



PROGRESS REPORT

on the implementation of
United Nations Security Council Resolution 1983

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EXECUTIVE SUMMARY

United Nations Security Council Resolution 1983 (UNSCR 1983), adopted on 7 June 2011, calls for urgent and coordinated international action to curb the impact of the HIV epidemic in conflict and post-conflict situations. The Resolution identifies numerous stakeholders as contributors in this effort. Within this overall effort, the Resolution stresses the importance of strong support by United Nations peacekeeping operations, including through the incorporation of HIV prevention, testing, treatment and support services within the implementation of peacekeepers' mandated tasks, and the continuation of such support during and after transitions to other configurations of the United Nations presence. The Resolution also calls for the United Nations Secretary-General to consider the HIV-related needs of people living with, affected by and vulnerable to HIV, including women and girls, within efforts to prevent and resolve conflict, to maintain international peace and security, and to prevent and respond to conflict-related sexual violence.

While fully recognizing the critical importance of coordinated action across all stakeholders referenced in UNSCR 1983, this report focuses primarily on the contribution of United Nations peacekeeping operations and collaboration with other United Nations entities in implementing the Resolution. Where relevant information and data were available, the specific activities and roles of other entities, including United Nations Country Teams, have been included.

Five years after the adoption of UNSCR 1983, the United Nations system, and in particular United Nations peacekeeping operations, have made a considerable contribution to the AIDS responses in conflict and post-conflict situations. A basic package of HIV awareness, prevention and testing services is provided almost routinely to peacekeeping personnel. These efforts appear to be working: there is no evidence that HIV has significantly impacted the effectiveness of a peacekeeping mission. The incorporation of HIV awareness-raising and HIV service delivery within the mandated activities of peacekeeping missions were evident in progress reports from six missions. These missions' contributions to national AIDS responses often include HIV sensitization and awareness training to national military, national police, ex-combatants and internally displaced people; training of peer educators within national uniformed services; and extension

of voluntary HIV testing and counselling, condom distribution and post-exposure prophylaxis to the host population. Most missions in countries with relatively high HIV prevalence have integrated HIV services with efforts to prevent and respond to sexual and gender-based violence. Collaboration among relevant United Nations system entities—at headquarters and country level—has been consistently associated with positive results and smoother transition of United Nations support from post-conflict and humanitarian modalities to longer-term national and local reconstruction and development programmes.

Meanwhile, the response to HIV has transitioned from emergency management of a global crisis to a systematic effort to deliver HIV services at the level required to end AIDS as a public health threat by 2030. Data trends underscore the importance of continued engagement by the United Nations within conflict and post-conflict settings during this phase of the AIDS response. The number of people living with HIV accessing antiretroviral therapy and the number of people displaced by conflict are both rising steadily. These two independent trends will likely make conflict-related disruption of life-saving HIV treatment more common. A similar trend can be seen regarding humanitarian emergencies. In 2013 more than 1 million people living with HIV affected by emergencies did not have access to HIV treatment, including 161 500 children and 56 000 pregnant women. United Nations structures and guidance must be ready for this challenge. For example, policy and programmatic guidance on HIV for peacekeeping missions requires periodic updating to incorporate the immense changes in recent years in the HIV epidemic and the body of knowledge on how to respond to it effectively, as well as the emergence of conflict-related sexual violence on the agenda of the Security Council.

Ensuring the most effective use of limited resources requires a review and update of the architecture for joint United Nations action against AIDS in emergency settings—including conflict and post-conflict—to reflect the most recent international commitments on AIDS, the links between sexual violence and HIV infection in conflict and post-conflict settings, and the latest knowledge on effective responses to HIV. The results of such a review should include an updated cooperation framework among relevant United Nations entities, updated policy and programmatic guidance, and reinforced management and accountability structures for implementation.

METHODOLOGY

UNSCR 1983 emphasizes the urgent need for coordinated international action to address HIV and AIDS in conflict and post-conflict situations among numerous stakeholders, including Member States, United Nations entities, international financial institutions and others. United Nations peacekeeping operations are recognized as important contributors to an integrated response. While fully recognizing the critical importance of coordinated action, this progress report focuses primarily on the contribution of United Nations peacekeeping operations and collaboration with other United Nations entities.

Inputs for this report were sought from a wide range of sources. Progress reports on the implementation of UNSCR 1983 were received from 14 peacekeeping missions¹ and four Country Offices of the Joint United Nations Programme on HIV/AIDS (UNAIDS).² In addition, a desk review was undertaken of relevant documentation, reports and studies conducted since the Security Council's first resolution on HIV in 2000, with a particular focus on documentation that followed the adoption of UNSCR 1983 in 2011. This included regular reporting on HIV responses by United Nations Member States and the United Nations system. Inputs were reviewed and collated by a team of independent consultants, and the report was finalized by UNAIDS and the Department of

Peacekeeping Operations (DPKO), in consultation with United Nations entities, including the Department of Political Affairs (DPA), the Office of the High Commissioner for Human Rights, and the Office of the Special Representative of the Secretary-General on Sexual Violence in Conflict.

An important limitation is the ad hoc nature of progress reporting to date. This is due in large part to the unstable nature of conflict and post-conflict environments, and also the absence of a specific monitoring and evaluation framework for the implementation of UNSCR 1983. The scope of the report is therefore focused primarily on the actors that provided the most information: United Nations peacekeeping missions and their closest partners in the delivery of HIV services, such as United Nations system agencies. The actions of other entities in the operative paragraphs of the Resolution, such as Member States, may be underrepresented as public health systems often struggle to report data from areas affected by conflict—especially the output, outcome and impact data used to measure collective efforts to achieve national and international targets. The findings of the report are thus limited to the systems in place within the United Nations system to implement the Resolution, the level of United Nations implementation of the Resolution within settings where reports are available, and a comparison between these levels of implementation and the local HIV epidemic.

¹ The United Nations Mission for the Referendum in Western Sahara (MINURSO), the United Nations Multidimensional Integrated Stabilization Mission in the Central African Republic (MINUSCA), the United Nations Multidimensional Integrated Stabilization Mission in Mali (MINUSMA), the United Nations Stabilization Mission in Haiti (MINUSTAH), the United Nations Organization Stabilization Mission in the Democratic Republic of the Congo (MONUSCO), the United Nations Assistance Mission in Afghanistan (UNAMA), the African Union–United Nations Hybrid Operation in Darfur (UNAMID), the United Nations Peacekeeping Force in Cyprus (UNFICYP), the United Nations Interim Force in Lebanon (UNFIL), the United Nations Mission in Kosovo (UNMIK), the United Nations Mission in Liberia (UNMIL), the United Nations Mission in the Republic of South Sudan (UNMISS), the United Nations Operation in Côte d'Ivoire (UNOCI) and the United Nations Truce Supervision Organization (UNTSO).

² Central African Republic, Côte d'Ivoire, Democratic Republic of the Congo and Haiti.

INTRODUCTION

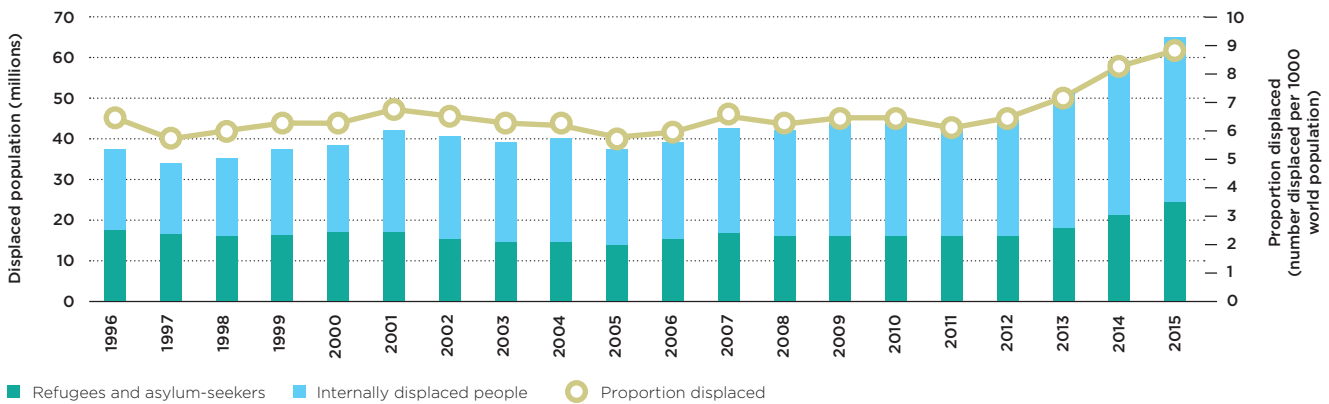
UNSCR 1983 (2011) was adopted as the number of people forcibly displaced by conflict began to climb to unprecedented levels. The United Nations High Commissioner for Refugees (UNHCR) reported that a record high of 42.5 million people were forcibly displaced worldwide in 2011 as a result of persecution, conflict, generalized violence or human rights violations (1). By 2015, this number had risen to 65.3 million people—an increase of more than 50% in five years (Figure 1) (1). In 2014, when 59.4 million were displaced by conflict, an additional 19.3 million people were displaced by natural disasters (2).³

Over the same period, there has been tremendous progress in the expansion of medical treatment for people living with HIV. Global coverage of antiretroviral therapy grew from 9.1 million people in

2011 to 17 million people in 2015 (3). These gains in HIV treatment are largely responsible for a 26% decline in AIDS-related deaths since 2010 (Figure 2) (3). Wider availability of antiretroviral medicines has played a major role in the steady scale-up and improvement of services to prevent mother-to-child transmission of HIV, which has in turn reduced the annual number of new infections among children globally by 56% since 2010 and by 70% since 2000 (4).

