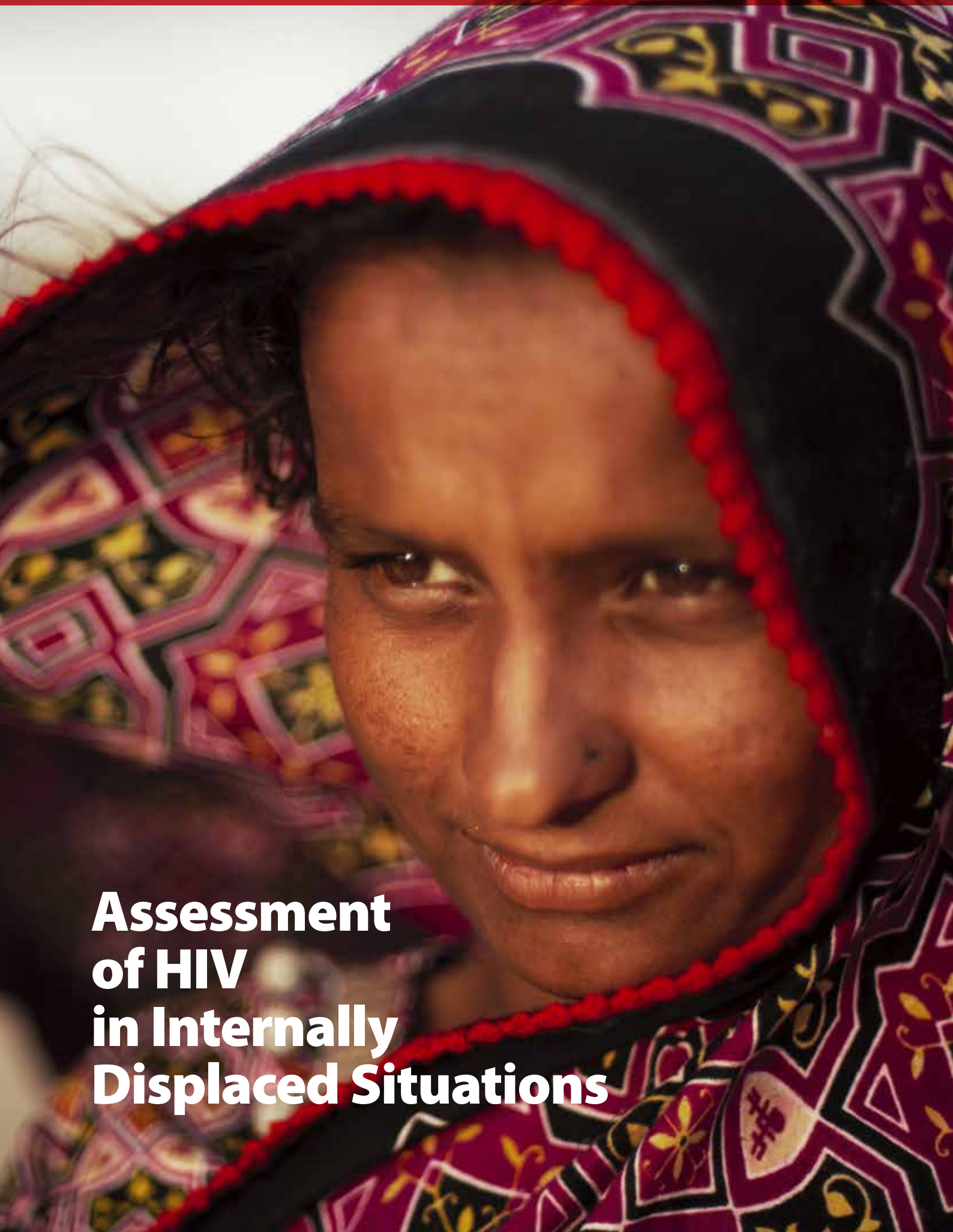
Inter-Agency Task Team to Address HIV in Humanitarian Emergencies



Assessment of HIV in Internally Displaced Situations

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Graphic design : Alessandro Mannocchi, Rome

Assessment of HIV in Internally Displaced Situations

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ANNEXES

List of Acronyms and Abbreviationss

AIDS	Acquired Immune Deficiency Syndrome
ART	Antiretroviral Therapy
ARV	Antiretroviral
HIV	Human Immunodeficiency Virus
CBO	Community-Based Organization
IASC	Interagency Standing Committee
IATT	Interagency Task Team
IDPs	Internally Displaced Persons
M&E	Monitoring and Evaluation
MOH	Ministry Of Health
NAC	National AIDS Council
NAP	National AIDS Programme
NGO	Nongovernmental Organization
OVCs	Orphans and Vulnerable Children
PLHIV	People Living With HIV
PMTCT	Prevention of Mother-To-Child Transmission
PWID	People Who Inject Drugs
STI	Sexually Transmitted Infection
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNHCR	United Nations High Commissioner for Refugees
VCT	Voluntary Counseling and Testing
UN	United Nations
UNICEF	United Nations Children's Fund
UNFPA	United Nations Population Fund
WHO	World Health Organization
WFP	World Food Programme

Acknowledgements

This is the second revised edition of an assessment tool for HIV in internally displaced situations developed by the Inter-Agency Task Team (IATT) for HIV in Emergencies written in 2013.

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For the first edition: Michel Carael (Consultant), Ann Burton (UNHCR), Karl Dehne (UNAIDS), Hsu Lee Nah (IOM), Nabina Rajbhanari (UNAIDS), Susan Purdin (IRC), Marian Schilperoord (UNHCR), Paul Spiegel (UNHCR), Isabel Tavitian-Exley (UNAIDS) and the UNAIDS cosponsors.

For the second edition: Alice Fay (Save the Children), Sarah Karmin (UNICEF), Fatiha Terki and Joan Manuel Claros (WFP), Ando Tiana Raobelison (World Vision), Marian Schilperoord, Sathyanarayanan Doraiswamy and Gabriel Munene (UNHCR) and Heinz Henghuber (Consultant).

1. Introduction

The factors that determine HIV transmission in internally displaced situations are complex and depend on the context. Internally displaced persons (IDPs) are defined as "persons or groups of persons who have been forced or obliged to flee or to leave their homes or places of habitual residence, in particular as a result of, or in order to avoid, the effects of armed conflict, situations of generalized violence, violations of human rights or natural or human-made disasters, and who have not crossed an internationally recognized state border" (1).

In IDP situations, existing gender inequalities may be further exacerbated, making women and children disproportionately more vulnerable to HIV. For example, as a consequence of loss of livelihoods and a lack of employment opportunities, sex work and sexual exploitation may increase. Mass displacement may lead to the separation of family members and the breakdown of community structures and of the social cohesion and sexual norms that regulate behavior. Women and children may be used by armed groups and be particularly vulnerable to HIV infection as a result of sexual violence and exploitation. Rape may be used as a means of warfare. People living with HIV (PLHIV) and other key populations at higher risk of exposure to HIV may require specific measures to protect themselves against neglect, discrimination and violence.

Essential services that existed beforehand may be disrupted during situations of internal displacement. People may no longer have access to information about HIV prevention, condoms or services for the prevention of mother-to-child transmission (PMTCT) of HIV. PLHIV often suffer from disruption of antiretroviral therapy (ART) and treatment for opportunistic infections. Their health is put at risk because their nutritional needs are not met, and palliative and home-based care may be disrupted. Orphans and other vulnerable children may have lost contact with their care providers. HIV prevention, treatment, care and support programmes existing before the onset of a crisis may have to be re-established (2).

Following immediate response in emergencies, including minimal initial HIV and reproductive health interventions (2,3,4), more comprehensive HIV programming needs to be developed for IDPs. A broader framework for response is needed because the focus of intervention shifts from individuals to general social situations, processes, and displacement phases in which IDPs and their families live, which may continue for long periods of time.

BOX 1
OVERVIEW OF THE SITUATION ASSESSMENT TOOL OF HIV RELATED NEEDS IN IDP SITUATIONS

What is the need for a tool?	In 2010, a review of HIV and AIDS strategic plans for eight African countries with large numbers of IDPs showed that few plans identified IDPs as a target population and in most cases, no specific HIV programmes addressed IDPs' needs (5). Assessments are often the starting point for understanding needs and pave the way for needs based programming. Realizing the non-existence of updated tools for carrying out HIV related needs assessments in displaced situations, the Inter-Agency Task Team (IATT) on Addressing HIV in Emergencies felt a pressing need to develop an updated tool to assist stakeholders.
Why use this tool?	Experience has demonstrated the predominant advantages of engaging inter-governmental agencies, governmental and non-governmental organizations (NGOs) in inter-agency assessments regarding IDPs. Adopting standardized approaches when conducting inter-agency assessments would ensure that all important information on HIV-related needs of IDPs are included and allow for quicker and comparable analysis. It should also foster agreement on common objectives for HIV intervention programmes as well as operational synergy.
Who is this tool for?	The primary intended users of this rapid HIV situation assessment tool are programme planners and implementers, primarily at central and sub-national levels. Governments, UN agencies and NGOs are all likely users of this tool.
Where can this tool be used?	It's appropriate to use this tool with IDP (and host) populations affected by conflict or by natural disasters. These populations can be displaced recently or in the past. In any case, such an assessment requires a basic level of stability and physical (security) access to the IDP population. Right after the onset of a crisis, rapid multi-sectorial assessments with integrated HIV components are more appropriate (examples 7,8). **As with any set of tools, it will need to be adapted to each specific context.**
When will this tool be useful?	Anywhere from a few days to a few months into an internally displaced situation.
What are the factors to be considered before using the tool for assessment?	▪ The availability of staff to conduct an inter-agency mission; ▪ The number and accessibility of IDP formal or informal sites, including security; ▪ Pre-existing information on HIV in the IDPs; ▪ The level of detail of information to be collected; ▪ Available budget.

2. HIV-related Needs among IDPs

2.1 **HIV situation assessment**

This document provides guidance on how to conduct a joint assessment of crisis-induced vulnerabilities, and specific HIV related needs among IDPs. A situation assessment of HIV refers to gathering basic information within a short period of time to guide advocacy and the planning of specific HIV programmes.

The objectives of the rapid HIV situation assessment are provided in BOX 2 below.

BOX 2
OBJECTIVES OF THE SITUATION ASSESSMENT OF HIV-RELATED NEEDS AMONG IDPS

1. To assess the effects of conflict on HIV vulnerabilities and risk behaviours among IDPs with special attention to vulnerable population sub-groups.
2. To map existing HIV programs and identify specific gaps and needs (short-term and long-term) for new or revised programming.
3. To develop advocacy strategies for prevention, care, support and treatment of HIV and AIDS among IDPs.

2.2 **Supporting tools and other resources**

This tool is focused on specific steps to conduct a rapid situation assessment. It can be used before initiating HIV and sexual and reproductive health programmes or to guide further development or refinement of existing programmes. Other documents give specific instructions about the planning and implementation of HIV interventions (2, 9). The tool is not a stand-alone document. It complements existing tools on related issues, such as the *Inter -Agency Standing Committee (IASC) Guidelines for Addressing HIV in Humanitarian Settings; UNHCR & WHO Rapid Assessment of Alcohol and Other Substance Use in Conflict-affected and Displaced Populations Field Guide; Inter-Agency Field Manual on Reproductive Health in Refugee Situations; Inter-Agency Manual of Reproductive Health Kits for Use in Crisis Situations; and South Asia Research and development Initiative & UNDP Situational Assessment on Migration and HIV/AIDS in South Asia* (6-8,10, 13-17).

