2016)'[Global Trends: Forced Displacement in 2015](#)'[pdf]
- 7. ALNAP (2015) [State of the Humanitarian System report](#) [pdf]
- 8. AIDSTAR-One (2012) [HIV Treatment in Complex Emergencies](#)[pdf]
- 9. Paul Spiegel, United Nations High Commissioner for Refugees (2004) [HIV/AIDS among Conflict-affected and Displaced Populations](#)[pdf]
- 10. AIDSTAR-One (2012) [HIV Treatment in Complex Emergencies](#)[pdf]
- 11. International HIV/AIDS Alliance (2014) [The HIV response in emergencies: Lessons learnt from the 2010 Haiti earthquake](#)[pdf]
- 12. Paul Spiegel, United Nations High Commissioner for Refugees (2004) [HIV/AIDS among Conflict-affected and Displaced Populations](#) [pdf]
- 13. Brady W. Bennett et al. (2015) '[HIV Incidence Prior to, during, and after Violent Conflict in 36 Sub-Saharan African Nations, 1990-2012: An Ecological Study](#)'
- 14. Brown University (2015) '[HIV spreads faster as violent conflict looms](#)' (accessed 05/05/2017)
- 15. Ukrainian Center for Socially Dangerous Disease Control of the Ministry of Health of Ukraine (UCDC) '[Ukraine Country Progress Report 2015](#)'
- 16. Paul Spiegel, United Nations High Commissioner for Refugees (2004) [HIV/AIDS among Conflict-affected and Displaced Populations](#) [pdf]
- 17. UNAIDS (2015) [HIV in Humanitarian Emergencies](#) [pdf]
- 18. UNAIDS et al (2014) '[Guidelines for the Delivery of Antiretroviral Therapy to Migrants and](#)

- [Crisis-Affected Persons in Sub-Saharan Africa' \[pdf\]](#)
- 19. Paul Spiegel [HIV in emergencies – much achieved, much to do in HIV/Aids security and conflict](#)
  - 20. Paul Spiegel et al. (2010) ['Conflict-affected displaced persons need to benefit more from HIV and malaria national strategic plans and Global Fund grants'](#)
  - 21. Paul Spiegel et al. (2010) ['Conflict-affected displaced persons need to benefit more from HIV and malaria national strategic plans and Global Fund grants'](#)
  - 22. UNAIDS (2015) [HIV and Humanitarian Emergencies](#)
  - 23. AIDSTAR-One (2012) [HIV Treatment in Complex Emergencies](#)
  - 24. STOPAIDS (2014) [Factsheet HIV and failing states\[pdf\]](#)
  - 25. STOPAIDS (2014) [Factsheet HIV and failing states \[pdf\]](#)
  - 26. IPPF ['The Forgotten Priority: Sexual and Reproductive Health in Crises'](#) (Accessed on: 04/05/2017)
  - 27. UNHCR and IGAD (2010) [HIV Behavioural Surveillance Survey in Dadaab refugee camp\[pdf\]](#)
  - 28. STOPAIDS (2014) [Factsheet HIV and failing states \[pdf\]](#)
  - 29. Paul Spiegel, United Nations High Commissioner for Refugees (2004) [HIV/AIDS among Conflict-affected and Displaced Populations \[pdf\]](#)
  - 30. STOPAIDS (2014) [Factsheet HIV and failing states \[pdf\]](#)
  - 31. Oxfam (2007) [Humanitarian Programmes and HIV and AIDS - A Practical Approach to Mainstreaming](#)
  - 32. STOPAIDS (2014) [Factsheet HIV and failing states \[pdf\]](#)
  - 33. Ann Burton et al. [Addressing HIV and sex work in HIV/Aids security and conflict](#)
  - 34. ODI Briefing paper (2009) [HIV and emergencies: One size does not fit all](#)
  - 35. IRIN (2012) ['Sex Workers Need Help Too'](#)
  - 36. IRIN (2012) ['Sex Workers Need Help Too'](#)
  - 37. UNHCR (2010) [HIV and sex work in refugee situations: A practical guide to launching interventions\[pdf\]](#)
  - 38. BMJ (2015) [Remote districts are still inaccessible five days after second Nepal earthquake](#)
  - 39. IRIN (2013) [HIV and emergencies - the data quandary](#)
  - 40. UNAIDS (2015) [HIV in Humanitarian Emergencies \[pdf\]](#)
  - 41. UNAIDS (2015) [HIV in Humanitarian Emergencies\[pdf\]](#)
  - 42. Marita Mann et al. (2013) ['Effects of Political Conflict Induced Treatment Interruptions on HIV Drug Resistance'](#), AIDS Reviews, 15(1), 15–24.
  - 43. UNAIDS (2015) [HIV in Humanitarian Emergencies \[pdf\]](#)
  - 44. UNAIDS (2015) [HIV and Humanitarian Emergencies](#)
  - 45. Ann Burton (2010) [HIV, refugees and conflict affected populations in Asia in HIV/AIDS, security and conflict: making the connections, Forced Migration review](#)
  - 46. UNAIDS (2015) [HIV in Humanitarian Emergencies\[pdf\]](#)
  - 47. UNAIDS (2015) [HIV in Emergency Contexts\[pdf\]](#)
  - 48. UNAIDS and WFP (2014) [Nutrition assessment, counselling and support for adolescents and adults living with HIV\[pdf\]](#)
  - 49. Paul Spiegel, United Nations High Commissioner for Refugees (2004) [HIV/AIDS among Conflict-affected and Displaced Populations](#)
  - 50. The Sphere Project [Essential health service – sexual and reproductive health standard 2: HIV and AIDS](#)
  - 51. UNAIDS (2015) [HIV in emergency contexts \[pdf\]](#), UNAIDS (2015) [HIV in Humanitarian Emergencies](#), AIDSTAR-One (2012) [HIV Treatment in Complex Emergencies\[pdf\]](#)
  - 52. UNAIDS (2015) [HIV and Humanitarian Emergencies](#)

**Last full review:** 04 May 2017

**Last updated:** 12 June 2017

**Next full review:** 04 May 2020