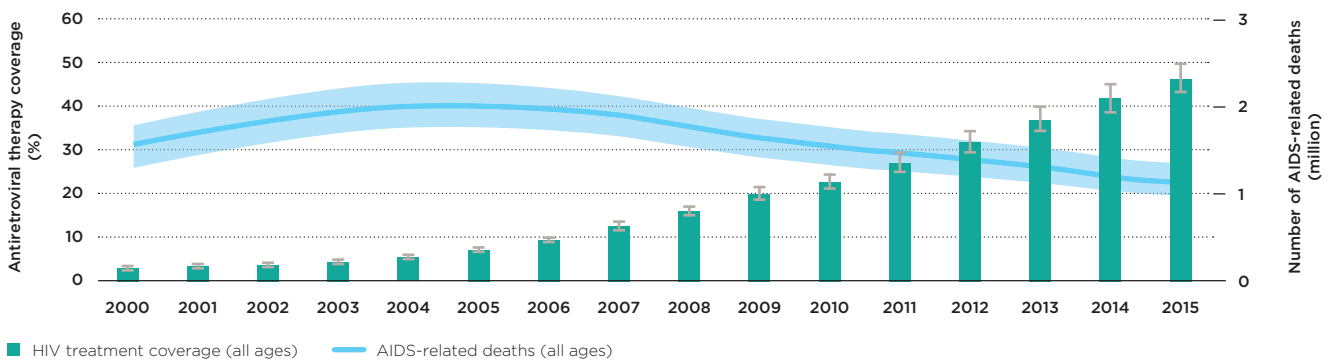
Progress on reducing new HIV infections among adults (aged 15 years and older) has slowed, however, remaining static at an estimated 1.9 million new infections annually from 2010 to 2015 (Figure 3) (4). This levelling of new HIV infections, combined with the steady reduction in AIDS-related deaths, has seen the number of people living with HIV rise from an estimated 33.3 million [30.9 million–36.1 million] in 2010 to 36.7 million [34.0 million–39.8 million] in 2015 (3).

Figure 1
Trend of global displacement and proportion displaced, 1996–2015



Source: Global trends: forced displacement in 2015. Geneva: United Nations High Commissioner for Refugees; 2016.

Figure 2
Antiretroviral therapy coverage and number of AIDS-related deaths, global, 2000–2015

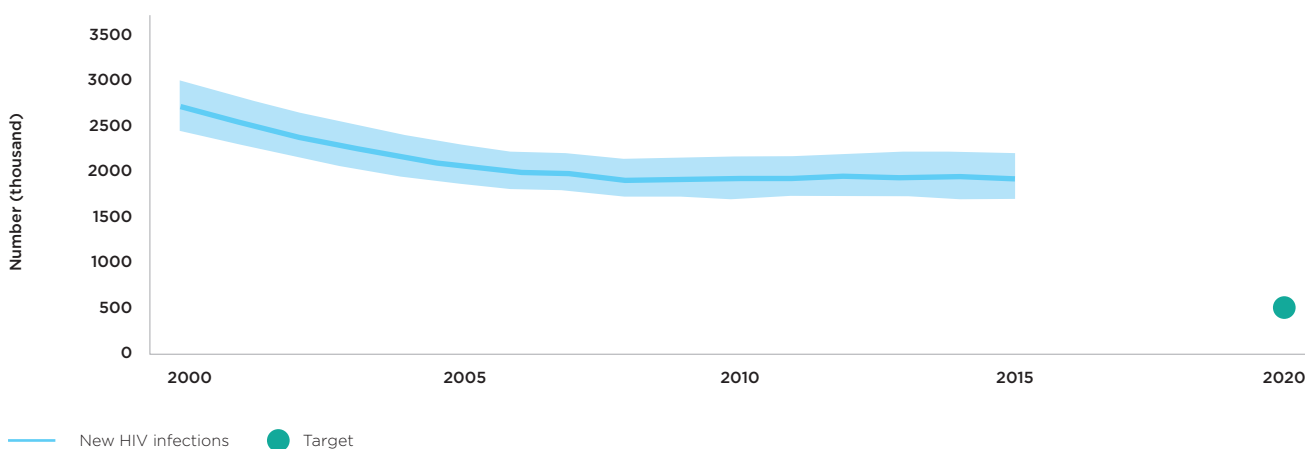


Sources: Global AIDS Response Progress Reporting 2016; UNAIDS 2016 estimates.

³ A significant fluctuation in the number of people displaced by natural disasters from year to year is driven by relatively infrequent but huge events that displace millions of people at a time. The average annual number of people displaced from 2008 to 2014 was 26.4 million, with a high of 42.4 million in 2010 and a low of 15.0 million in 2011.

Figure 3

New HIV infections among adults (aged 15 years and older), global, 2000-2015



Source: UNAIDS 2016 estimates.

The increasing number of people living with HIV accessing antiretroviral therapy, combined with parallel growth in conflict-related displacement of people, increases the likelihood that conflict or natural disaster will disrupt the delivery of life-saving HIV treatment. Moreover, the risk of sexual violence and exploitation increases significantly during population flight and in refugee and displacement settings, although social stigma and cultural taboos may prevent victims from seeking justice and medical services even when they are available. Joint research conducted by the United Nations Children’s Fund (UNICEF), UNHCR and the World Food Programme (WFP) produced a conservative estimate of 1.6 million people living with HIV affected by humanitarian emergencies in 2013 (5). More than 80% of these people were in sub-Saharan Africa (5). Five years after the United Nations Security Council adopted UNSCR 1983, its encouragement of the incorporation of HIV prevention, testing and counselling, treatment, care and support into the implementation of mandated tasks of peacekeeping operations appears prescient.

HIV, CONFLICT AND UNITED NATIONS PEACEKEEPING

Peacekeeping operations are deployed to carry out a broad variety of mandates, ranging from monitoring ceasefires, to providing

good offices, implementing peace agreements, and consolidating peace by providing security and contributing to building inclusive and responsive state institutions. To this end, they are tasked with an increasingly diverse range of activities, which may include protecting civilians, facilitating political dialogue, monitoring and reporting on violations of human rights, preventing and responding to sexual and gender-based violence,⁴ including conflict-related sexual violence,⁵ supporting electoral processes, disarmament demobilization and reintegration processes, and security sector reform, to name but a few.

In 2000, the United Nations Security Council’s first-ever resolution on HIV, UNSCR 1308, focused on the provision of HIV prevention training and HIV testing and counselling for peacekeeping personnel both before and after deployment. The content of UNSCR 1308 reflected fears regarding the role that peacekeeping could play in the spread of HIV, and included measures to mitigate the risk of HIV among peacekeepers. An Expert Panel on HIV Testing in United Nations Peacekeeping Operations was convened in 2001 in response to concerns expressed by United Nations Security Council Members. The Expert Panel recommended voluntary HIV counselling and testing, within a comprehensive and integrated package of HIV prevention and care services, as the most effective means of preventing the transmission of HIV, including among peacekeepers, host populations, and the spouses and partners of

⁴ The term “sexual and gender-based violence” refers to any type of violence directed against individuals or groups on the basis of their sex. The reference includes any act that inflicts physical, mental or sexual harm or suffering, threats of such acts, coercion and other deprivations of liberty. Although women, men, girls and boys can all be victims of gender-based violence, women and girls are the main victims. In post-conflict countries, levels of sexual and gender-based violence are especially high (6).

⁵ The term “conflict-related sexual violence” refers to incidents or patterns of sexual violence—that is, rape, sexual slavery, forced prostitution, forced pregnancy, enforced sterilization or any other form of sexual violence of comparable gravity against women, men, girls or boys. Such incidents or patterns occur in conflict and post-conflict settings and other situations of concern. They also have a direct or indirect nexus with the conflict or political strife itself—that is, a temporal, geographical or causal link. In addition to the international character of the suspected crimes (which can, depending on the circumstances, constitute war crimes, crimes against humanity, acts of torture or genocide), the link with conflict may be evident in the profile and motivations of the perpetrator(s), the profile of the victim(s), the climate of impunity/weakened state capacity, cross-border dimensions or the fact that it violates the terms of a ceasefire agreement (7).

peacekeepers (9). No member of the panel supported mandatory testing by or for the United Nations. The 2004 HIV Testing Policy for Uniformed Peacekeepers issued by DPKO and the Department of Field Support (DFS) states that the sole criterion for deploying and retaining a peacekeeper is “fitness to perform peacekeeping duties during the term of deployment ... the HIV status of an individual is not in itself considered an indication of fitness for deployment in a peacekeeping mission”.

In response to UNSCR 1308, DPKO developed a comprehensive strategy on peacekeeping and HIV that went beyond the expectations of the Resolution by including the establishment of projects for outreach to local communities and mainstreaming the issue of AIDS into mission mandates (10). Efforts by peacekeeping operations to support the host government to address HIV risks within vulnerable communities in post-conflict environments were recognized in a Presidential Statement that followed the 18 July 2005 United Nations Security Council discussion on HIV/AIDS and international peacekeeping operations. In 2007 DPKO and DFS issued a Policy Directive on the Role and Functions of HIV/AIDS Units in United Nations Peacekeeping Operations. The Directive describes a range of HIV services that should be provided to peacekeeping mission personnel to reduce their risk of contracting or transmitting HIV, including HIV sensitization and awareness training, voluntary and confidential HIV counselling and testing, condom distribution and post-exposure prophylaxis. The 2007 Directive also states that HIV/AIDS units within missions should also support, as appropriate, integration of HIV concerns in the specific mission mandate, such as the integration of HIV sensitization and awareness within disarmament, demobilization and reintegration efforts and the reform of state security services; gender mainstreaming efforts; public information campaigns; and Quick-Impact Projects focused on HIV-related outreach or capacity-building. The directive stresses that peacekeeping missions are neither the lead nor a primary actor in supporting national AIDS responses, and that the integration of HIV concerns in relevant mission-mandated functions should be based on collaboration and coordination with the United Nations Country Team.

A joint UNAIDS–DPKO review in 2011 of programmes that addressed HIV among international peacekeepers and uniformed services between 2005 and 2010 found that HIV had been mainstreamed into all active peacekeeping missions during the reporting period, that pre-deployment HIV training had become standard practice for all troop- and police-contributing countries, and that an increased level of HIV prevention and care

services had been provided to uniformed services and United Nations peacekeeping personnel (11). Evidence available to the review suggested that the impact of AIDS on the health of international peacekeeping personnel and uniformed services has been mitigated by these efforts. It also noted that efforts to make condoms available to peacekeepers were implemented in conjunction with clear rules on appropriate behaviour and stringent measures against sexual exploitation and abuse.⁶ In addition, major gaps and challenges were identified, including insufficient budget allocation, inconsistent condom use among peacekeeping personnel, insufficient emphasis on HIV prevention, and a need to address HIV-related stigma and discrimination. The report called for greater policy attention and service continuity during post-conflict situations. It recommended Member States and the United Nations to adopt a “command-centred approach” with clear lines of accountability and enforcement mechanisms for both HIV prevention and the prevention of sexual violence—coupled with the notion of zero tolerance for sexual abuse by peacekeepers—within conflict-affected environments (11).