The initial assessment tool was developed and then field-tested during a rapid assessment of IDPs and other conflict-affected populations in Nepal in 2006 (15). This was followed in 2007 by extensive testing of the tool in two other HIV and IDP situational assessments in conflict-affected areas of Côte d'Ivoire and the Democratic Republic of Congo (14). The tool was also discussed in working groups at the First Global Consultation on HIV and Internally Displaced Persons in Geneva in 2007 (16) and, based on feedback from the meeting, it was finalized and published. Following lessons learned in 2008 – 2012, the tool underwent a revision in 2013.

2.3 **Purpose of the assessment tool**

Immediately upon the onset of a disaster or large population movement, the minimum interventions as outlined in the guidelines for addressing HIV in Humanitarian Settings (2) should be applied. These minimum interventions should be rolled out independent of the context and do not need to wait until the assessment happens. This HIV situation assessment tool should enable assessment teams to use an array of appropriate methodologies across a range of settings to map service availability, collect stakeholder perespectives on the impact displacement has had on the population and understand risks and vulnerabilities of the general population and at-risk groups. The tool will require adaptation for use in a specific context due to the heterogeneity of IDP situations and the characteristics of the HIV epidemic (see BOX 3). Thus, the guides for interviews in the annexes are simply general staetments for further adaptation. They are also available in MS-Word format for download to be easily adapted to the respective context.

BOX 3
THE NEED TO ADAPT THE RAPID SITUATION ASSESSMENT TOOL FOR IDPS TO THE CONTEXT OF LOCAL HIV EPIDEMICS

In case of generalized epidemics

The tool should explore such issues as exposure to multiple partners, commercial and transactional networks, level of condom availability or use, care seeking for HIV and sexually transmitted infections (STIs) and care seeking in the case of sexual violence. Young girls, adolescents, widows, orphans, single women and PLHIV among both IDPs and host populations should be interviewed. A mapping of HIV prevention, treatment and care services, such as STI and HIV case management including ART and MPTCT availability, HIV counseling and testing, condom outlets, mother and child health services, and blood safety should be made available.

In case of a low level or concentrated HIV epidemic

The situation assessment tool should focus more on patterns of commercial sex interactions (both clients and sex workers) and people who inject drugs (PWID), sexual violence, men who have sex with men and other populations most at risk for HIV. Sexual and reproductive health concerns, including sexually transmitted infections and unwanted pregnancies, may be seen as more important than HIV issues and the tool should be adapted accordingly.

3. Situation Assessment Designs

3.1 Challenges in assessing HIV-related needs among IDPs

In theory, various methods of data collection and study designs are available to assess HIV-related needs of IDPs, from quantitative survey approaches to data monitoring and in-depth ethnographic studies to rapid cross-sectional qualitative studies. However, in practice, there are multiple factors that make the collection of relevant information on HIV and AIDS for IDPs challenging. In particular, structured interview surveys with random or probability samplings are difficult – but not impossible – to carry out in the context of IDPs and HIV (see BOX 4).

BOX 4
WHAT MAKES STRUCTURED INTERVIEW SURVEYS DIFFICULT FOR ASSESSING THE HIV-RELATED NEEDS OF IDPS AND HOST POPULATIONS?

- Multiple topics, such as HIV vulnerability and risk behaviours, need to be explored, and little relevant data exists at central and local levels for comparison purposes.
- IDPs may be dispersed rather than located in a single neighbourhood. Many have fled as individuals or small family units; many are uprooted, displaced repeatedly or continually mobile.
- Some IDPs are absorbed into non-displaced households of relatives or friends.
- IDPs may not want to reveal their HIV and displaced status for fear of retaliation or discrimination.
- Even when camps are established, many IDPs reside elsewhere.
- Insecurity may be an important impediment to access IDPs.
- There are different definitions of IDPs used by governments, development partners and the UN, which make population identification and common assessments difficult.

Many displaced populations are uprooted from rural to urban areas where they reside in slum neighbourhoods and spontaneous settlements that are characterized by poor infrastructure and low levels of public services. In these settings, they often experience discrimination, may wish to hide from authorities, and may not be able to participate in studies.

Governments may also be unable or unwilling to deliver on their responsibility to provide basic public services to IDPs. They may also not permit assessments in populations that may be labelled 'sensitive'. Though scientifically not sound, rapid situation assessments are the only feasible methods to examine HIV related needs among IDPs.

3.2 **Inter-Agency Assessments**

Joint situation assessment missions on HIV-related needs of IDPs require consensus on objectives and priorities but also common standardized approaches and tools. It must be recognized that tools need to be adapted in each specific context. Experience has shown that a joint assessment has many advantages (see BOX 5).

BOX 5
ADVANTAGES OF INTER-AGENCY HIV SITUATION ASSESSMENT OF IDPS

Well-conducted inter-agency assessments can:

- Facilitate HIV advocacy for resources and programming to address IDP needs.
- Ease the integration of HIV-related IDP issues into the humanitarian and post-conflict response by using the cluster approach.*
- Improve efficient use of scarce resources (e.g. staff, money, and logistics).
- Facilitate involvement of other agencies – government, UN, NGOs, community based organisations and networks – in the IDP response.
- Increase coordinated planning and implementation of future projects.
- Reduce host community fatigue from multiple assessment missions repeated by separate agencies.

* The cluster approach strengthens the coordination and response capacity by mobilizing clusters of humanitarian agencies (UN, Red Cross-Red Crescent, international organizations, NGOs) to respond in particular areas of activity, each cluster having a clearly designated and accountable lead as agreed by the Humanitarian Coordinator and the country team.

The HIV- situation assessment among IDPs should aim to become an integral part of the national planning mechanism and, thus, an element of the national AIDS response in affected countries, as well as Emergency Preparedness and Response Programmes. Findings from assessments should guide the expansion of HIV programming to ensure services are delivered where needs are the most pressing.

3.3 **Advantages and disadvantages of situation assessment methods**

A situation assessment includes a combination of qualitative methods such as key informant interviews, focus group discussions and observations. Assessors should recognize the advantages and disadvantages of selected methods independently of their use for HIV issues (see BOX 6).

BOX 6
ADVANTAGES AND DISADVANTAGES OF RAPID ASSESSMENT METHODS

Advantages	▪ Many topics can be covered and triangulation can be applied. ▪ Meaningful participation of IDPs in data collection process fosters community ownership of the process. The data collection process is flexible and dynamic. ▪ New topics discovered during an assessment can be quickly explored further. ▪ Emergency and security situation may only allow such a qualitiative approach.
Disadvantages	▪ Requires more skilled interviewers than those needed for a structured questionnaire survey. ▪ Harder to analyze because of narrative nature of qualitative data that may be of uneven quality. ▪ Harder to harmonize across various teams and sites when compared with a questionnaire survey. ▪ Less "scientific" than survey methods using random samples; findings are not generalizable.

3.4 **Adapting the situation assessment tool to complement other existing tools**

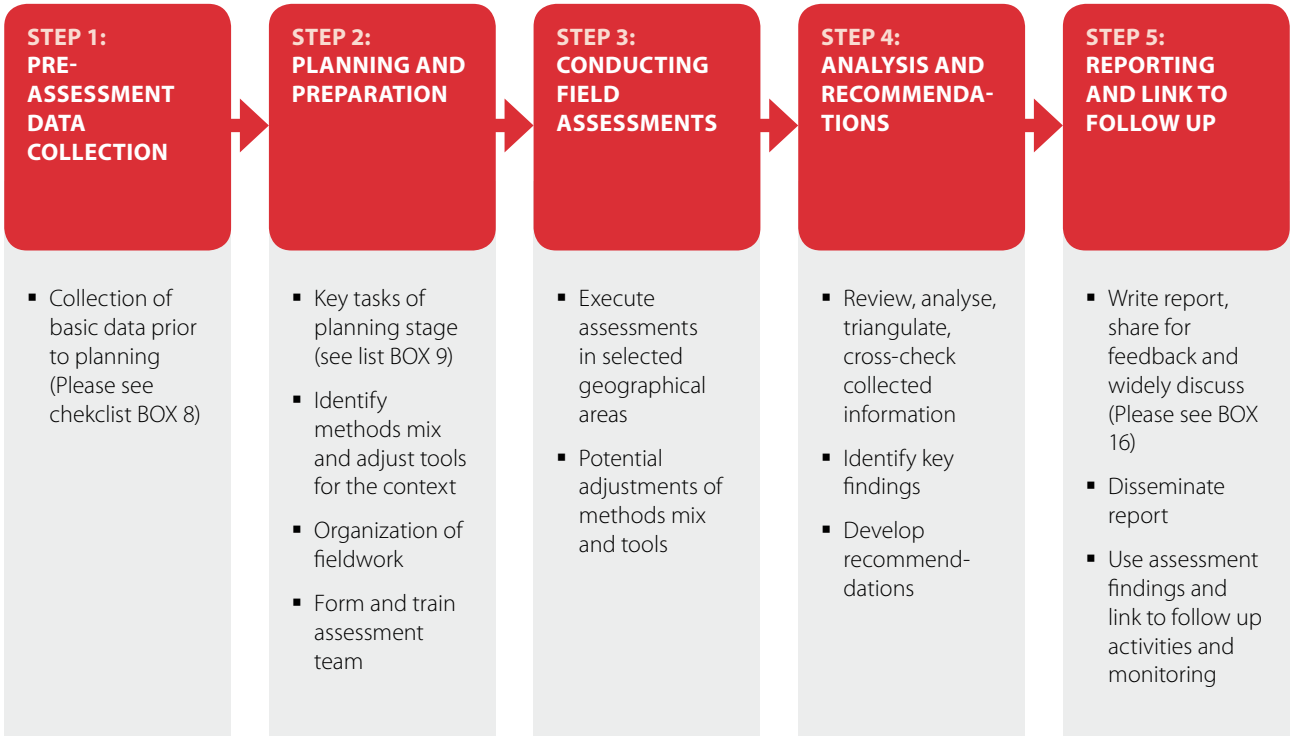
There are specific situations where the situation assessment tool may need to be specifically adapted to complement exisiting tools and take into account other methods of data collection such as monitoring or surveillance (see BOX 7).

BOX 7
SETTINGS WHERE THE SITUATION ASSESSMENT TOOL MUST BE SPECIFICALLY ADAPTED

In case of an acute emergency	▪ The HIV assessment may be part of the inter-agency rapid assessment. Humanitarian agencies should first jointly determine who does what and where, under the umbrella of a comprehensive humanitarian action plan. ▪ A minimum response package of HIV interventions should be implemented in accordance with IASC guidelines independent of an assessment taking place or not. The minimum response package covers 10 broad areas: water and sanitation; food security and nutrition; shelter; health; coordination; assessment and monitoring; protection; education; behaviour change communication; and workplace. The package comes with monitoring checklists and can be used to complement the situation assessment tool (2-4).
In case of a high level of insecurity and armed conflict	▪ Only a few questions to key informants among IDPs and host populations and a quick assessment of services are recommended to guide the minimum responses in such situations (11-12).
In case of already well established HIV and AIDS services in districts hosting IDPs	▪ Quantitative data can be collected through service programme monitoring. ▪ Characteristics of patients or clients can be disaggregated according to length of residence in district and district of origin. ▪ HIV behavioural surveillance surveys can be carried out to establish trends over time (23). ▪ The situation assessment tool can complement or inform quantitative data collection by assessing whether IDPs are actually served by those programmes in such situations.
In case of camps or formal settlements of IDPs	▪ Probability sampling and structured interview surveys can be used, taking advantage of existing standardized questionnaires (11, 23). ▪ HIV behavioural surveillance surveys can be carried out (23). ▪ A rapid assessment tool can complement or inform quantitative data collection in these situations.