PASSAGE OF UNSCR 1983

Shortly after the release of the joint review, the United Nations Security Council met on 7 June 2011 to discuss the impact of the HIV epidemic on international peace and security. The resulting resolution, UNSCR 1983, underlines that urgent and coordinated international action is required to curb the impact of the HIV epidemic in conflict and post-conflict situations. It notes the disproportionate burden borne by women and girls in conflicts as a result of their vulnerability to sexual and gender-based violence, and it urges Member States, United Nations entities, international financial institutions and other relevant stakeholders to support the development and strengthening of capacities of national health systems and civil society networks in order to provide sustainable assistance to women living with or affected by HIV in conflict and post-conflict situations. The Resolution also requests the United Nations Secretary-General to consider the HIV-related needs of people living with, affected by and vulnerable to HIV within United Nations efforts to prevent and resolve conflicts, to build peace in post-conflict settings, and to maintain international peace and security. It reaffirms the past Security Council’s resolutions on conflict-related sexual violence,⁷ and it calls for the consideration of HIV-related issues within efforts to prevent and respond to conflict-related sexual violence. It also requests the Secretary-General to continue and strengthen implementation of the zero-tolerance policy on sexual exploitation and abuse in United Nations missions.

⁶ “Sexual exploitation” is any actual or attempted abuse of a position of vulnerability, differential power or trust for sexual purposes, including, but not limited to, profiting monetarily, socially or politically from the sexual exploitation of another. “Sexual abuse” is the actual or threatened physical intrusion of a sexual nature, whether by force or under unequal or coercive conditions (8).

⁷ Relevant United Nations Security Council Resolutions include UNSCR 1308 (2000), UNSCR 1325 (2000), UNSCR 1820 (2008), UNSCR 1888 (2009), UNSCR 1889 (2009), UNSCR 1894 (2009), UNSCR 1960 (2010) and UNSCR 2106 (2013).

UNSCR 1983 recognizes United Nations peacekeeping operations as important contributors to an integrated AIDS response and expressly welcomes the incorporation of HIV-related communications in mandated activities and outreach projects for vulnerable populations. The Resolution further notes the importance of strong support by United Nations mission civilian and military leadership for comprehensive HIV services, and encourages the incorporation of HIV prevention, testing, treatment and support services within the implementation of mandated tasks of peacekeeping operations, such as assistance to national institutions, security sector reform, and disarmament, demobilization and reintegration processes, and the continuation of this support during and after transitions from peacekeeping missions to other configurations of the United Nations presence.

IMPLEMENTATION OF UNSCR 1983

At both the global and the mission level, United Nations peacekeeping activities on HIV should be developed and implemented in consultation with the wider United Nations system. DPKO and UNAIDS signed a Cooperation Framework in 2001 on mitigating the impact of HIV on international peace and security, and assisting in the development of a comprehensive HIV and AIDS policy within DPKO. Within this framework, UNAIDS provides technical and advisory support to DPKO in the development and organization of training, codes of conduct, HIV testing of mission personnel, in-mission treatment, prevention and best practices.

Implementation of UNSCR 1983 begins before deployment, when troop-contributing countries prepare their military units to serve as peacekeepers. The Resolution calls for continued cooperation among Member States for the development and implementation of sustainable HIV and AIDS prevention, treatment, care and support, capacity-building, and programme and policy development for uniformed and civilian personnel to be deployed to United Nations missions. In practice, the pre-deployment training and HIV testing policies of troop-contributing countries vary. Concerns regarding the consistency and quality of troop-contributing countries' preparation for deployment to peacekeeping operations in the region were paramount during a 2013 effort by the African Union, the International Labour Organization (ILO) and UNAIDS to develop a standard protocol for African Union Member States to follow. Interaction with senior military and medical staff from African Union Member States revealed that military sectors in the African Union are conversant on HIV and keenly aware of its implications for recruitment into the military, deployment on peacekeeping missions and reintegration on return from peacekeeping missions.

They also shared the challenges faced by contributing countries, including insufficient time available to ministries of defence and military staff to organize deployment and include voluntary and confidential HIV testing and counselling in the pre-deployment schedule; maintaining confidentiality of HIV test results; and addressing HIV-related stigma and discrimination within their militaries. Other regional efforts to improve the consistency and quality of the HIV training and services provided to uniformed services and troop-contributing countries of peacekeeping missions include the West and Central Africa Military Network on the Fight Against AIDS and the Committee for Prevention and Control of Armed Forces and Police in Latin America and the Caribbean.

Following deployment, a standard package of HIV services for United Nations peacekeeping personnel—HIV awareness and sensitization induction training, condom programming, voluntary counselling and testing and post-exposure prophylaxis—is provided almost universally at the mission level. Eleven of 14 active missions were providing all of these services in 2016, according to progress reports from peacekeeping missions.⁸ Most field missions conduct specialized training for peer educators; assistants for promotion of HIV testing; and design and development of information, education and communication materials to address specific issues. United Nations peacekeeping policies on HIV call for this to be repeated in step with, and so as to cover, all troop rotations and induction of civilian personnel. HIV awareness training for peacekeeping personnel is sometimes conducted in collaboration with UN Cares, the United Nations system-wide workplace programme on HIV.

Efforts to incorporate HIV-related communications and outreach into the mandated tasks of the peacekeeping mission were evident in progress reports from six missions: the United Nations Multidimensional Integrated Stabilization Mission in Mali (MINUSMA), the United Nations Stabilization Mission in Haiti (MINUSTAH), the United Nations Organization Stabilization Mission in the Democratic Republic of the Congo (MONUSCO), the African Union–United Nations Hybrid Operation in Darfur (UNAMID), the United Nations Mission in the Republic of South Sudan, (UNMISS) and the United Nations Operation in Côte d'Ivoire (UNOCI). These missions' contributions to national AIDS responses often include HIV sensitization and awareness training to national military, national police, ex-combatants and internally displaced people; training of peer educators within national uniformed services; and extension of voluntary HIV testing and counselling, condom distribution and post-exposure prophylaxis to the host population.

⁸ Exceptions include the United Nations Mission for the Referendum in Western Sahara (MINURSO), where HIV-related activities are limited to in-mission briefings and distribution of condoms; and the United Nations Peacekeeping Force in Cyprus (UNFICYP), where voluntary and confidential HIV testing and counselling is not available to mission personnel due to capacity constraints.

A “delivering-as-one” approach among United Nations entities and flexible partnerships (including national governments, nongovernmental organizations and civil society) have been critical to implementation of UNSCR 1308 and UNSCR 1983 (12). Many individual missions stressed within their progress reports the importance of coordination with other entities within the United Nations Country Team, such as UNAIDS, the United Nations Population Fund (UNFPA) and UNICEF, as well as local and international nongovernmental organizations. In South Sudan, for example, collaboration between UNMISS and the United Nations Country Team is guided by a five-year joint programme of support and joint annual work plans.

The breadth and depth of HIV-related programming undertaken by the United Nations system in conflict and post-conflict settings generally correlates with the severity of the HIV epidemic within the host country. During periods of greater instability, peacekeeping missions tend to play larger roles within the wider system of United Nations support. In South Sudan, following a deterioration in the security situation in December 2013 and an increase in the number of people internally displaced by conflict, UNMISS collaborated with UNAIDS and the International Organization on Migration in 2014 to provide comprehensive HIV services to more than 400 000 internally displaced people at six protection sites.

A notable exception to this pattern is the United Nations Multidimensional Integrated Stabilization Mission in the Central African Republic (MINUSCA). The MINUSCA report notes that the mission has a different structure, and two staff from the MINUSCA medical unit provide HIV services to all mission personnel, including awareness-raising, condom distribution, and voluntary and confidential HIV counselling and testing. In a host country where HIV prevalence among adults over the age of 15 years is 3.7%, HIV prevalence among women over the age of 15 years is 4.3%, and antiretroviral treatment is available to only 24% of an estimated 120 000 people living with HIV, HIV issues have not been incorporated into mandated activities. The medical unit has expressed concerns regarding the mission’s ability to appropriately handle HIV-positive test results and the treatment and care of mission personnel living with HIV.

MINUSMA in Mali previously did not incorporate HIV concerns into mission-mandated tasks and provided minimal HIV services to mission personnel. Upon the establishment of an HIV/AIDS unit and laboratory services in 2015, however, voluntary and confidential HIV testing and counselling is now available to mission personnel and HIV services are being incorporated into disarmament, demobilization and reintegration and security sector reform processes.

Some missions reported the use of Quick-Impact Projects—small-scale, low-cost and short-timeframe projects that aim to build confidence in the mission, the mandate or the peace process—to provide more robust contributions to conflict and post-conflict

AIDS responses in collaboration with the wider United Nations system. In Mali, Quick-Impact Projects were used by MINUSMA and UNAIDS to provide nutritional support to 224 people living with HIV and educational support to 400 children living with or affected by HIV. In Côte d’Ivoire, UNOCI and the United Nations Country Team used Quick-Impact Projects to work with local governments and people living with HIV to refurbish health-care facilities providing HIV testing and treatment and prevention of mother-to-child transmission services, as well as the headquarters of the network of people living with HIV.

Several mission reports cited insufficient financial and human resources as the principal challenges to full implementation of UNSCR 1983. The budgetary and resource requirements of peacekeeping operations come under heavy scrutiny by Member States and audit bodies. Linked to this, there has also been a stronger recognition that peacekeeping operations are meant to be time-bound, limited presences in a country. In an effort to make peacekeeping operations illustrate their efficiency, effectiveness and responsiveness to the dynamic environments in which they operate, the Security Council has therefore become more vocal about the importance of benchmarks, comparative advantages, transitions and exit strategies.

For example, United Nations Security Council Resolution 2098 (2013), relating to the mandate of MONUSCO, refers to a division of labour between the mission and the United Nations Country Team and calls for transfer of appropriate tasks to the Government or the Country Team. The HIV/AIDS unit of MONUSCO was a critical actor during the early stages of the post-conflict recovery process; by 2014 a framework for the progressive handover to UNAIDS and civil society organizations was established.

In transition settings, as peacekeeping operations prepare to downsize and withdraw, HIV/AIDS units must strengthen partnerships with United Nations entities and others. For example, in Côte d’Ivoire in 2015–2016, the UNOCI HIV/AIDS unit has begun handing over external HIV activities to the United Nations Country Team and has limited its future activities to HIV services for mission personnel. During this transition, UNAIDS has provided additional technical support to efforts to sensitize ex-combatants in HIV, sexually transmitted infections and gender-based violence, and UN Women launched a media campaign on the rights of women survivors of violence that incorporated HIV (13). Similarly, a contraction of the size of the United Nations Mission in Liberia (UNMIL) included the incorporation of the HIV/AIDS unit into a broader mission support division in July 2015 and the limiting of HIV-related services to mission personnel.

The mandates of some missions preclude the incorporation of HIV services into mandated tasks. For example, the United Nations Truce Supervision Organization (UNTSO) operating in

Israel, Lebanon, the Syrian Arab Republic, Egypt and Jordan is mostly a military observer mission that does not engage in the kinds of activity that lend themselves to HIV awareness-raising or service delivery. HIV awareness training for UNTSO mission personnel is provided by the United Nations Interim Force in Lebanon (UNIFIL), which acts as a regional hub and services provider for neighbouring peacekeeping missions, in addition to its primary mandated tasks (14). Although UNIFIL activities are fundamentally internal to the mission, the HIV/AIDS unit also provides culturally sensitive HIV and life skills development activities to 1613 people in local communities, the majority of whom are women and in-school youth.

More detailed HIV epidemic and peacekeeping mission response profiles are included in Annex 1 of this report.

HIV AND SEXUAL AND GENDER-BASED VIOLENCE, INCLUDING CONFLICT-RELATED SEXUAL VIOLENCE

An increasing body of evidence shows that violence against women and girls, especially intimate partner violence, increases the risk of HIV infection within high-prevalence settings (15). Violence has also been linked to quicker HIV-related disease progression among women and girls living with HIV. Violence and trauma can lead to lower CD4 counts,⁹ higher viral loads and lower adherence to prevention and treatment (16). High rates of sexual exploitation and violence within conflict and post-conflict environments create particular HIV risks, including lack of safe and accessible clinical care. Forced sex, including anal rape, is associated with increased genital trauma, abrasions and coital injuries, which facilitate HIV transmission (17). In addition, perpetrators of sexual violence are more likely to practise unprotected sex and have multiple sexual partners, increasing the probability that they have HIV or another sexually transmitted infection (18). The short- and long-term effects of sexual violence and HIV can be physically and psychologically debilitating for the survivors.

United Nations efforts to address conflict-related sexual violence are reported annually by the Secretary-General, as required by UNSCR 1820 (2008), UNSCR 1888 (2009), UNSCR 1960 (2010) and UNSCR 2106 (2013).¹⁰ This report complements those reporting efforts by focusing specifically on the United Nations Security Council's call within UNSCR 1983 for the strengthened implementation of a zero tolerance policy on sexual violence in United Nations missions and for the consideration of HIV-related issues within efforts to prevent and respond to conflict-related

sexual violence. This call was strengthened in UNSCR 2106 (2013), which urges United Nations entities, Member States and donors to support the development and strengthening of capacities of national health systems and civil society networks in order to provide sustainable assistance to women and girls living with or affected by HIV and AIDS in armed conflict and post-conflict situations.

The women's protection advisers and focal points deployed in MINUSCA, MINUSMA, MONUSCO, UNAMID, UNMISS and UNOCI have been mainstreaming HIV considerations in their advocacy, political engagements, preventive measures and coordinating service provision. The link between HIV and conflict-related sexual violence and measures to address them effectively are being included in upcoming guidance and a training curriculum on conflict-related sexual violence.

Efforts to integrate mission activities on HIV and conflict-related sexual violence need to be considered within the overall context of the HIV epidemic and the prevalence of sexual and gender-based violence in these countries. The UNSCR 1983 progress reports from missions in countries with relatively high HIV prevalence show that most have integrated HIV services with efforts to prevent and respond to sexual and gender-based violence. In the Democratic Republic of the Congo, for example, training of health-care workers on how to treat and counsel survivors of sexual violence included training on the provision of post-exposure prophylaxis for HIV infection. This particular effort appears to respond to findings within the reports of the Secretary-General on conflict-related sexual violence that survivors of conflict-related sexual violence have limited access to post-exposure prophylaxis. In contrast, there is no reporting on the integration of HIV and conflict-related sexual violence efforts by MINUSCA in the Central African Republic, where only 26% of survivors seek assistance within 72 hours, missing a critical opportunity to prevent HIV transmission or unwanted pregnancy and to gather forensic evidence (19). Even before the outbreak of violent conflict, the Central African Republic's National Committee for the Fight Against AIDS noted in 2013 the lack of a framework for providing services to survivors of sexual violence (20). Since then, the Government of the Central African Republic and the United Nations Country Team have provided some services. In 2015 UNFPA supported the training of 55 young, conflict-affected mothers in Bossangoa and Kaga Bando to conduct peer outreach on the prevention of HIV and sexually transmitted infections, gender-based violence and family planning. The peers reached 690 single mothers, 436 of whom received HIV tests and 5 of whom tested positive for HIV. A similar outreach programme conducted in partnership with le Haut-Commissariat à la Jeunesse Pionnière Nationale in Bangui reached 541 young people, including nine who tested positive for HIV (21).

⁹ CD4 cells are an essential part of the human immune system. HIV infection leads to a progressive reduction in the number of these CD4 cells, which in turn suppresses the immune system. The level of immunosuppression in a person living with HIV can therefore be measured through counting the number of CD4 cells within a cubic millimetre of blood.

¹⁰ The two most recent reports of the Secretary-General on conflict-related sexual violence are S/2015/203 and S/2016/361.

Close collaboration between the mission, the United Nations Country Team, the host government and local organizations appears to deliver more robust results. For example, UNOCI worked with UNICEF, UNAIDS and UNFPA to train 469 representatives from 60 local women's organizations on sexual and gender-based violence and HIV. These community workers went on to sensitize about 1500 people, register 32 survivors of sexual violence and provide medical support to 11 of them.

UNSCR 1983 requests the Secretary-General to continue and strengthen implementation of the zero-tolerance policy on sexual exploitation and abuse in United Nations missions. The Secretary-General reported to the United Nations General Assembly on 16 February 2016 on special measures being undertaken in response to allegations of sexual exploitation and abuse in the United Nations system (22). The 2007 DPKO-DFS Policy Directive on the Role and Functions of HIV/AIDS Units in United Nations Peacekeeping Operations stresses that the United Nations' zero tolerance policy on sexual exploitation and abuse must be adhered to under all circumstances by all United Nations personnel.

CONTINUING GLOBAL ATTENTION

The adoption of the 2030 Agenda for Sustainable Development reaffirms the interconnectedness of development, human rights and peace and security, providing an opportunity to build more concrete bridges between Goal 3 on good health and well-being, including reducing the spread of the AIDS epidemic, Goal 5 on gender, and the United Nations broader engagement on peace and conflict. The 2014–2015 Ebola crisis in West Africa was a stark reminder of the political, social, economic, humanitarian and security dimensions of complex health emergencies. It also spoke of the importance of a coordinated United Nations response and rapid, effective and efficient action to address a global health crisis.

The UNAIDS Programme Coordinating Board dedicated the thematic session of its 30 June–2 July 2015 meeting to HIV in emergency contexts. An analysis presented at the meeting found that increases in sexual violence and transactional sex, and decreases in access to resources and services during emergencies, led to increases in HIV-related risks—and yet people affected by humanitarian emergencies, such as armed conflicts, were rarely given due attention within HIV strategies or programmes (23). An analysis by UNHCR, UNICEF and UNAIDS found that more than 1 million people living with HIV and affected by emergencies did not have access to HIV treatment in 2013, including 161 500 children and 56 000 pregnant women (24). WFP noted that people living with HIV in emergency situations are particularly vulnerable to food shortages and malnutrition (23). Presenters at the session also noted that emergencies have adverse effects on key populations, increasing their vulnerability to gender-based violence, deepening poverty, contributing to further

marginalization and discrimination, and prompting many people to turn to transactional sex in order to survive (23).

The UNAIDS Board has called on the UNAIDS Secretariat and Cosponsors to ensure that appropriate HIV interventions are routinely incorporated in all humanitarian emergency preparedness and response programmes, and to assist national AIDS programmes to incorporate an appropriate level of preparedness and disaster risk-reduction strategies to ensure continuation of comprehensive HIV services during humanitarian emergencies. Within these efforts, the UNAIDS Board called for particular action on gender-based violence, cross-border and regional collaboration, production and use of strategic information, and advocacy for increased funding for organizations working on HIV in humanitarian emergencies (23).

The overlapping concerns around conflict-related sexual violence, allegations of sexual exploitation and abuse by peacekeeping personnel, and the spread of HIV in conflict and emergency settings were addressed by a multisectoral panel of eminent experts on the sidelines of the 2016 United Nations General Assembly High Level Meeting on Ending AIDS. Panellists cautioned that HIV and high-risk social drivers such as sexual violence must be squarely addressed during conflicts and humanitarian crises in order to achieve the HIV target within the 2030 Agenda for Sustainable Development. Impassioned calls were made for the survivors of sexual violence to receive comprehensive assistance, including a full range of sexual and reproductive health services, HIV awareness and response measures, psychosocial and livelihood support, and avenues for legal recourse and justice. It was noted that peacekeeping missions and the wider United Nations system can help create an enabling environment and provide support, but only the reform of national security, military and justice institutions can provide long-term solutions. Panellists agreed that allegations of sexual exploitation and abuse by peacekeepers require a strong response, including United Nations system-wide action and measures by troop- and police-contributing countries to hold their personnel to account. DPKO also reaffirmed its commitment to ensuring appropriate HIV and AIDS preparedness of all peacekeeping personnel, and that peacekeeping operations are early contributors to strong and coordinated HIV responses in conflict and post-conflict settings (25).