4. Situation Assessment Process

The process of a joint HIV situation assessment in IDP populations includes five steps: 1) the pre-assessment data collection; 2) planning and preparation; 3) field assessment; 4) analysis and recommendations and 5) reporting and follow up, as illustrated in the diagram below.



4.1 **Pre-assessment data needs**

Key preliminary information about IDPs and HIV-related needs is required as a first step before deciding to conduct an HIV-related needs assessment (see BOX 8). The sources of information at the national level include a library search for published articles, the National AIDS Commission or National AIDS Programme (e.g. reports, survey data, monitoring data), the Joint UN Teams on AIDS, and NGOs (e.g. unpublished documents, mission reports) PLHIV networks and groups (regional, national and local).

BOX 8
CHECKLIST OF PRE-ASSESSMENT DATA NEEDS

- Whether IDPs are included in national HIV plans and policies.
- Scope and main demographic characteristics of internal displacement.
- Major primary and secondary causes of displacement.
- Patterns of displacement and numbers (rural, urban, migration).
- Mapping of regions and districts with displacement.
- Characteristics of IDPs (family, individual, age, sex, other).
- Health data, STI and HIV data among IDPs and affected populations.
- Whether there is a local or international HIV programme for uniformed services.
- Effects of conflict or natural disaster on security and livelihoods, health and education services, and coping mechanisms.
- Summaries of existing national HIV response.

When districts/locations of the situation assessment among IDPs are determined, there is also a need to collect similar data at that level. Some information is usually available at the central level and some at the provincial or district levels.

4.2 **Planning the Inter-Agency assessment**

A series of steps needs to be carried out – some alongside each other – before implementing the situation assessment (see BOX 9). After consultations with the National AIDS Programme, the first task is to determine the composition of the joint team and task a core group with organizing the preparatory work such as scheduling and budgeting for the field mission.

BOX 9
CHECKLIST OF KEY CONCOMITANT TASKS OF THE PLANNING AND PREPARATION STAGE

- Create an inter-agency working group. Describe and assign tasks; establish a timetable; and select and engage team members (staff or consultants).
- Understand safety and security concerns and/or restrictions (e.g., closed roads, heightened threats, composition of assessment team, travelling with cash, permission to transport other partners) (19).
- Determine criteria to identify the numbers and locations of sites/districts with IDPs to be assessed.
- Inform local authorities, as well as donors and other decision makers; obtain security clearance.
- Establish contact lists to ensure access to names and phone numbers of participating partners (28).
- Liaise with local NGOs and community-based organizations and plan fieldwork (local support, transport, appointments, etc.).
- Locate and secure adequate accommodation where and when necessary.
- Prepare for any necessary protocol or legal requirements (e.g. travel permits, mission orders, official letters) (28).
- Prepare informed consent form and ethical guidelines.
- Collect and review secondary information from written sources about IDPs and HIV in the selected districts.
- Adapt tools and questionnaires to the specific context, and translate questionnaires into local languages if needed.
- Organize the briefing and training of all team members before the fieldwork.
- Determine availability of key resources (e.g. fuel, water, paper, vehicles, computers).
- Ensure that cash is available to cover immediate costs such as per diems.
- Determine availability of key services (e.g. catering, drivers, translation, printing, communications).

Overlapping of tasks or steps should follow a logical sequence. For example, training cannot occur before the finalization of the forms, and analysis of available information on IDPs in the selected districts should immediately follow decisions about the selected sites for the assessment.

4.2.1 **Participation of local NGOs, IDPs, and host populations**

The assessment tool requires the identification and participation of people most knowledgeable about the situation and also of those most affected. The assessment team should work with local NGOs, Community Based Organisations (CBOs) and other key informants to gather information from a local perspective. Primary informants such as IDPs, key populations (sex workers, men who have sex with men, people who inject drugs, transgender people) and those with increased HIV risk in crisis situations (women and girls, children, orphans, sexually exploited adolescents and children, widows, demobilized children and adults and people with disabilities) and other stakeholders should be consulted individually or in groups to identify the most pressing needs in terms of HIV programming.

Peer networks and peer groups of PLHIV have great importance in responding to HIV in emergencies and crisis situations (22). Often they are part of key solutions, particularly when access to IDP populations is restricted. Hence they are crucial groups, who can be directly integrated into the joint assessment teams or asked to participate in crucial informant interviews and focus group discussions.

4.2.2 **Team composition and training**

The tool can be used by team members who have relatively little professional training in social research. The team composition must be balanced with regards to expertise, gender, nationals/internationals and organizational representation (e.g. UN, government, NGOs, affected populations, experts/academics, PLHIV, etc.). Public health generalists rather than specialists are usually required in the rapid assessment. Indeed, an inter-agency assessment operation will imply multi-disciplinary teams with various levels of experience in field enquiry. However, it is critical that at least one or two HIV experts are active members of the team and participate in the field visits.

Responsibilities within the team should be defined (e.g. coverage by sector or by geographical areas) and a team leader chosen. For each member that does not speak the local language, an interpreter must be included. Three to five teams should be deployed to cover the heterogeneity of the IDP situation.

A short training or orientation course of at least two days is recommended, even where team members are relatively experienced. The training should include the local teams of the identified sites and districts, including interpreters. Informed consent and ethical issues should be explained. Each member of the team should ensure confidentiality after the data collection process and each tool should be introduced and explained during the training. The way to present the purpose of the situation assessment and to introduce the assessment team to the local leaders, local population and IDPs should be reviewed and agreed upon. Advice on interviewing (e.g. be non-judgmental, use probing questions, let the interviewee lead, avoid leading questions, etc.) and note taking should be provided. Practicing a few interviews through role-plays is required to familiarize team members with the questionnaires and to clarify possible differences in understanding. Half a day should be used for briefing the assessment team members on the field procedures, the logistics arrangements and the detailed schedule of activities. Experience from former assessments show focus group facilitators need a special training for the group discussions.

5. Conducting Field Assessments

5.1 **Organisation of fieldwork**

The number of sites or districts to be assessed should initially be no more than three to five for practical reasons, concentrating on those most severely impacted by IDPs. A distinction should be made as to whether the selected sites refer to administrative areas (e.g. districts) or point locations (e.g. towns, villages or camps). After the early phase, National AIDS Council managers may want to encourage district AIDS coordinators (or equivalent) to assess their situation and thereby extend the assessment to other districts beyond the initial ones.

The number of interviews with key informants per IDP site will vary according to the size of the site, the composition of the team, time and resources available, security and other local factors. The choice of sample size becomes a matter of judgment; the aim is to obtain information from typical members of each category of interest – taking into account that behaviours and circumstances of individuals are variable – until a saturation point is reached and no new information is obtained. The gender and age of respondents in particular should be looked at carefully because expressed HIV-related needs are likely to be very different.

An example is provided of the type and number of respondents selected for each of the three districts surveyed in Nepal (see BOX 10).

BOX 10
TYPE AND NUMBER OF RESPONDENTS SELECTED IN THREE DISTRICTS - EXAMPLE FROM NEPAL (2006)

	Type of Respondents	N° of respondents per district	
		Men	Women
Key informants	District officials	2	
	Community leaders such as teachers, health providers, social workers	1	1
	Young people including adolescents (10-24 years)	1	1
	Uniformed services	2	
	Service providers	1	1
Individuals	Internally displaced persons - general	2	2
	Migrants	2	2
	People who inject drugs	2	1
	Sex workers	-	2
	People living with HIV	1	1
Focus group discussions	Internally displaced persons - general	10	10
	Young people including adolescents (10-24 years)	10	10
	Total	34	31

The interviewers in each location should work in teams. The number of investigators in each team should be kept relatively small and manageable (i.e. from five to six) for logistics (transport) and supervision reasons. Attempts should be made to have both men and women in each team; local cultural sensitivities regarding gender interactions must be considered while assigning interviewees. Each interview team should conduct three to four interviews per day or participate in one focus group. There will be a need for a minimum of two local male and two local female translators/interviewers/facilitators, usually recruited among local NGOs or affected communities.

5.2 **Field timetable**

The timetable should be realistic and take into account a variety of factors (see BOX 11). The duration of the fieldwork has important implications for the budget.

BOX 11
FACTORS INFLUENCING THE TIMETABLE

- The availability of the staff of the inter-agency mission;
- The number and accessibility of IDP formal or informal sites, including security;
- The available budget; and
- Pre-existing information on IDPs.

An example of a typical fieldwork timetable in one district (see BOX 12) takes into account that pre-assessment data has already been collected and that the preparation and orientation of the team requires two days before the departure to the field. In Nepal, for example, two districts and Kathmandu city were assessed over the course of six days by three teams of six investigators. Different team members conducted many of the activities simultaneously.

The total budget of an HIV inter-agency situation assessment may vary considerably according to the scope and the context of the IDP situation and depending on available resources and expertise. Carefully consider how costs will shape your assessment efforts and planning.

BOX 12
EXAMPLE OF A 10-DAY TEAM TIMETABLE FOR AN ASSESSMENT IN ONE DISTRICT

Field visit timetable	Days
Team orientation and preparation	2
Travel to district	3
Meeting with local team and authorities	3
Orientation for local translators/facilitators	4
Stakeholder interviews	4-6
Target group interviews	4-6
Visits to health centres and services	4-6
Focus group preparation	4
Focus group sessions	5-7
Wrap-up	7
District-city return	8
Preparation for presentation to key stakeholders	9
Dissemination of findings	9-10
Finalization of draft report	8-10

5.3 **Qualitative Information Gathering**

Qualitative information gathering is an iterative, or repetitive, open-ended process. It allows revision, correction, expansion and reorganization of previously reviewed information. Based on the first round of information, subsequent key informants and focus group participants are asked new or revised questions. The process is stopped at the point of saturation: when the interviewer does not get any new information from a variety of additional respondents. In some contexts, for subjects like STIs, sexual behaviour and HIV, some populations may find it inappropriate to discuss these issues in an open forum. In-depth interviews with individuals should then replace focus groups.

5.4 **The Methods Package**

5.4.1 **Deciding on a methods mix for HIV situation assessment**

The main methods employed in this situation assessment are: 1) review of existing information and observation of services; 2) Semi-structured interviews; and 3) Focus group discussions. Interview guides are provided for each of the main methods (see Annexes A-E). They are accompanied by guidelines that provide the methodological and analytical framework (see BOX 13).

BOX 13
METHODS FOR HIV SITUATION ASSESSMENT AMONG IDPS AND AFFECTED POPULATIONS

District assessment	Review of existing information on the number of IDPs, the district sexual and reproductive health situation (including HIV/STI data), complemented by observations of services and data collected on health, WASH, protection, food, education and social services.	Annex B
Semi-structured interviews	Undertake with key informants who are selected because of their knowledge about the issues in the district. These persons may be public authorities, community leaders, representatives of young people including adolescents, commanders of uniformed services or health service providers (public and private). Additional semi-structured interviews may be conducted with members of selected IDP sub-groups, such as people who inject drugs, sex workers and sexually exploited adolescents and children, men who have sex with men, people living with HIV, host populations who have IDPs living with them, working children or other relevant categories as advised locally, such as widows, demobilized child soldiers or street children.	Annex C, D
Focus group discussions	Undertake with groups of IDPs, crisis-affected populations, and always include host populations; peer groups of PLHIV. These persons may be male or female young people including adolescents, male or female adults or from some of the IDP sub-groups mentioned above.	Annex E

Figures concerning IDPs, although often hard to obtain in situations of conflict or displacement (see BOX 4), provide important elements to gauge the breadth and scope of HIV vulnerability and risks in a given district. The assessment methods chosen provide insight to the scope of the problems and the needs related to HIV programmes in a limited time span. The assessment methods are designed to involve the affected population and other stakeholders as much as possible. In selecting respondents, in addition to IDP status, the team must actively look for representation of key populations and those with increased HIV risk in crisis situations and for equitable gender and age representation.