The United Nations General Assembly 2016 Political Declaration on HIV and AIDS notes the increased vulnerabilities of displaced people and people affected by humanitarian emergencies and commits United Nations Member States to pursuing the continuity of HIV prevention, treatment, care and support and to providing a package of care for people living with HIV, tuberculosis or malaria in humanitarian emergencies and conflict settings, with a particular focus on women living with, at risk of or affected by HIV in conflict and post-conflict situations. Rising numbers of people living with HIV and much higher coverage of antiretroviral therapy

in regions with conflict and post-conflict situations increase the likelihood of a disruption of life-sustaining medical care. The United Nations system must be better prepared to recognize and respond to these disruptions in antiretroviral therapy and other critically needed HIV services and contribute to efforts to achieve 90–90–90¹¹ and other Fast-Track targets agreed by the General Assembly.

In April 2016 the United Nations System Chief Executives Board adopted a statement of commitment that puts forth concrete commitments on how the United Nations system can support conflict prevention within the 2030 Agenda for Sustainable Development. DPA supports United Nations Country Teams in undertaking conflict and political analysis, and in designing and implementing conflict-sensitive programming through the United Nations Development Programme–DPA Joint Programme on Building National Capacities for Conflict Prevention. Such support could be expanded to include a focus on HIV in conflict and post-conflict settings, where relevant.

MAIN FINDINGS

The contribution of United Nations peacekeeping operations to the AIDS responses in a multitude of conflict and post-conflict situations to date underscores the importance of continued engagement by United Nations peacekeeping operations and other United Nations entities as the world endeavours to reach the level of service coverage required to end AIDS as a public health threat by 2030. Progress towards this ambitious goal requires a continuation of what is working well and addressing areas of inconsistency and inefficiency using the latest tools and knowledge on effective HIV responses.

HIV SERVICES FOR UNITED NATIONS PEACEKEEPING PERSONNEL

A basic suite of HIV services for peacekeeping personnel—including HIV awareness-raising during pre-deployment and mission induction training, condom programming, voluntary and confidential HIV testing, and post-exposure prophylaxis—is provided almost routinely. The impact of these predominantly preventive measures is difficult to measure. In the words of one independent review in 2015, however, “there is no evidence to indicate that HIV has had a significant impact on peacekeeping effectiveness to date. This may be attributable, at least in part, to the programmes and policies the United Nations has put in place” (26). As the same cannot be said consistently of other communicable diseases, the systematic rights-based approach to HIV awareness and prevention among mission personnel should be viewed as a model to similar pre-deployment and in-mission

efforts to ensure the good health and appropriate behaviour of peacekeepers.

Predeployment training by some troop-contributing countries needs strengthening. A 2012 rapid assessment of pre-deployment policy and training on HIV and gender-based violence among troop-contributing countries in eastern and southern Africa, the region with the highest prevalence of HIV, found that neither commanding officers nor rank-and-file troops were equipped adequately to participate in HIV and AIDS activities and programmes alongside host or protected populations (27). In addition, serious consideration should be given to include sensitization on sexual orientation and gender identity, and protection of the lesbian, gay, bisexual and transgender community, as part of the pre-deployment training for United Nations peacekeepers.

INCORPORATION OF HIV WITHIN MANDATED ACTIVITIES OF PEACEKEEPING MISSIONS

Whether missions incorporate HIV awareness-raising and HIV service delivery within the mandated activities of peacekeeping missions, and at what level, has been driven by a number of factors, including the scope of the mission mandate, the severity of the HIV epidemic within the mission area, the levels of human and financial resources made available, and the level of collaboration with the wider United Nations family and other key stakeholders. In most cases, the prioritization or de-prioritization of HIV among a range of potential health and humanitarian actions appears to be driven by rational decision-making within the mission command structure. In a few cases, however, the absence of an HIV/AIDS advisor or a dedicated HIV/AIDS unit within a mission, or lack of integration of HIV concerns within mission activities despite the presence of these human resources, is difficult to justify within settings where HIV is clearly a major public health concern.

HIV-related awareness-raising and service delivery by the United Nations should be guided by the most recent programmatic experience and scientific innovations. The 2007 DPKO and DFS policy directive on the HIV-related roles and responsibilities of peacekeeping missions requires periodic updating to ensure that the HIV-related work of missions in conflict and post-conflict situations remains relevant and effective.

INCORPORATION OF HIV INTO EFFORTS TO ADDRESS SEXUAL AND GENDER-BASED VIOLENCE, INCLUDING CONFLICT-RELATED SEXUAL VIOLENCE

The links between HIV and conflict-related sexual violence reinforce the fact that HIV is a human rights challenge as well as a public

¹¹ 90% of people living with HIV know their HIV status, 90% of people who know their HIV-positive status are accessing treatment, and 90% of people on treatment have suppressed viral loads.

health challenge (28). Increased attention to conflict-related sexual violence is an opportunity to improve the effectiveness of AIDS responses and provide greater protection to women, girls and other vulnerable groups within conflict and post-conflict settings. However, this opportunity needs to be recognized more strongly and acted upon by United Nations peacekeeping missions and United Nations Country Teams. Meanwhile, considerable efforts have been made to evaluate efforts to address violence against women and its links to HIV, including within conflict settings, and to identify good practices that are delivering real results. A recent expert review highlighted research showing that sexual violence during conflicts and other complex emergencies is often committed by intimate partners or other civilians (16). The findings also suggest that effective strategies to address intimate partner violence and HIV, such as the economic empowerment of women and girls through cash transfers, keeping girls in school and gender transformation programmes, may also be effective in conflict and post-conflict settings. It is important to ensure that the United Nations system uses these findings to improve the consistency and effectiveness of its interventions.

UNITED NATIONS COORDINATION AND COLLABORATION

Collaboration among relevant United Nations system entities—at headquarters and country level—has consistently been associated with positive results and smoother transition of United Nations support from post-conflict/humanitarian modalities to longer-term national and local reconstruction and development programmes. At the country level, more consistent engagement of missions' HIV/AIDS units in coordination mechanisms such as joint United Nations working groups on HIV, gender or protection may contribute to more effective use of resources available to the United Nations system to support national and local HIV responses. At the headquarters level, strengthening the partnership among DPKO, DFS, DPA and UNAIDS will be essential to the improvement of policy and programmatic guidance, leadership and accountability regarding how the United Nations incorporates HIV into gender-informed peacekeeping, peacemaking and peace-building. The United Nations Secretariat efforts to strengthen system-wide assessments, planning and analysis could support further integration and collaboration across the United Nations development, human rights and peace and security pillars on HIV-related issues. In addition, collaboration with the office of the Special Representative of the Secretary-General on Sexual Violence in Conflict should be strengthened further to ensure synergies between the AIDS response and efforts to prevent and address sexual violence in conflict and post-conflict settings.

MANAGEMENT, GUIDANCE AND ACCOUNTABILITY

A 2011 UNAIDS–DPKO review found that HIV prevention successes in military forces were most often achieved through

approaches that place responsibility for HIV policy and practice within the military command rather than its health services (11). The review recommended a command-centred approach to HIV policy development and implementation with clear lines of accountability and enforcement mechanisms.

Despite the subsequent adoption of UNSCR 1983, there have been minimal changes in the policy guidance on HIV for United Nations peacekeeping. Policy guidance on the roles and responsibilities of missions' HIV/AIDS units has not changed since 2007—a nine-year period of time that has seen immense change in the HIV epidemic and the body of knowledge on how to respond to it effectively. The policy guidance also offers little specific advice to missions regarding the delivery of HIV services within conflict and post-conflict environments.

In addition, reporting of results by missions appears to be ad hoc in nature, driven by occasional headquarters' requests rather than through systematic monitoring and evaluation. Missions also struggle to obtain sufficient strategic information to design effective interventions. DPKO leadership has recognized that improved collection of data on the nature and scope of the HIV risk and vulnerable communities is required to improve United Nations peacekeepers' responses to HIV and conflict-related sexual violence (29).

THE DANGER OF COMPLACENCY

Following more than a decade of strong global progress against HIV—especially expansion of the availability of antiretroviral therapy, bringing both treatment and preventive benefits—one of the greatest threats to the global AIDS response is complacency. At a policy level, steady declines in AIDS-related deaths may be misperceived by national governments or international institutions as a signal that HIV is no longer a global priority. Behind fragile gains in the delivery of HIV treatment and the prevention of mother-to-child transmission of HIV lurks a steady rate of new HIV infections among adults globally. Epidemic models based on the latest available data suggest that HIV prevalence will remain stable for years to come. HIV awareness and prevention efforts within conflict and post-conflict settings undertaken by the United Nations, the African Union and other national and multinational entities require additional vigilance. Efforts to establish higher standards of pre-deployment preparations—such as the draft protocol developed by the African Union, UNAIDS and ILO—should be reinvigorated. There is also an opportunity to build on the HIV and conflict-related sexual violence prevention training provided to peacekeeping personnel. Troop-contributing countries could, for example, be encouraged to facilitate the use of former military, police and civilian peacekeepers upon their repatriation as peer educators within national uniformed forces or as providers of appropriate services to the local civilian population.