5.4.2 **Ethical issues**

Ethical issues must be observed in the assessment process (see Annex A). Informed consent procedures must be agreed on and simple forms developed to communicate the necessary information about the assessment to the respondent. In most field situations, verbal consent is used; respondents should be reminded that they could skip any question that is objectionable.

Investigators of the team should be aware in advance of how to handle responses to questions related to difficult or sensitive situations, such as sexual exploitation and abuse of children, because there is an ethical obligation to report. Interviews with children formerly associated with armed forces or groups or with children who are in working contexts may uncover crimes inflicted on them. It is strongly recommended that before embarking on interviews, the team identifies the resources, whether individuals or institutions, for follow-up investigation of crimes that are exposed during the interview.

Collecting data on individual experiences of sexual violence and interviewing children on sensitive issues require time, confidence-building measures and highly trained interviewers. This is usually difficult during a rapid assessment, unless a local NGO that has already worked on the issue is part of the team. Thus, if such interviews are part of the scope of the assessment, members of the team who possess the needed expertise must conduct these. Keep in mind the following considerations:

- Certain issues, such as HIV status, sexual violence or working children, place high requirements on confidentiality (e.g. privacy during data collection and protection of confidentiality of data after collection) and anonymity. While information about protection issues may be used in the report, sources must be treated confidentially. Because respondents may be sharing very personal information, it is important to honestly assess how much confidentiality can be promised. An important consideration is how the confidentiality of individuals will be preserved when the data is analyzed and reported.
- Children constitute a vulnerable group because they are underage and stand in a dependent relationship with adults. Obtaining informed consent can be difficult when children are involved. In virtually all cases, it is necessary to have the consent of an adult guardian before interviewing a minor, in addition to the consent of the minor. This is why the assessment tool does not include questions for young people, working children or children below age 16 formerly associated with an armed group, as per the Helsinki Declaration of 1964.
- Useful indirect data on these sensitive topics can sometimes be obtained from local or national NGOs working in these areas. If these data are not available, it is recommended that the assessment team use the guidelines specific to the particular issues that arise during the collection of information from children and child soldiers and on sexual violence in emergencies (17, 18, 19).

5.4.3 **District assessment tool**

The district assessment tool is to be completed with information collected prior to and during the fieldwork. This data is likely to come from routine government and agency reports, maps, and monitoring systems. Information should be collected on the district response to the crisis and to HIV, and on the extent to which HIV programmes are in place. Data should also be collected on population demographic characteristics, as well as information on health status indicators. This data should be disaggregated as much as possible across characteristics such as age, gender, ethnicity, displaced status, and administrative level (from national to local).

During field visits, additional information should be collected at the regional or district level and at the health facility level. Field visits should include visits to social services, NGOs, and health facilities. These health facilities can include, but are not limited to, district hospitals, health centers, health posts, free-standing voluntary counseling and testing centers, and pharmacies and other private providers.

The selection of sites to visit should be informed by their proximity to or use by IDP populations. Taking the pre-crisis situation as a baseline, the assessment should define and analyze the impact of the crisis or the presence of IDPs in the health system. In health facilities, key indicators of the quality of health services, such as hours of operation, number and qualifications of personnel, availability of equipment and consumables, and attendance, should be quickly reviewed and the impact of the crisis on them determined. Rather than producing "shopping lists" of missing resource items, realistic opportunities for improvement should be identified. Interviewing health personnel will generate data needed to complete the health component of the district assessment form.

5.4.4 **Semi-structured interviewing**

Semi-structured interviewing has been defined as a guided conversation in which only the topics are predetermined and new questions or insights arise as a result of the discussion. Interviews should first be conducted with key informants from the following categories:

- Persons who possess specific information (e.g. government officials, community leaders, health professionals, camp managers);
- Persons who are already working on the problem in some capacity (e.g. from community-based organizations or NGOs).

New key informants may appear during the fieldwork; the team may come across key informants that had not been thought of in the planning stage and should be open to spending time with them.

Interviews should also be conducted with persons affected by the displacement such as PLHIV, key populations and those with increased HIV risk in IDP situations. Most of the individual respondents should be identified by the local NGO prior to the arrival of the assessment team. However, these selected informants are sometimes better off, better educated, and more powerful community members than IDPs and other vulnerable groups who are not not selected for interviews, which may introduce a bias that should be corrected during the fieldwork. It is possible that the selected respondents do not represent the views of the more vulnerable segments of the population affected by the displacement, such as young women and children. Local NGOs and key informants should also be asked to facilitate contacts with others who may be able to provide specific insights.

Information gathered through semi-structured key informant interviews will guide the process of collecting data through focus group discussions.

5.4.5 **Focus group discussions**

Focus group discussions have the advantage of having access to a larger body of information in a relatively short period of time. Focus groups can be highly effective and produce useful information on attitudes, norms and values, or they can be unproductive, depending on the skills of the facilitator and the selection of participants. A climate of mutual respect and non-discrimination should be established as a guiding principle from the outset. The length for one focus group session may be up to two hours. The assessment should not include more than eight focus group discussions with up to ten participants each. Two to four days will be needed to complete focus group discussions. The analysis and write-up of a focus group can take up to one week.

Focus group discussions should be conducted with recent IDPs (less than two years) and members of the host population. Confidentiality and anonymity are critical; creating an environment where participants feel safe and comfortable to open up and share their views is essential – and sometimes difficult to establish. To facilitate expressions of opinions and attitudes, the selection of participants for each session should aim at homogeneity. Gender, age, ethnicity, socio-economic class, language, marital status, and IDP and HIV status may all be locally important categories for constituting homogeneous groups. The exact composition of the focus groups should depend on the preliminary results of the interviews, and focus on the most relevant topic regarding IDPs and HIV in the setting. A trained moderator should conduct the discussions, informed by the interview guide, if possible in local language. Less experienced facilitators for focus groups may need a special training for the group discussions. The moderator should be partnered with a local counterpart who can assist with interpretation and analysis. Affected groups or individuals who are more difficult to find or reluctant to appear openly, may be sought out for semi-structured interviews.

6. Analysis

6.1 **Lessons from the field**

A few lessons have emerged from the field to improve data analysis and interpretation (see BOX 14).

BOX 14
LESSONS FROM THE FIELD: HOW TO CONDUCT DATA ANALYSIS

- Feedback is critical. Each evening, the team, together with members of selected local or international NGOs implementing programs in the districts, should discuss the findings of the data collected that day. The team should then follow up and make adjustment based on the discussions. Analysis begins during data collection with triangulation and cross checking.
- At the end of every day, team members should summarize interviews in a standard format following the key themes of each interview guide.
- When possible, regular contact should be established with teams working in different districts to compare major findings or common issues.
- All joint team members should use the same format for their written notes on major findings and recommendations on a continuous basis. A simple standard format can be agreed upon at the beginning of the assessment. For the final analysis, the team should aggregate selected common findings across sites while keeping track of site specificities and local HIV needs.

6.2 **Misconceptions about HIV situation assessments**

Analyses of data collected in districts using situation assessment methods may quickly become overwhelming because of the amount and the variety of information collected. Open-ended questions during individual interviews and focus group discussions usually generate a lot of detailed information of unknown validity. Unless a systematic process of synthesis is in place, looking at common patterns and differences, it can be difficult to get a clear picture of the HIV-related needs of IDPs and host populations (see BOX 15).

BOX 15
COMMON MISCONCEPTIONS ABOUT SITUATION ASSESSMENTS

Common belief	Common mistake
What each person says needs to be counted.	Not crosschecking or triangulating across different sources on the same issue. Undertaking a quantitative analysis on qualitative data.
More data is (always) better.	Not taking into account the saturation point where additional data does not provide any new or different types of information.
Field notes are easy to analyze.	Not organizing them chronologically and by key words on the very day they are written.
More informants are (always) better.	Not selecting the most knowledgeable informants, those most familiar with local issues regarding the conflict and the circumstances of IDPs.
The interview guide has to be followed line by line.	Not adapting questions to situations and individuals.
There is a need to wait until the end of the data collection process so you have all the information before analyzing it.	Not using interactions and feedback to guide the collection of new information and to test new hypotheses while in the field. Not sharing information among different groups covering different areas.

6.3 **Analysing qualitative data**

When asking questions and interpreting informants' answers, the distinction between two kinds of statements should be kept in mind: statements about actual HIV risk behaviours and statements about beliefs and ideas. The information collected always turns out to be a mixture of these two features. Both are important but they should be clearly differentiated. Triangulation – comparing data obtained from one source to another, or data from one tool with data obtained using another tool – is an important process to minimize the potential for bias in assigning value to expressed opinions and attitudes. Triangulation also aims at strengthening the credibility and validity of the findings.

The interpretation of the mostly qualitative data gathered in a situation assessment is difficult. If data analysis and interpretation are not done carefully, teams risk simply reinforcing preconceived assumptions. Subjective judgments and generalizations are common; lists of needs may have been pre-established and not prioritized to the local situation; variability and operative adaptive mechanisms may not be recognized. One assumption can completely alter the interpretation of the whole data set – for example, the *a priori* assumption that a certain population group is the most at-risk for HIV.

Determining and describing the situation prior to the crisis is critical to being able to compare HIV vulnerability before and after displacement, and to differentiate between chronic and acute needs. It is also helpful to differentiate between vulnerability to acquiring HIV and vulnerability for people already living with HIV. Where no baseline exists, established international or regional norms can be used for comparing the findings in the current situation.

It should never be assumed that no information means "no problem". It should be clearly stated, for instance, which population groups or sites have been omitted or missed and why. If information is deemed relevant but unavailable, this should be explained in the report.

7. Reporting and Disseminating

The final report should be clear, standardized, action-oriented, timely, and widely discussed and distributed. The executive summary should highlight the main recommendations for policy-makers and planners. Presentations of the preliminary results to various audiences, including financial, political and managerial constraints, should immediately follow the fieldwork and employ the use of audiovisual aids. The final report should include more detailed descriptions of the assessment, the methods chosen, their limitations and the main assumptions made by the assessment team (see BOX 16).

Reported vulnerability factors may include the direct impact of the crisis on health, education, security and violence – depending on the context – and the indirect impact such as displacement, migration, family separation and domestic violence. Risk factors for HIV should focus on the most important modes of transmission and on key populations and those with increased HIV risk in crisis situations. The formation of new groups of populations at risk because of the crisis should be highlighted as well as the differences within them. Assumptions about needs and risks of particular groups or places should be well documented, as well as assumptions about what will work among the recommendations made and why. To effectively communicate the findings of the assessment, the report must: a) be in a form that meets some accepted scientific criteria; b) meet ethical standards such as confidentiality and respect; and c) be readable and usable for its intended audiences. In some cases, different reports may be needed for different audiences. In the use of quotations, an appropriate balance should be found between including endless quotations that will bore the audience and including only a few that appealed to the assessment team.

One lesson learned from assessments was to link the findings and the recommendations of the assessments early with any follow-up activities(21). The report should contain a short section on how the follow-up could be organized and monitored.