RECOMMENDATIONS

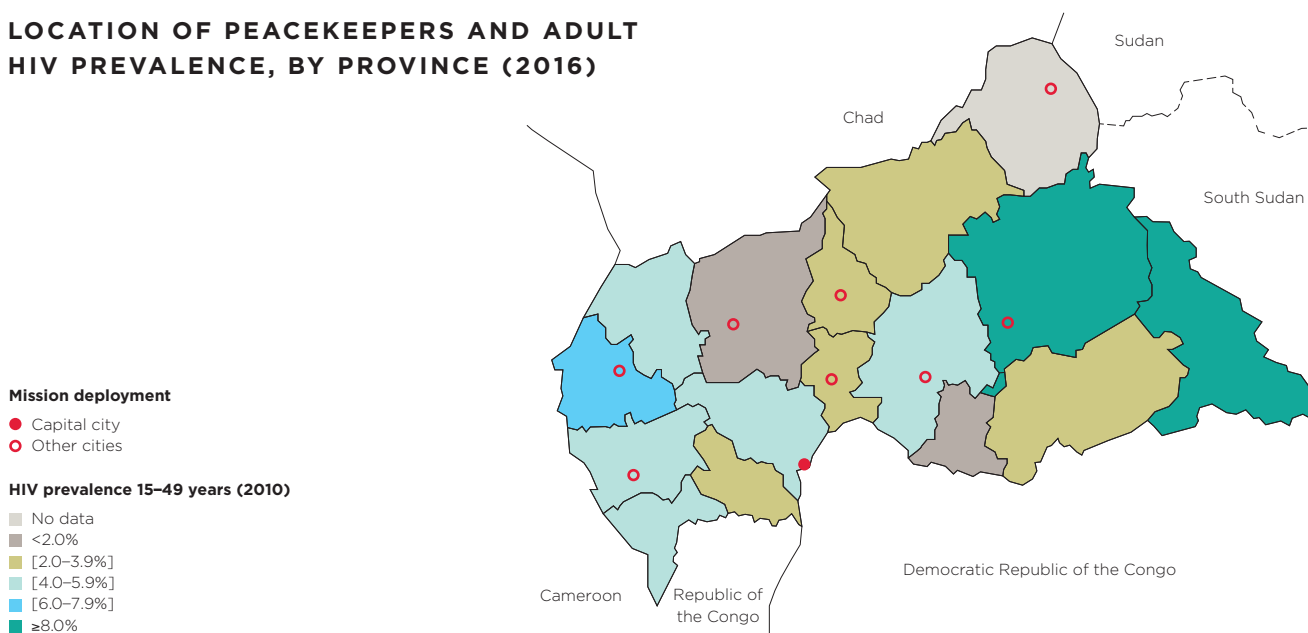
Ensuring the most effective use of limited resources requires stronger and smarter joint United Nations action against AIDS in emergency settings, including conflict and post-conflict settings, that reflects the most recent international commitments on AIDS and conflict-related sexual violence, and applies the latest knowledge on effective responses to HIV in a variety of settings.

- an updated cooperation framework among relevant United Nations entities for supporting AIDS responses in emergency settings, including conflict and post-conflict, that reflects the comparative advantages, roles and responsibilities of the United Nations entities directly engaged in United Nations peace operations, humanitarian responses and the relevant UNAIDS Cosponsors; such a framework should define clearly who does what both on the ground and at headquarters level;
- a specific, evidence-driven mechanism to guide the inclusion of HIV services—including psychosocial support, sexual and reproductive health care, and socioeconomic reintegration support—within the mandated activities of peacekeeping missions so they are tailored to the nature and scale of the HIV epidemic and the needs of vulnerable communities and key populations at higher risk of HIV infection within the mission area, and thus make the best use of limited resources;
- up-to-date policy and programmatic guidance on HIV service delivery by the United Nations system within conflict and post-conflict situations (e.g. population mobility, temporary camps or informal settlements for refugees and displaced people), with particular emphasis on:
 - the continuation of HIV prevention and testing services, and life-sustaining medical treatment and care for people living with HIV in conflict, post-conflict situations and displacement settings;
 - well-integrated, cross-cutting, human rights-based and gender-transformative programming on sexual and gender-based violence, including conflict-related sexual violence, and HIV;
 - clear procedures for the transition of peacekeeping missions' HIV-related support to other configurations of the United Nations presence in post-conflict situations;
 - meaningful engagement of people living with and affected by HIV in all aspects of HIV responses within conflict and post-conflict settings;
 - improved collection and analysis of sex- and age-disaggregated data during programme design, and inclusion of monitoring and evaluation frameworks with periodic reporting of sufficient data to measure the effectiveness of implementation;
 - a research agenda to improve understanding of the dynamics between HIV transmission and sexual and gender-based violence in conflict and post-conflict settings, including access to key services, that is led by United Nations entities with the relevant research capacities and leverages the presence of peacekeeping missions.

ANNEX

*Eight United Nations
peacekeeping missions
operating in areas of higher
HIV prevalence*

LOCATION OF PEACEKEEPERS AND ADULT HIV PREVALENCE, BY PROVINCE (2016)

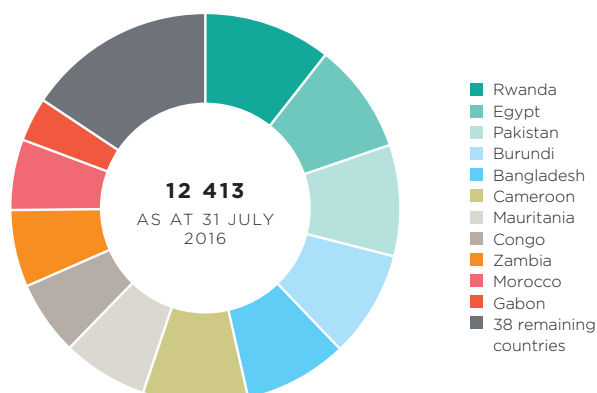


NATIONAL HIV EPIDEMIC AND RESPONSE DATA (2015)

COUNTRY	CENTRAL AFRICAN REPUBLIC
HIV prevalence (adults, 15–49)	3.7% [3.2–4.2%]
Annual new HIV infections (all ages)	7000 [5700–8900]
Number of people living with HIV (all ages)	120 000 [100 000–130 000]
Annual AIDS-related deaths (all ages)	7800 [7000–8600]
Percentage of PLHIV receiving ART	24% [21–27%]
Coverage of PMTCT services	56% [49–64%]

TOTAL MISSION PERSONNEL: 13 327

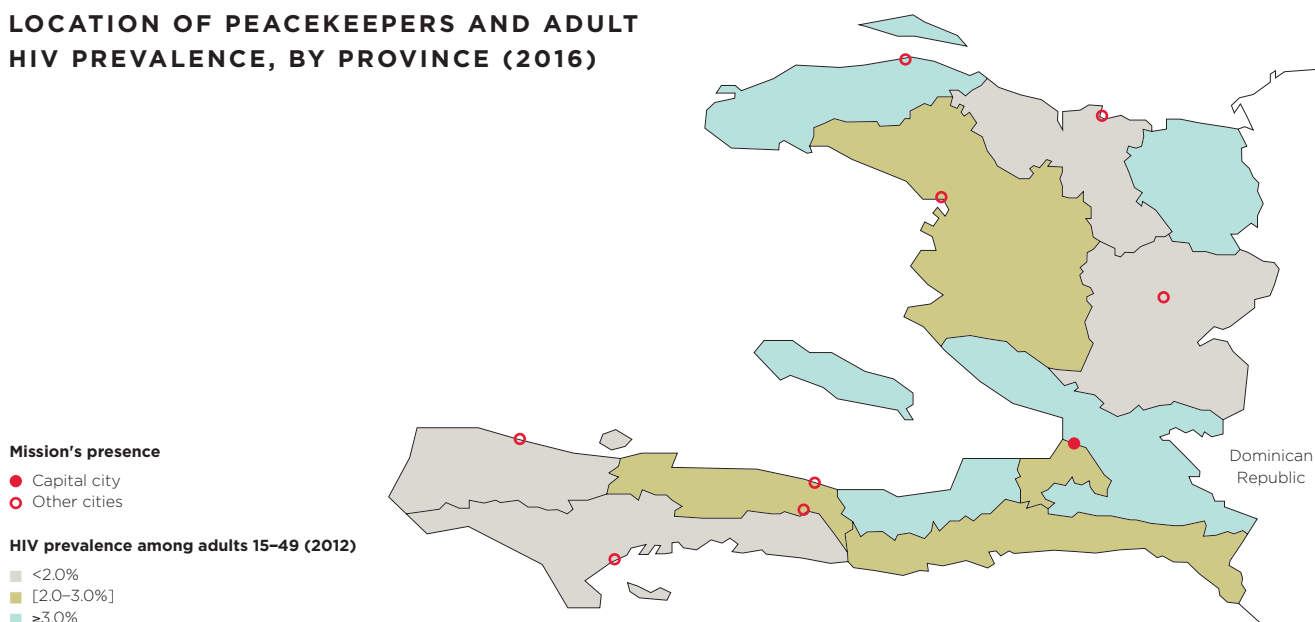
UN military and police personnel by contributing countries:



MINUSTAH

United Nations Stabilization Mission in Haiti

LOCATION OF PEACEKEEPERS AND ADULT HIV PREVALENCE, BY PROVINCE (2016)

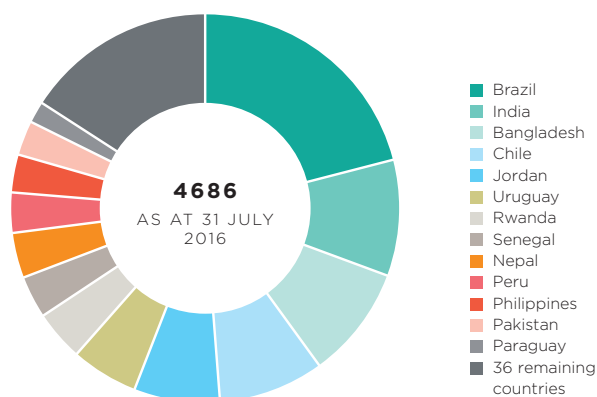


NATIONAL HIV EPIDEMIC AND RESPONSE DATA (2015)

COUNTRY	HAITI
HIV prevalence (adults, 15–49)	1.7% [1.4–2.1%]
Annual new HIV infections (all ages)	1500 [1000–2300]
Number of people living with HIV (all ages)	130 000 [110 000–160 000]
Annual AIDS-related deaths (all ages)	8000 [5500–11 000]
Percentage of PLHIV receiving ART	52% [43–62%]
Coverage of PMTCT services	>95% [79–>95%]

TOTAL MISSION PERSONNEL: 6014

UN military and police personnel by contributing countries:



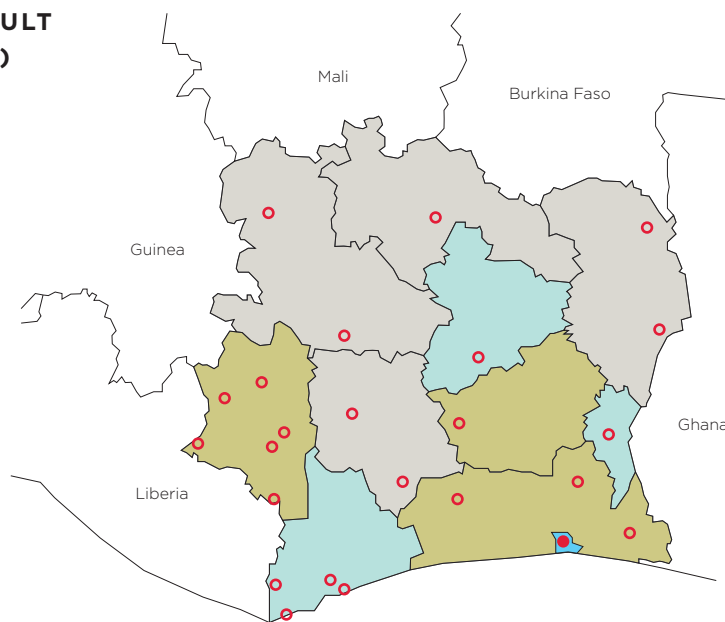
LOCATION OF PEACEKEEPERS AND ADULT HIV PREVALENCE, BY PROVINCE (2016)