BOX 16
OUTLINE OF A SITUATION ASSESSMENT REPORT

- Executive summary
- Introduction and objectives
- Outline of methods used and people interviewed at each step
- Results/findings, including:
  - Vulnerability factors for HIV among IDPs and host populations
  - Risk behaviour for HIV among IDPs and host populations
- Current responses at national and local levels
- HIV programme needs and potential resources
- Conclusions
- Recommendations to government sectors and development partners
- Follow-up
- Annexes

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9. Working Definitions

Abuse	anything that individuals or institutions do or fail to do that directly or indirectly harms children or adults. There are different types of abuse such as physical and sexual abuse, substance abuse, elderly abuse, and emotional abuse.
Additional consent	consent required from adults working with children, such as teachers, clergy, youth workers, and others, to gain access to gather information from children.
Adolescent	individual in the state of development between the onset of puberty and maturity; definitions vary according to culture and custom (WHO definition is from age 10 through age 19).
Age of consent	age at which an individual may give consent to sexual activity with another person.
Anonymity	conditions under which the identity of the participant is not collected and cannot be traced from the information provided.
Child or minor	individual younger than age 18; definitions vary according to culture and custom.
Confidentiality	conditions under which the information revealed by an individual participant in a relationship of trust will not be disclosed to others without permission.
Consent	affirmative agreement of an individual who has reached the legal age of maturity.
Crisis (humanitarian)	is defined as a singular event or a series of events that are threatening in terms of health, safety or well being of a community or large group of people. Examples of humanitarian crises include armed conflicts, epidemics, famine, natural disasters and other major emergencies.
Disaster	is a sudden, calamitous event that causes serious disruption of the functioning of a community or a society causing widespread human, material, economic and/or environmental losses which exceed the ability of the affected community or society to cope using its own level of resources.
Informed consent	process of ensuring that each participating individual does so willingly and with adequate understanding.

Internally displaced persons	persons or groups of persons who have been forced or obliged to flee or to leave their homes or places of habitual residence, in particular as a result of, or in order to avoid, the effects of armed conflict, situations of generalized violence, violations of human rights or natural or human-made disasters, and who have not crossed an internationally recognized state border.
Risk of HIV	is the likelihood that a person will become infected with HIV either due to his or her own actions (knowingly or not) or due to another person`s action. Unprotected sex with multiple partners and sharing contaminated needles for instance are risky activities that increase the probability of HIV infection.
Vulnerability to HIV	is a person's or a community's inability to control their risk of infection. It may be attributed, inter alia, to poverty, disempowering gender roles or migration (25).
Young people	a young person; definitions may vary according to culture and custom (WHO definition is from age 15 through age 24).

Annexes

The tools in the ANNEX can be downloaded under
http://www.unhcr.org/cgi-bin/texis/vtx/search?page=&comid=4acda9f29&cid=49aea9390&keywords=HIV-bss-assessments
in MS-Word Format to be adjusted and to be used directly.

Annex A. **Ensuring Ethical Standards - Checklist**

CHECKLIST OF THE ETHICAL QUESTIONS TO CONSIDER BEFORE PROCEEDING WITH THE SITUATION ASSESSMENT:
1) Is the required information available elsewhere? Does it already exist in documents or can it be gathered from other informants?
2) Will the IDPs benefit from this assessment?
3) Is this assessment designed to get valid information?
4) Have efforts been made to ensure that local communities understand the purpose of the assessment and likely outcomes to avoid raising false expectations?
5) Has the team anticipated possible adverse consequences of the assessment?
6) Are field staff and community focal points prepared to anticipate, recognize and respond to IDPs' need for follow-up?
7) Do all team members know the circumstances under which participant confidentiality should be breached?
8) Has the informed consent form been pre-tested and translated into local language(s), and has agreement been reached about oral and written consent?
9) Is it clear to all team members that informed consent should be sought prior to the data collection?
10) Is there a guarantee that no name will be recorded?
11) Are rules defined in case of medical or social emergency?
12) Are rules defined for interviewing youth, such as the necessary authorization of parents or guardians?
13) Is there a clear plan and adequate funding to give community members and partner organizations access to the results of the assessment?
14) Is there a plan for follow-up activities shared with all stakeholders?

Annex B. **District Programme Assessment Tool for IDPs and Host Populations**

Objective
To assess general district information on health, nutrition and health education to collect HIV- and AIDS-related prevention, care, support and treatment information; and to identify services and programmes in place.
** The District Programme Assessment tool has been adapted from reference (8).*

Method
Some parts of this assessment form should be filled out at the national and/or district level with the assistance of local health providers, other public sectors and NGOs. Separate forms (see section J) for each health facility may be used. This descriptive information should be complemented by additional information collected through semi-structured interviews and focus group discussions. The District Programme Assessment tool can be downloaded in MS-Word format at
http://www.unhcr.org/cgi-bin/texis/vtx/search?page=&comid=4acda9f29&cid=49aea9390&keywords=HIV-bss-assessments
and it can be easily adjusted for the individual assessment and respective context.

Source of data
National Statistics Office, Public Health Officer, district health information system, local survey, NGOs records, other

A. GENERAL HEALTH DATA**				
Crude mortality rate	**Under 5 mortality rate**	**Infant mortality rate**	**Maternal mortality ratio**	**Crude birth rate**
Deaths/1,000 persons/year	U5 deaths/1,000 U5s/year	U1deaths/1,000 U1s/ year	Pregnancy-related deaths/100,000 live births/year	Live births/1,000 persons/year

***National data for year preceding assessment, if available*

B. GENERAL DISTRICT INFORMATION			
Date:			
Assessor's name:			
District name:			
Respondent's name:			
Location:			
Location	**Sub-District**	**District**	**County**

DISTRICT POPULATION DEMOGRAPHIC CHARACTERISTICS (NUMBERS AND PERCENTAGES)

Non-displaced persons			Displaced persons		
Ages*	Male	Female	Ages	Male	Female
<5			<5		
5-9			5-9		
10-14			10-14		
15-19			15-19		
20-49			20-49		
50+			50+		
Total			Total		
Ratio M:F	1.00			1.00	
Total population					

**Age groups may vary according to data sources; age brackets can be 10-17 or 10-24*

CURRENT ETHNIC GROUP(S) AND PERCENT OF TOTAL POPULATION (IF APPROPRIATE):

Location	Ethnic group/caste	Displaced status	Percent of population

MAJOR POPULATION MOVEMENTS IN PAST FIVE YEARS: IDPS

Year	Size of population	Influx + / Egress -	Group	Place of origin/ destination

FOOD AND NUTRITION

Food quantity (if food distribution)	kilocalories/person/day
Prevalence of acute malnutrition	% global acute malnutrition
Scored	❑ z-score ❑ % median
How measured	❑ survey ❑ other
Date of last determination	(dd/mm/yy)

HEALTH FACILITIES

Are health facilities available?	❑ yes ❑ no
Do internally displaced persons use health care facilities?	❑ yes ❑ no
If yes, what proportion of clients have they represented in the last 12 months?	% ❑ register ❑ estimation

C. INVENTORY OF HIV AND OTHER SEXUALLY TRANSMITTED INFECTION PREVENTION ACTIVITIES AND MAIN ACTORS IN DISTRICT

Activities	Who?	Where?	How are they affected by the displacement?
Prevention			
Blood safety			
Standard precautions			
Condom promotion and distribution			
HIV and STI awareness programs			
STI management and control			
Programs/services for youth*			
HIV integrated in school curriculum			
Programmes/services for sex workers*			
Programmes/services for people who inject drugs*			
Programmes/services for transgender people			
Programmes/services for men who have sex with men*			
Prevention of mother-to-child transmission (EMTCT)			

C. INVENTORY OF HIV AND OTHER SEXUALLY TRANSMITTED INFECTION PREVENTION ACTIVITIES AND MAIN ACTORS IN DISTRICT			
Activities	**Who?**	**Where?**	**How are they affected by the displacement?**
Voluntary counseling and testing services			
Post-exposure prophylaxis for survivors of sexual violence			
Post-exposure prophylaxis for occupational exposure			
* To be detailed:			
Care, support and treatment			
Treatment of opportunistic infections			
Prevention of opportunistic infections			
Antiretroviral therapy for adults Antiretroviral therapy for children			
Pediatric treatment			
Basic medical care for people living with HIV			
Counseling and other psychosocial support of people living with HIV			
Home-based care, palliative care			
Nutrition support or OVCs			
Other programs, to be specified…			
Prevention			
Syphilis screening at antenatal clinics			
HIV sentinel surveillance			
HIV behavioural surveillance			

D. PROTECTION	
Are the following in place in the district? If yes, describe, including how they are monitored.	
1. Specific measures to ensure that women/girls and unaccompanied children have access to relief items and food?	❑ yes ❑ no
2. Registration of separated unaccompanied children and single women?	❑ yes ❑ no
3. Measures to monitor the needs of separated and unaccompanied children?	❑ yes ❑ no
4. Family tracing and family reunification?	❑ yes ❑ no
5. Specific measures in place to reduce economic vulnerability of female-headed households and unaccompanied girls?	❑ yes ❑ no
6. Any specific protection interventions for adolescents?	❑ yes ❑ no
7. Any specific programs for infants born to HIV+ mothers?	❑ yes ❑ no

E. SEXUAL VIOLENCE (PLEASE CONSIDER ETHICAL STANDARDS)	
Which components of programming are in place for the prevention and response to sexual violence?	
Community education and awareness raising	❑ yes ❑ no
Psychosocial support/counseling	❑ yes ❑ no
Emergency contraception	❑ yes ❑ no
Confidential and accessible medical care incl. STI treatment	❑ yes ❑ no
Hepatitis B immunization	❑ yes ❑ no
Post-exposure prophylaxis to prevent transmission of HIV	❑ yes ❑ no
Medical reporting and collection of forensic evidence	❑ yes ❑ no
Guidelines for responding to incidents of sexual violence	❑ yes ❑ no

Is there a reporting system in place (either with health, other services or authorities)?	❑ yes ❑ no
If yes, list number of cases reported	
Total number of cases reported	
Total population	
Total of number of months reviewed	

F. REPRODUCTIVE HEALTH	
Safe delivery practices:	
Where do most women deliver?	
Percent of health facility deliveries and home deliveries:	%
Who attends women in labour?	
Do attendants have access to protective wear in facility deliveries?	❑ yes ❑ no
Do attendants have access to protective wear in home deliveries?	❑ yes ❑ no
Are clean delivery kits provided?	❑ yes ❑ no
If yes, to whom?	
Are midwifery kits available?	❑ yes ❑ no

G. PROGRAMMES FOR KEY POPULATIONS & THOSE WITH INCREASED HIV RISK IN DISPLACED SITUATIONS	
Do specific HIV and AIDS programmes and services exist for:	
IDPs	❑ yes ❑ no
Women	❑ yes ❑ no
Girls	❑ yes ❑ no
Children	❑ yes ❑ no
Orphans	❑ yes ❑ no
People who inject drugs	❑ yes ❑ no
Sex workers	❑ yes ❑ no
Sexually exploited adolescents and children	❑ yes ❑ no
Men who have sex with men	❑ yes ❑ no
Transgender people	❑ yes ❑ no
Widows	❑ yes ❑ no
Demobilized children	❑ yes ❑ no
Demobilized adults	❑ yes ❑ no
People with disabilities	❑ yes ❑ no

Insert NA where not applicable; add other programmes if present

Information, education and communication	
Are HIV related information, education and communication materials available in the district in appropriate languages?	❑ yes ❑ no
If yes, comment on availability…	

Condoms (if not free, indicate price in local currency and USD equivalent)		
Are male condoms available in:		
❑ local bars (free/$)	❑ secondary schools (free/$)	❑ health centers (free/$)
❑ pharmacies (free/$)	❑ other: …… (free/$)	❑ other: …… (free/$)
Are female condoms available in:		
❑ local bars (free/$)	❑ secondary schools (free/$)	❑ health centers (free/$)
❑ pharmacies (free/$)	❑ other: …… (free/$)	❑ other: …… (free/$)

Sexually transmitted infections			
Where are sexually transmitted infections diagnosed and treated?			
❑ Outpatient department	❑ antenatal clinic	❑ referral hospital	❑ other:
Do antenatal clinics screen pregnant women for syphilis?			❑ yes ❑ no

Education	
Are specific measures in place to ensure female enrolment and retention in schools?	❑ yes ❑ no
If yes, please describe:	
Do displaced children have access to schooling in the government sector?	❑ yes ❑ no
Do orphans have free access to schooling in the government sector?	❑ yes ❑ no
What percentages of school attendees are displaced children?	In primary:……% In secondary:……%
Are HIV and AIDS topics implemented in the school curriculum?	❑ yes ❑ no
If yes, where? ❑ primary school ❑ secondary ❑ other:	
Are there informal out-of-school education activities such as youth clubs, peer education groups, religious lessons?	
If yes, do they provide HIV and AIDS education?	❑ yes ❑ no
Please specify:	

Family Planning	
Are family planning services available in the district?	❑ yes ❑ no

H. TREATMENT AND CARE

Antiretroviral therapy (ART)	
Is ART available in the district for people living with HIV?	❑ yes ❑ no
Are ARV for PMTCT available?	❑ yes ❑ no
Is pediatric treatment available?	❑ yes ❑ no
If yes, do displaced persons have access?	❑ yes ❑ no
If ART is not available, what distance is the nearest ART centre?	km

Tubercolosis			
Where is pulmonary tuberculosis diagnosed?	❑ public clinic	❑ referral hospital	❑ other:
Are newly diagnosed TB patients referred for HIV testing?			❑ yes ❑ no
Are newly diagnosed HIV patients referred or tested for TB?			❑ yes ❑ no

Nutrition and livelihood support	
Is extra food provided to households affected by HIV or AIDS?	❑ yes ❑ no
If yes, what are the selection criteria?	
Are programmes available that provide other forms of livelihood support (e.g. money, livestock, income generation activities, skills training) to families affected by HIV or AIDS?	❑ yes ❑ no
If yes, what are the selection criteria?	
Are children with Severe or Moderate Acute Malnutrition tested for HIV?	❑ yes ❑ no
If yes, are they referred for treatment and follow up?	

I. SURVEILLANCE AND MONITORING AND EVALUATION (M&E):	
Are there any current M&E systems in place to evaluate:	
HIV programs	❑ yes ❑ no
Sexually transmitted infections programs	❑ yes ❑ no
TB programs	❑ yes ❑ no

AIDS case reporting	
Is AIDS or advanced HIV infection a diagnosis listed on mortality forms?	❑ yes ❑ no
Is AIDS or advanced HIV infection a diagnosis listed on morbidity forms?	❑ yes ❑ no
If yes, is there a case definition?	❑ yes ❑ no

LIST HIV PREVALENCE (PROPORTION HAVING HIV AT A PARTICULAR TIME), DATES, POPULATIONS, METHOD, LOCATION AND SOURCE (IN ANNEXES) WITH PARTICULAR ATTENTION TO IDPS.

	Date	Population group	IDPs	Population size	Locations	Data source
HIV prevalence %						

Behavioural Surveillance Survey or Knowledge, Attitudes, Practices surveys:
List dates, populations, methods, location, and sources disaggregated by local and IDP

OTHER IMPORTANT DATA SOURCES

Prevention of mother-to-child transmission of HIV	
% of antenatal clinic attendees that are offered HIV counseling and testing	%
% of antenatal clinic attendees that accept HIV counseling and testing	%
% of women tested who are HIV-positive	%
% of HIV positive pregnant women who receive treatment (disaggregated by initiating or continuing)	%
% of HIV positive children who receive treatment (disaggregated by initiating and continuing)	%
% of partners of antenatal clinic clients who accept HIV counseling and testing	%
TB/HIV	
% of TB patients who are tested for HIV	%
% of TB patients who are HIV-positive	%
% of HIV patients who are tested for TB	%
Blood donation data	
% of donated blood units that test positive for HIV	%
Sexually transmitted infection data	
% of pregnant women who test positive for syphilis	%

J. HEALTH FACILITY SPECIFIC FORM

Is ART available in the Health Facility for people living with HIV?	
Do displaced persons use this health care facility?	❑ yes ❑ no
If yes, what proportion of clients have they represented in the last 12 months?	
……% ❑ register ❑ estimation	
What type of HIV testing is available?	
❑ diagnostic ❑ provider-initiated ❑ client-initiated ❑ blood transfusion ❑ Pregnant women incl. PMTCT	
Is mandatory HIV testing (testing without informed consent of the client) conducted under any circumstances?	❑ yes ❑ no
If yes, please describe in what context and how the information is used:	
Is pre- and post-test counseling offered in HIV testing?	❑ yes ❑ no
When are clients informed of the test result?	(N° of days)
What proportion of clients overall get their results?	
Male……%; Female…… %	
Are there measures in place to conduct testing confidentiality?	❑ yes ❑ no
Are there measures in place to monitor, report and respond to breaches in confidentiality?	❑ yes ❑ no
If yes, please describe:	
Are any specific measures taken if a client tests positive for HIV or if their HIV-positive status is known?	
If so, describe. (This can include referrals but also possible notification of health authorities, quarantine/ limitations on freedom of movement or any other discriminatory measures).	
Is this facility capable of giving blood transfusions?	❑ yes ❑ no
If yes: Are blood donors pre-screened with a risk assessment questionnaire?	❑ yes ❑ no
If yes: Do guidelines exist for determining who gets blood transfusions?	❑ yes ❑ no
Check if blood is screened for: ❑ HIV ❑ syphilis ❑ hepatitis B ❑ hepatitis C	
Is this screening consistently done for each test checked above?	❑ yes ❑ no
If no, list tests that were not consistently used in the last six months:	

Are the following in place for maintenance of universal precautions?	
Hand-washing facilities (with soap)	❑ yes ❑ no
Reliable water source	❑ yes ❑ no
Gloves in stock	❑ yes ❑ no
Needles in stock	❑ yes ❑ no
Syringes in stock	❑ yes ❑ no
Sharps containers present	❑ yes ❑ no
Equipment for boiling, steaming or chemical sterilization	❑ yes ❑ no
Satisfactory medical waste disposal system	❑ yes ❑ no
Has there been a stock-out of ARV drugs (type, adults, pediatric etc.) or test kits of more than one week over the last twelve months? (Please check stock records.)	❑ yes ❑ no
Has there been a stock-out of gloves, needles or syringes of more than one week over the last twelve months? (Please check stock records.)	❑ yes ❑ no
If yes, describe:	
Has there been a stock-out of condoms of more than one week over the last twelve months? (Confirm by reviewing stock records.)	❑ yes ❑ no
Are protocols available for treating sexually transmitted infections (STIs) with a syndromic approach?	❑ yes ❑ no
What protocols for STI?	
Are appropriate drugs available to treat STIs?	❑ yes ❑ no
Has there been a stock-out of STI drugs of more than one week over the last 12 months? *(Confirm by reviewing stock records.)*	❑ yes ❑ no
Are condoms offered as a component of STI management? *If yes,* confirm availability in facility.	❑ yes ❑ no

Annex C. **Interview Guide: Key Representatives**

Objectives
This guide describes key elements of the interviews, lists suggestions for thematic areas that should be covered during the interviews and offers sample questions and suggestions for probing. These lists should not be regarded as exhaustive. The focus is on topics rather than specific questions per se. Questions are given as illustrations and not to be taken as the only way, or indeed the optimum way, of exploring the issue. All interview guides can be downloaded in MS-Word format at
http://www.unhcr.org/cgi-bin/texis/vtx/search?page=&comid=4acda9f29&cid=49aea9390&keywords=HIV-bss-assessments
and can be easily adjusted for the individual assessments and respective contexts.

Information gathered through semi-structured key informant interviews will guide the process of collecting data through focus group dicsussions.

Adjustments
Each rapid assessment team must develop its own individual style of questioning in order to gain information in culturally appropriate and sensitive ways. Each team is expected to spend time in refining and agreeing on the final topic list relative to the particular setting and understood HIV risk behaviours of the IDPs.

At the beginning of each interview:

- Introduce yourself, explain the purpose of the situation assessment;
- Read out the consent form and obtain consent;
- Assure the respondent about anonymity and confidentiality;
- Thank the respondent for agreeing to participate in the interview and offer to answer any questions they may have before, during and after the interview.

At the end of each interview:

- Thank the respondent for their time;
- Ask the respondent if they have any questions;
- Tell the respondent that their answers have provided an important contribution to information about the impact of the crisis on the population and will help to establish the HIV-related needs and priorities of that district.

DISTRICT OFFICIALS (LOCAL DEVELOPMENT OFFICER, CHIEF DISTRICT OFFICER, DISTRICT PUBLIC HEALTH OFFICER)

Record: Sex (M/F), age bracket (youth, adult, elder), job title or occupation

Please tell me:

1) How long have you lived here? If less than two years: Where did you live before coming here?
2) How long have you been working in this position?
3) What is your ethnic group/caste? *(If appropriate)*
4) In your opinion, what have been the **major impacts** of the crisis on the population of the district, in general terms and for HIV and AIDS in particular?
5) What are the major HIV and other sexually transmitted infection risk factors associated with the crisis? Who are the most affected population groups with regard to HIV and sexually transmitted infections?
6) Probe for information about vulnerability and risk factors.

Vulnerability factors

- Poverty
- Displacement
- Disruption of families
- Poor nutrition/food insecurity
- Illness
- Lack of information about HIV, sexually transmitted infections or availability of services
- Lack of services (sexually transmitted infections, voluntary counseling and testing, care and treatment)
- Lack of access to basic education
- Lack of access to basic health care
- Marginalization
- Violence
- Domestic labor
- Others

Risk factors for HIV/sexually transmitted infections

- Multiple sex partners
- Transactional sex
- Change in sexual networks
- Coerced or forced sex
- Injecting drug use
- Sharing of needles
- Non-use of condoms
- Re-use of needles and syringes
- Unsafe blood transfusions
- Prevalence of sexually transmitted infections
- Others

The current response

1) What has been the local institutional response (government sector) to HIV? Is it a part of the national policy?
2) Do the district authorities provide resources for HIV and AIDS interventions?
3) What has been the local response (community, civil society and private sector)?

Improving programmes and services

1) What should be the priority activities to alleviate the impact of the crisis with regard to HIV and sexually transmitted infections?
2) What type of programme and activities are needed to control HIV?
3) What would make it easier for IDPs to access HIV prevention, care and treatment services?
4) What additional resources (human and finance) are needed in this location?
5) Are there any additional comments you would like to add?

COMMUNITY LEADERS; REPRESENTATIVES OF WOMEN AND MEN

Record: Sex (M/F), age bracket (youth, adult, elder), job title or occupation

Please tell me:

1) What is your role in the district/community/agency/organization?
2) How long have you been working there?
3) What is your caste/ethnic group? (If appropriate)

Now, may I ask you some questions about local conditions and services?