Mission military and police presence

- Capital city
- Other cities

HIV prevalence 15–49 years

- [2.0–2.9%]
- [3.0–3.9%]
- [4.0–4.9%]
- ≥5.0%

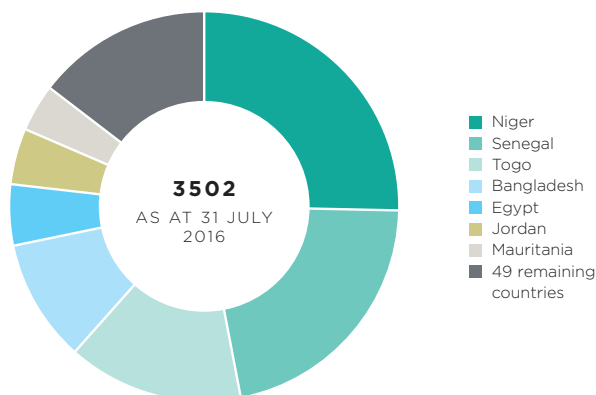


NATIONAL HIV EPIDEMIC AND RESPONSE DATA (2015)

COUNTRY	CÔTE D'IVOIRE
HIV prevalence (adults, 15–49)	3.2% [2.7–3.6%]
Annual new HIV infections (all ages)	25 000 [18 000–33 000]
Number of people living with HIV (all ages)	440 000 [400 000–530 000]
Annual AIDS-related deaths (all ages)	25 000 [20 000–30 000]
Percentage of PLHIV receiving ART	35% [30–40%]
Coverage of PMTCT services	79% [67–91%]

TOTAL MISSION PERSONNEL: 4556

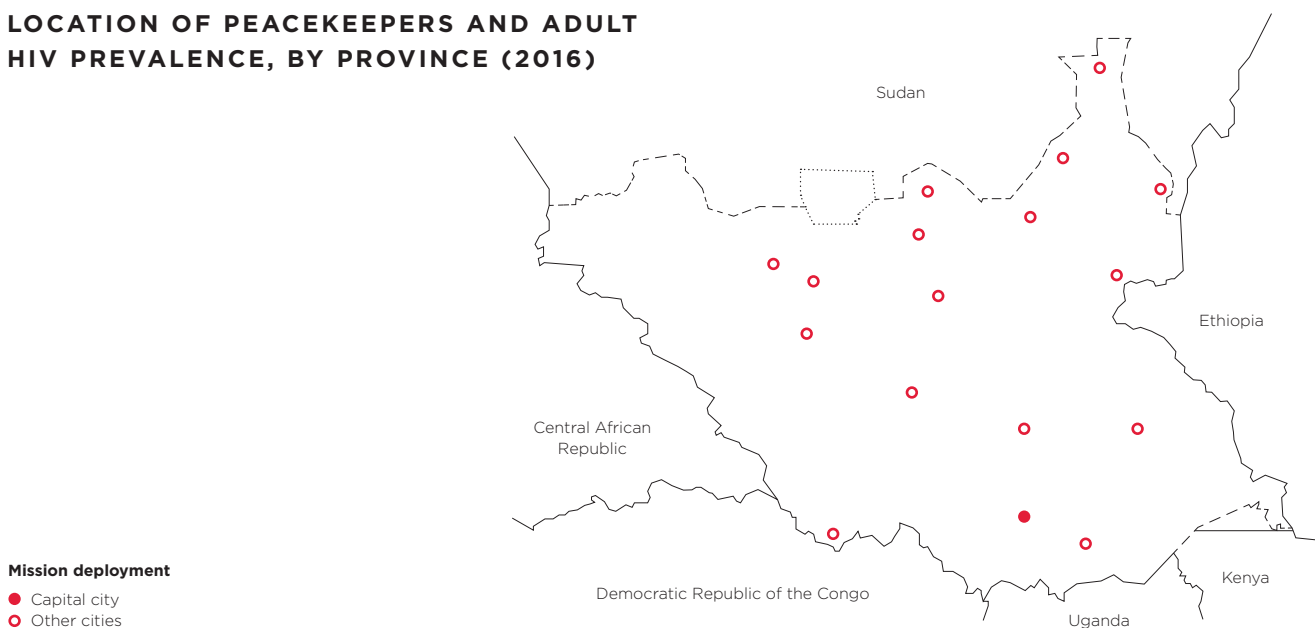
UN military and police personnel by contributing countries:



UNMISS

United Nations Mission in South Sudan

LOCATION OF PEACEKEEPERS AND ADULT HIV PREVALENCE, BY PROVINCE (2016)

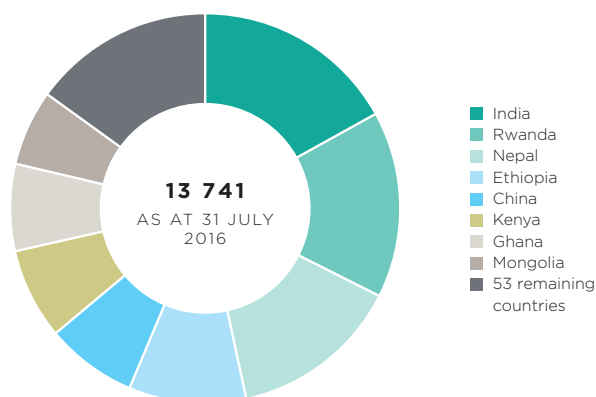


NATIONAL HIV EPIDEMIC AND RESPONSE DATA (2015)

COUNTRY	SOUTH SUDAN
HIV prevalence (adults, 15–49)	2.5% [1.6–3.4%]
Annual new HIV infections (all ages)	15 000 [6400–23 000]
Number of people living with HIV (all ages)	180 000 [110 000–240 000]
Annual AIDS-related deaths (all ages)	12 000 [7300–16 000]
Percentage of PLHIV receiving ART	11% [7–15%]
Coverage of PMTCT services	41% [26–57%]

TOTAL MISSION PERSONNEL: 16 147

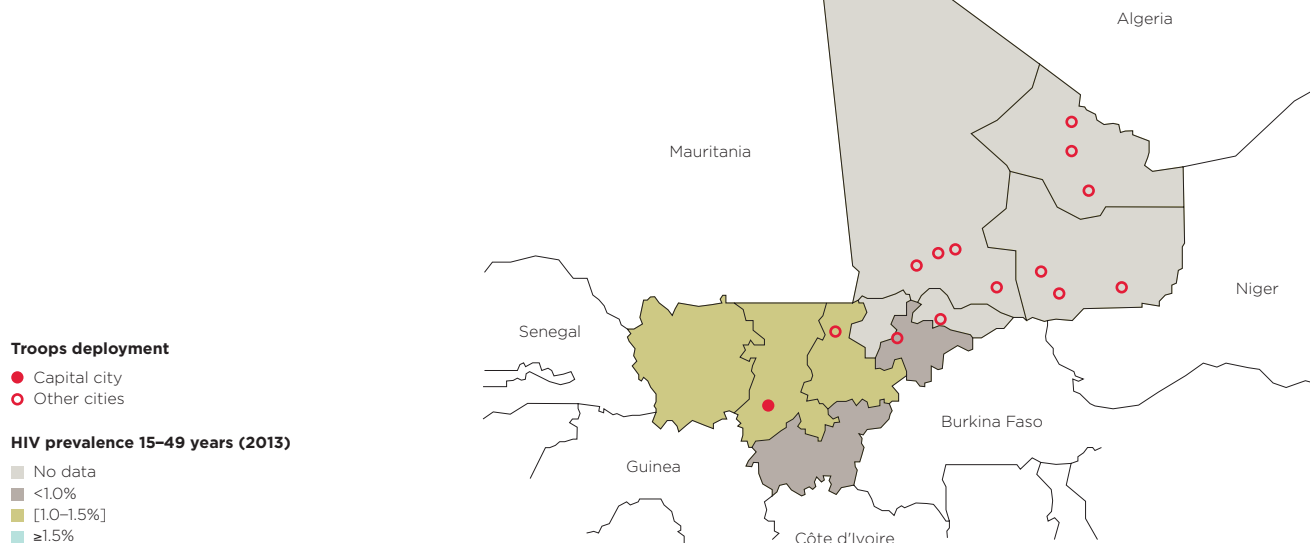
UN military and police personnel by contributing countries:



MINUSMA

United Nations Multidimensional Integrated Stabilization Mission in Mali

LOCATION OF PEACEKEEPERS AND ADULT HIV PREVALENCE, BY PROVINCE (2016)

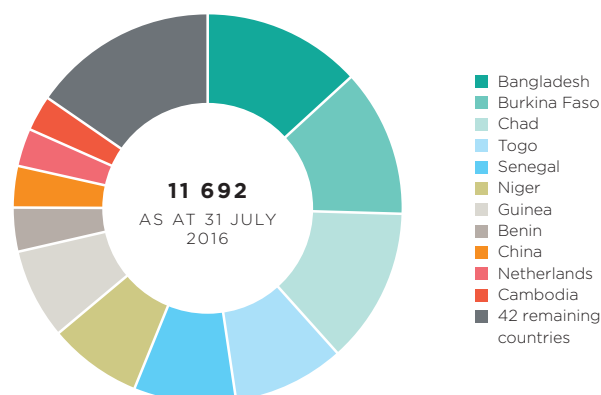


NATIONAL HIV EPIDEMIC AND RESPONSE DATA (2015)