1) How do people in your community earn money? What kinds of jobs or sources of income do men and women have? What do they spend money on?
2) What type of interaction is there between people that have moved here because of the conflict and the local population? How does the local population perceive the displaced persons? (*Probe*: Are there any problems between these two groups?)
3) What challenges has the community faced as a result of the conflict/crisis? (*Probe*: Disruption of food, health, water, sanitation, market and other services, incoming people straining resources, etc.)
4) Have any other changes occurred in the community due to the conflict/crisis? (*Probe*: Children sent out of the district, adolescents/young people out of school, in or out male migration, family structure, other.)
5) What do most displaced women do here during the day? Do any of them have jobs earning money?
6) Do you know some/many women displaced without their husbands/partners/male family members? What are some of the challenges that they face? (*Probe*: Equal access to employment, education, income generation, and agricultural resources.) Who protects them?
7) Has the conflict/crisis affected education and health services and attendance? Has the conflict affected security for children, women and young people?
8) Are there children/young people here without one or more parents? How are they cared for?
9) Are there children/young people/women here who are working for money? Or for other basic needs (i.e. food)? Has this increased, decreased or stayed the same with the conflict/crisis?
10) Where do local people go for health care? (Possible answers include government, NGO, private facilities, traditional healers, etc.) Where do displaced persons go for health care? *(May be the same or different.)* What limits or prevents some people from going to the health facility? *(Could be cost, lack of supplies, language, perceived discrimination, etc.)*

Would you mind if we talk about HIV and sexually transmitted infections?

11) Have you heard of HIV or AIDS? Do you know, or have you heard of, how HIV is transmitted? Do you know people living with HIV or AIDS in this location?
12) What do people do when they think they have a sexually transmitted infection or HIV? Can they get tests or treatment here? Do you think that the frequency of sexually transmitted infections has changed (increased or decreased) because of the conflict/crisis?
13) Is it common for young men and women in the community to have sex before marriage? Do people think this is wrong for young women? For young men? Do married men and women have sex outside of marriage? Has this changed because of the conflict/crisis? Has the age of first sexual encounter, or the age of marriage, changed since the conflict/crisis?
14) Are condoms easily accessible in the community? Where can they be found? Who uses them more often? Married couples? Single adults? Youth? Sex workers? (Try to ascertain which groups are less likely to have access to condoms). Has access to condoms changed because of the conflict/crisis?
15) Are there people in your community who take substances (opium, heroin, amphetamines, etc.) or alcohol? Which substances? Are these substances ever injected? Are there any services available for people who have a problem with alcohol or substance use? Can people who inject drugs access sterile injecting equipment? Has the consumption of substances/drugs changed as a result of the conflict/crisis?

COMMUNITY LEADERS; REPRESENTATIVES OF WOMEN AND MEN

I'd also like to ask some questions about forced sex and violence against women (sexual and domestic violence).

16) Do you know of women or girls (or men or boys) in this community who are forced to have sex when they don't want to? Where would a woman who has been raped go for help? Who would she talk to? What services are available? Do women look for help here when this happens to them?
17) How common is it for women to have sex for money, protection or food? Has this increased since the conflict/crisis? With whom do these women have sex? What is the attitude of the community about it? Has there been an increase in the number of people exchanging sex for money or other resources since the conflict?
18) Do you know about husbands who are violent with their wives (e.g., beat, hit, threaten or cut them)? Is it discussed or reported? Has this increased or decreased with the conflict? What is the attitude of the community towards this?

POLICE OFFICERS, ARMY PERSONNEL

Record: Sex (M/F), age bracket (youth, adult, elder), job title or occupation

Please tell me:

1) How long have you lived here? If less than two years, where did you live before coming here?
2) How long have you been working in this position?

I would like to ask you some questions about health among uniformed forces.

1) **Presence of military forces –** How many people serving in the military or police are in the district? (May be confidential.) What are the living conditions of those in the army? How does it affect their access to family or sexual partners?
2) **Health seeking behaviours of military forces and other uniformed services –** Is it possible for a soldier or policeman to get advice or treatment with regard to sexually transmitted infections? If yes, where? Is it available in the army medical services? Is the treatment free? Do they receive advice on prevention and condom use? Are condoms available and accessible for free? If so, where?
3) **HIV awareness –** Is HIV a concern? Are there programs or services relating to HIV and AIDS in the military? Is HIV testing and counseling available?
4) **Risk-taking –** When large groups of young men live together away from their families, what do they do for leisure? In this situation, sexual practices may change. What can you tell us about the sexual behaviour of the men stationed here? (Probe: alcohol consumption and associated sexual activity, commercial sex, male-to-male sex, sexual violence.)
5) **Stigma and discrimination –** In general, what is the attitude of men stationed here towards HIV and AIDS? How common is stigma/arrest/violence against people living with HIV, men who have sex with men, people who inject drugs, sex workers?
6) **Policy –** Do the military or other uniformed forces have policies concerning HIV in the workplace? Do you have any recommendations on policy issues relating to HIV such as HIV testing, educational programmes, condom availability? Is there a code of conduct in place in relation to sexual interactions between soldiers, police, etc. and displaced or conflict-affected populations? Have you received complaints about the behaviour of those in the uniformed services? How frequently? What type of procedures do you apply in such cases?

NGO WORKERS, HEALTH WORKERS, TEACHERS ETC.

Record: Sex (M/F), age bracket (youth, adult, elder), job title or occupation

Please tell me:

1) How long have you lived here? If less than two years, where did you live before coming here?
2) How long have you been working in this position?
3) What is your ethnic group/caste? (If appropriate)
4) What are the main activities/services of your organization in this district?
5) What are the main activities/services relating to HIV in your organization? (Probe: HIV-related coordination, protection, prevention, care and treatment, surveillance, monitoring and evaluation, funding.) How much do you serve or target IDPs?
6) Are there other agencies (private or public) providing similar services in the district? If yes: Which ones?
7) Are there any challenges in providing HIV-related services/programmes to IDPs and crisis-affected populations? (Probe: Police attitudes? Lack of legal protection? Confidentiality issues? Insecurity? Difficulties in accessing and following up with these populations?) If yes, describe.
8) Have the services/programmes been affected by the conflict/crisis? If yes, please describe. (Probe: Interruption of supplies, staff/government counterparts leaving, unable to meet demand).
9) What has been the local response (government, private sector and civil society) to IDPs and the sexual and reproductive health needs of IDPs, including HIV?
10) What services/programmes do you think are needed to prevent and respond to HIV in the district, including for IDPs? What resources (human and financial) should be engaged or supported?
11) Does your organization have a policy concerning HIV in the workplace?
12) Does your organization have or adhere to a code of conduct on sexual violence and exploitation?

Specific questions for health providers (triangulation for district assessment tool)

1) How has your health facility been affected by the crisis? Probe: Are health staff still here? Has there been looting? Do you have an increased caseload? How does that affect service delivery?
2) Do you currently offer HIV testing to all pregnant women who come to your facility? Is this for both host community and IDPs?
3) Do you offer ARVs for PMTCT to pregnant women (including adolescents) and children? Is this for both host community and IDPs?
4) What is the protocol you are using? Do you know if it is different from the one used in the community from which the displaced population is coming?
5) What difference has the IDP population made to your caseload? Are you able to access all supplies that are required for providing PMTCT and pediatric treatment?
6) Have you faced any stock outs? Of what? For how long? Is this something that you always face or is this related to the influx of IDPs? How do you resolve this?

Annex D. **Interview Guide: IDPs and Host Populations**

Objectives
This guide describes key elements of the interviews, lists suggestions for thematic areas that should be covered during the interviews and offers sample questions and suggestions for probing. These lists should not be regarded as exhaustive. The focus is on topics rather than specific questions per se. Questions are given as illustrations but should not be taken as the only way, or indeed the optimum way, of exploring the issue.

Information gathered through semi-structured key informant interviews should guide the process of collecting data through focus group discussions.

Adjustments
Each rapid assessment team must develop its own individual style of questioning in order to gain information in culturally appropriate and sensitive ways. Each team is expected to spend time in refining and agreeing on the final topic list relative to the particular setting and understood HIV risk behaviours of the IDPs.

At the beginning of each interview:

- Introduce yourself, explain the purpose of the situation assessment;
- Read out the consent form and obtain consent;
- Assure the respondent about anonymity and confidentiality;
- Thank the respondent for agreeing to participate in the interview and offer to answer any questions they may have before, during and after the interview.

At the end of each interview:

- Thank the respondent for their time;
- Ask the respondent if they have any questions;
- Tell the respondent that their answers have provided an important contribution to information about the impact of the crisis on the population and will help to establish the HIV-related needs and priorities of that district.

Record: Sex (M/F), age bracket (youth, adult, elder), job title or occupation

Please tell me:

1) How long have you lived here? If less than two years, where did you live before coming here?
2) How long have you been working in this position?
3) What is your ethnic group/caste? (If appropriate)
4) What are the main difficulties that you face here?
5) What have been the most significant impacts of the crisis on you? On your family and friends?

1. DISPLACED MEN AND WOMEN

1) Have you (been forced to move) moved your place of residence because of the crisis?
2) *If yes:* How many times have you been forced to move in the last five years (adapt as appropriate)? Where and for how long? For what reasons?
3) Where do you come from originally?
4) What difficulties did you face during your journey to _____ (present location)?
5) What are the differences between your assets here and those you left behind?
6) What are the differences in your income here and your original place of residence?
7) What are the differences in security?
8) How did moving affect your family composition?
9) How did it affect your work? Your social relations? Your responsibilities?
10) Do you think that the conflict/crisis is having an impact on your health? In what ways?
11) Do you think that the conflict/crisis is having an impact on your food intake?
12) When you experience health problems, where do you go? Why?
13) How has the conflict/crisis affected your sexual life? The number of your sexual partners? The type of your partners? More commercial sex encounters? The sexual behaviour of your partner? Drug use? *(If injecting drug use, move to specific questions about people who inject drugs)*
14) Have you ever heard of infections that can be transmitted sexually? (*Probe:* Specifically, have you heard of HIV or AIDS?) *If yes:* From where? What do you know about it? What are the different ways people can protect themselves against HIV?
15) For long-term displaced: Over the past two years, have there been any changes in the amount or type of food you consume (due to conflict)?
16) For long-term displaced: How easily can you and your family access health and education services? Community services? Are you registered and entitled to the same services as residents? Do your children have free access to public school? If not, what needs to be done to improve the situation?

2. PEOPLE WHO INJECT DRUGS

1) When and why did you first inject (year and circumstance)?
2) Do you have (a) casual or regular partner(s)? Is/are your sexual partner(s) (if any) also (an) injecting drug user(s)? Do you use condoms with all your sexual partners? *If no:* Why not?
3) How do you get money for drugs? (*Probe:* Do you have sex for drugs?)
4) Do you have access to sterile injecting equipment?
5) Do you do anything to injecting equipment before re-using it?
6) Have you ever shared injecting equipment? Why? Do you do anything to equipment before sharing?
7) Can you describe to me the last time that you injected? Where did the injecting equipment come from?
8) If other people were there, did they use the same equipment? How was the drug prepared? Communally or individually?
9) Are you aware of any infections that can be transmitted from sharing injecting equipment? *(Probe: HIV, hepatitis?)*
10) Are there any programmes for people who inject drugs in the district? *If yes,* what type of programmes? (*Probe:* Needle syringe exchange, peer outreach, education on safe injecting practices, drug substitution therapy?) Is anybody on a Methadone programme? *If yes:* Do you still get Methadone?
11) Are you aware of people who inject drugs that are not currently being reached by these programmes? Why aren't they being reached? (*Note*: if possible try to arrange an interview with one of them.)
12) When you experience health problems, where do you go? Why?
13) What HIV-related programmes/services are needed for people who inject drugs? (*Probe:* Where and how can these best be provided and by whom?)
14) Has the conflict affected your injecting drug use or other substance use? (*Probe:* Access to services, interruption in services? Needle syringe exchange programming? Outreach workers? Other effects?)
15) **I do not want to know the result**, but have you ever had an HIV test? Do you know where you could have an HIV test if you wanted to have one?
16) **I do not want to know the result**, but have you ever had a Hepatitis B & C test?