COUNTRY	MALI
HIV prevalence (adults, 15–49)	1.3% [1.0–1.5%]
Annual new HIV infections (all ages)	10 000 [7500–15 000]
Number of people living with HIV (all ages)	120 000 [100 000–150 000]
Annual AIDS-related deaths (all ages)	6500 [5400–7800]
Percentage of PLHIV receiving ART	28% [24–34%]
Coverage of PMTCT services	33% [28–40%]

TOTAL MISSION PERSONNEL: 13 426

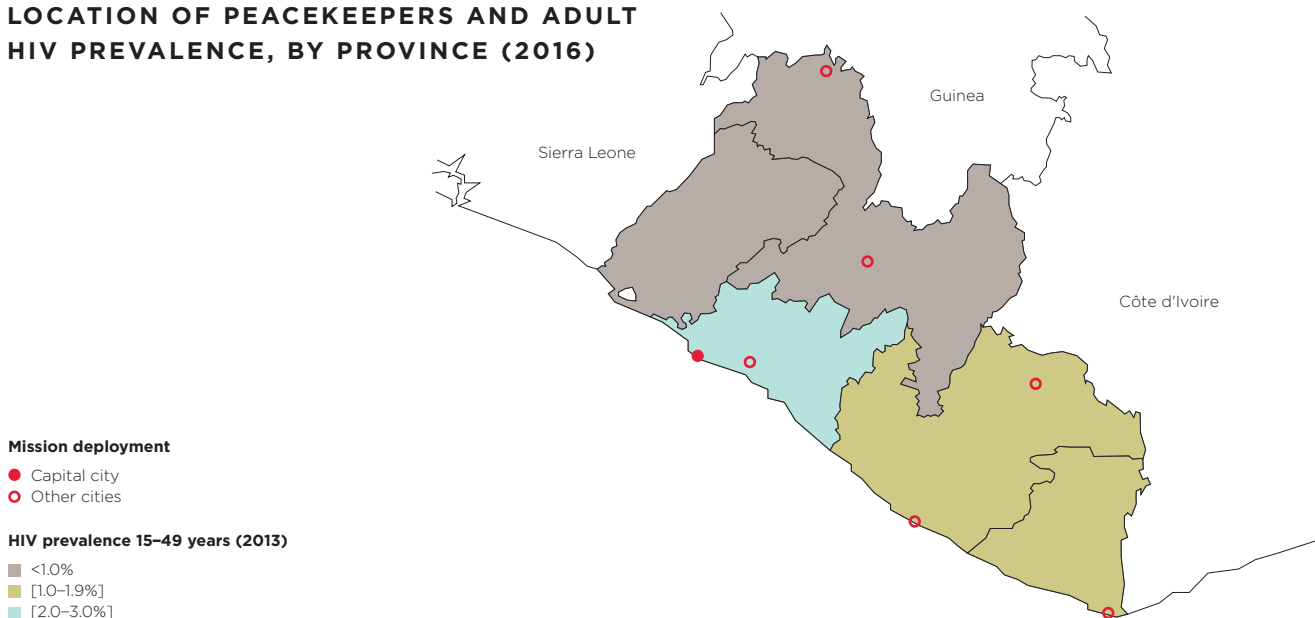
UN military and police personnel by contributing countries:



UNMIL

United Nations Mission in Liberia

LOCATION OF PEACEKEEPERS AND ADULT HIV PREVALENCE, BY PROVINCE (2016)

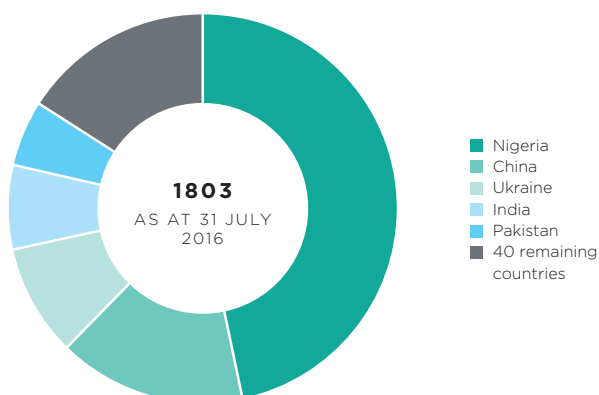


NATIONAL HIV EPIDEMIC AND RESPONSE DATA (2015)

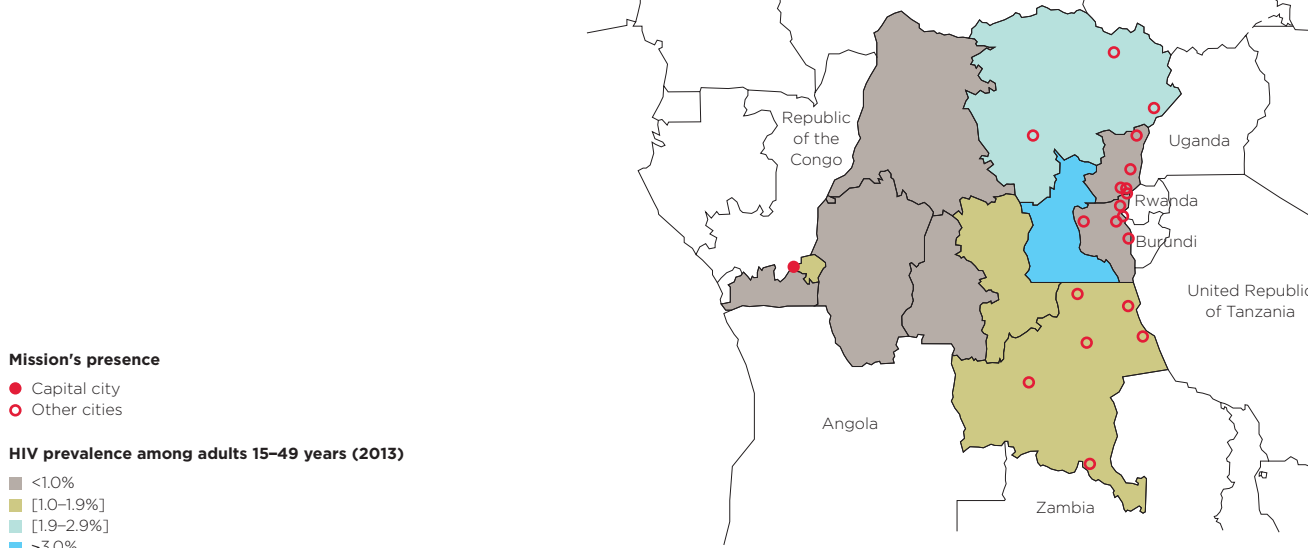
COUNTRY	LIBERIA
HIV prevalence (adults, 15–49)	1.1% [0.9–1.3%]
Annual new HIV infections (all ages)	1600 [1100–2200]
Number of people living with HIV (all ages)	30 000 [25 000–35 000]
Annual AIDS-related deaths (all ages)	1900 [1600–2300]
Percentage of PLHIV receiving ART	24% [20–29%]
Coverage of PMTCT services	70% [57–84%]

TOTAL MISSION PERSONNEL: 3100

UN military and police personnel by contributing countries:



LOCATION OF PEACEKEEPERS AND ADULT HIV PREVALENCE, BY PROVINCE (2016)

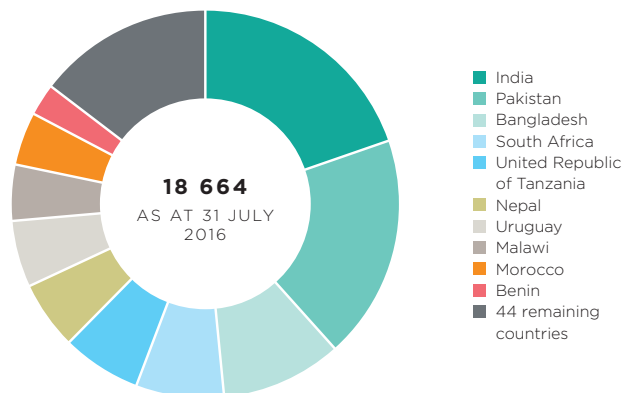


NATIONAL HIV EPIDEMIC AND RESPONSE DATA (2015)

COUNTRY	DEMOCRATIC REPUBLIC OF THE CONGO
HIV prevalence (adults, 15–49)	0.8% [0.7–1.1%]
Annual new HIV infections (all ages)	15 000 [8800–21 000]
Number of people living with HIV (all ages)	370 000 [290 000–460 000]
Annual AIDS-related deaths (all ages)	22 000 [16 000–28 000]
Percentage of PLHIV receiving ART	33% [26–40%]
Coverage of PMTCT services	67% [53–82%]

TOTAL MISSION PERSONNEL: 22 498

UN military and police personnel by contributing countries:



UNAMID

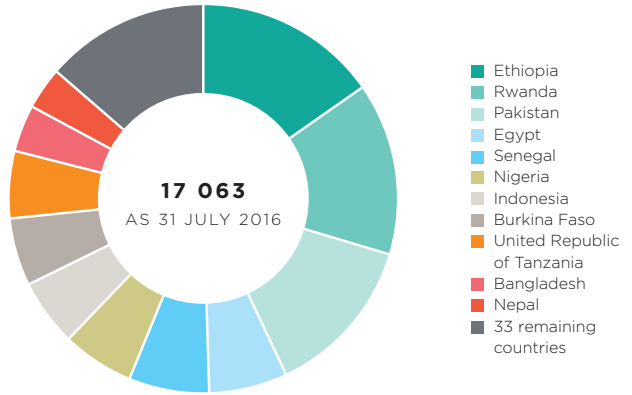
United Nations–African Union Mission in Darfur

NATIONAL HIV EPIDEMIC AND RESPONSE DATA (2015)

COUNTRY	SUDAN
HIV prevalence (adults, 15–49)	0.3% [0.1-0.4%]
Annual new HIV infections (all ages)	5600 [2000-11 000]
Number of people living with HIV (all ages)	56 000 [33 000-90 000]
Annual AIDS-related deaths (all ages)	3000 [2100-4300]
Percentage of PLHIV receiving ART	8% [5-13%]
Coverage of PMTCT services	4% [2-7%]

TOTAL MISSION PERSONNEL: 20 616

UN military and police personnel by contributing countries:



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UNAIDS
Joint United Nations
Programme on HIV/AIDS

20 Avenue Appia
1211 Geneva 27
Switzerland
+41 22 791 3666

unaids.org