3. MEN WHO HAVE SEX WITH MEN

Purpose:

a) Depending on the context this may be a key population for HIV

b) What services were provided before?

c) What is their personal situation that might impact on access and or uptake?

In many countries, relatively little information about men who have sex with men may exist. Where no such information is available, it may be helpful to look at what has been learned about HIV and men who have sex with men elsewhere.

1) What do you know about safer sex? What do you know about STI? What do you know about HIV and AIDS?
2) What are your sources of information about HIV/AIDS?
3) Are there any groups or networks for men having sex with men? Are they involved? What support do they offer?
4) What are the most difficult challenges faced by men having sex with men in this community/district? (*Probe:* Services? Discrimination? Access and cost of medications?)
5) What care and treatment services/programmes exist for men having sex with men (e.g. counseling projects, sexual health clinics and community groups)? How relevant and accessible are these services to you? Has the crisis affected those services?
6) How should care and treatment services/programmes be provided and by whom? What other services would be needed?
7) What understanding of the lifestyles and needs of men who have sex with men is there among staff working on local projects?
8) I do not want to know the result, but have you ever had an HIV test? *If no:* Do you know where you could have an HIV test if you wanted to have one?
9) Have you encountered prejudice, violence or harassment in relation to your sexuality? Has this changed with the crisis?
10) What are your perceptions of risk and safety in your live? Do you experience violence or harassment? If yes, under which circumstances?
11) Do you use condoms and water-based lubricant for sex? Are condoms available and affordable? Do you carry some with you? Do you also use them when you have sex with women?
12) Are there men selling sex to men? What economic constraints or choices influence male-to-male sex?
13) Do drug or alcohol uses affect the sexual behaviour of men who have sex with men?

4. FEMALE SEX WORKERS (BELOW 18 YEARS "SEXUALLY EXPLOITED")

1) When did you start this kind of work (exchanging sex for money, gifts or favours)? What made you start? (*Probe:* Any relation to conflict or displacement?)
2) Where do you usually meet your clients? (*Probe:* On the street, bars, cabin restaurants, tea shops, hotels, brothels?) Where does sex usually take place?
3) What are the most common occupations of your clients? Have there been any changes in your clients' ages and employment since you started?
4) Has there been a change in the number of clients since you started? What is your weekly number of clients?
5) Has there been a change in the number of sex workers since you started? (*Probe:* Have you seen more women in commercial sex because of the conflict/crisis?)
6) Has there been a change in the ages of the sex workers?
7) How much money on average do you charge per client? Does this vary? Have the amounts that you charge changed since you started?
8) Has there been any change in the demand for condom use by your clients since you started?
9) Do you have easy access to condoms? Do you use condoms with clients? (*Probe:* never, sometimes, usually or always?) (*Probe:* With the last client did you use a condom?)
10) What do you do when clients refuse to wear condoms? What reasons do they give for not wanting to use them?
11) Do you use condoms with your regular partner(s), if any?
12) Have you experienced violence in your work? *If yes:* From whom? Police? Soldiers? Clients? (*Probe:* Has there been a change in the violence you are subjected to? Which clients are more violent?)
13) How often have you been infected by sexually transmitted infections in the last month? Do you know how to prevent sexually transmitted infections? (Be specific about HIV.)
14) What do you do when you have a sexually transmitted infection? Where do you go? Why?
15) Are there any programmes or services for sex workers in the district?
16) *If yes:* What type of programmes/services? (*Probe:* Condom distribution, peer education, treatment of sexually transmitted infections, behavioural change communication? Others?)
17) Has the conflict affected access to these services?
18) Are you aware of sex workers that are not currently being reached by these programmes? Why aren't they being reached? *(Note: If possible try to arrange an interview with one of them.)*
19) What HIV-related programmes/services are most needed for sex workers? (*Probe:* Where and how can these best be provided and by whom?)
20) **I do not want to know the result**, but have you ever had an HIV test? *If no:* Do you know where you could have an HIV test if you wanted to have one?
21) Context specific: Are you using drugs? Are you injecting them? **I do not want to know the result**, but have you ever had a Hepatitis B&C test?

5. MOBILE MEN, SEASONAL WORKERS

1) Has the conflict/crisis had an impact on your employment? (If the interviewee is married: Has the conflict/crisis had an impact on your spouse's employment?)
2) Has the conflict/crisis affected the destination of your move? Has it affected the frequency and duration of your move?
3) Did you move alone? With other men? With your spouse? Others?
4) When you are away, do you live with others or alone? If others, please describe who.
5) When you are in _____ (place of current residence), what do you usually do for recreation?
6) Men who are away from their families often have sexual relationships with someone other than their wife or regular partner. Is this your experience as well? With whom do you have sex? Under what circumstances do you usually meet casual sexual partners? (*Probe:* In a bar, hotel, apartment?) How often do you have casual sexual relations? Do you exchange sex for money? How often?
7) Have you ever heard of infections that can be transmitted sexually? (*Probe:* Specifically, have you heard of HIV or AIDS?) *If yes:* From where? What do you know about it? What are the different ways people can protect themselves from HIV?
8) When you are travelling or away, do you have easy access to condoms? If so, from where? Do you use condoms? *If no:* Why not?
9) When you have problems with sexually transmitted infections, where do you go? Why?
10) What HIV-related programmes/services are needed for mobile men? (*Probe:* Where and how can these best be provided and by whom?)
11) I do not want to know the result, but have you ever had an HIV test? *If no:* Do you know where you could have an HIV test if you wanted to have one?
12) For longer-term displacement: Over the last two years, where have you moved for work and for how long? (*Probe:* Take note of the different places: cities, plantations, etc.) What sort of work have you been doing over the last two years? What did you do in your last job?

6. MOBILE WOMEN, SEASONAL WORKERS

1) Has the conflict/crisis had an impact on your employment? (If the interviewee is married: Has the conflict had an impact on your spouse's employment?)
2) Why have you moved?
3) Has the conflict/crisis affected the destination of your move? Has it affected the frequency and duration of your travel?
4) Did you move alone? With other women? With your spouse? With family members? Others?
5) When you are away, do you live with others or alone? If others, please describe who.
6) When you are in _____ (place of current residence), what do you usually do for recreation?
7) When you are away, do you experience harassment or violence from men? Do you receive some protection? Do you have casual partners while away?
8) Do you ever have sex in exchange for food, favours, gifts or money?
9) Have you ever heard of infections that can be transmitted sexually? (*Probe:* Specifically, have you heard of HIV or AIDS?) *If yes:* From where? What do you know about it? What are the different ways people can protect themselves from HIV?
10) When you are travelling or away, do you have access to condoms? If so from where? Are they free? Do you use condoms? *If no:* Why not?
11) When you have health problems while away, where do you go? Why?
12) What HIV-related programmes/services are needed for mobile women? (*Probe:* Where and how can these best be provided and by whom?)
13) I do not want to know the result, but have you ever had an HIV test? *If no:* Do you know where you could have an HIV test if you wanted to have one?
14) For longer-term displacement: Over the last two years, where have you moved for work? What sort of work have you been doing over the last two years? What was your last occupation?

7. MEN AND WOMEN LIVING WITH HIV (IN IDP AND IN HOST POPULATION)

1) What are the most difficult challenges faced by persons living with HIV in this community/district? (*Probe:* Services? Discrimination? Access and cost of medications?)
2) Are you on ARV treatment? Are ARV drugs still available or are there shortages?
3) How did you first learn of your HIV status? (*Probe:* Aware of being tested, informed consent obtained, confidentiality maintained, referred for appropriate services?)
4) Are there other people in your family or community that are aware of your HIV status? How did they find out? Was there a change in the way they treated you when they learnt of your HIV status? If so how?
5) If you have not told family or friends of your HIV status, why have you not told them?
6) What services are available for persons living with HIV in this district/community? (*Probe:* Access to voluntary counseling and testing, to antiretroviral therapy, to social services? Where are the services available? Do you access these services? If not, why not? Has the conflict/crisis affected your access to health services?). Are there specific problems for people under antiretroviral therapy who have moved or who will return to their district?
7) Are there any groups or networks for PLHIV? Are they involved? What support do they offer?
8) Do people living with HIV receive nutritional support or extra food? Do you receive some form of livelihood support? If yes: What kind of livelihood support?
9) What care and treatment services/programmes are needed for people living with HIV? How should they be provided and by whom?
10) What services/programmes should be in place to prevent HIV transmission?
11) Do you have to pay for services? *If yes:* For which services and how much?
12) For women, probe about discrimination and special needs such as contraception, family planning, and children.

8. FORMER CHILD SOLDIERS (ABOVE 16 YEARS)

Please consider the specific ethical requirements for child soldiers (see also Annex A)

1) In what circumstances were you enrolled in military forces? (*Probe:* Abduction, forced recruitment, survival). For how long were you involved? Did you participate in armed combat? Were you injured? Did you experience violence? Did you witness violence?
2) In your opinion, how many demobilized child soldiers are in the district?
3) What is your current occupation? What kind of work would you like to have?
4) Where do you live? With whom?
5) Have you resumed contact with your family and relatives? With your previous friends?
6) What are your feelings about what has happened? (*Probe:* Fear, regret, revenge, anger, etc.)
7) Do you receive any support (for example, training, psychosocial, other) from the state or from NGOs? What type of support?
8) Do you suffer from health-related problems, or are you in good health?
9) Did you take drugs such as alcohol, heroin or amphetamines during the conflict? Did you inject drugs? Did you share needles?
10) Did you have sexual relations? Were you forced to have sexual relations?
11) Have you ever heard of infections that can be transmitted sexually or through blood? What is your past experience of sexually transmitted infections? (*Probe:* Specifically, have you heard of HIV or AIDS?) If yes, from where? What do you know about it? What are the different ways people can protect themselves from HIV?
12) Do you know of any organization that looks after demobilized children and that could help you if you needed help?
13) Do you know of any health or social service nearby that you could attend if you needed to?

9. WIDOWS, FEMALE-HEADED HOUSEHOLDS, SINGLE WOMEN

1) For widows: Since when have you been alone (How long have you been alone)?
2) For widows: How does the family of your husband support you? How do they treat you? How does your family support you? How does your family treat you? Do you have access to your family's land or shared house?
3) For widows: What were the reactions of the community after the death of your husband?
4) With whom do you live now? Where are your children and other family members? (*Probe:* Abduction for service in militias? Disrupted families?) Are there any new members in the household? Any other children?
5) Do you have access to your family's land or shared house? Did you experience extortion or expropriation of land or property?
6) Do you work? What type of work? How much do you earn? Is it enough for you (and your children)? How much are your work and your income affected by insecurity? Are you performing tasks that men usually do?
7) How else do you support yourself and the children? (*Probe:* What do you do if you do not have enough money to buy food or other essential items? Do you have working children?)
8) Do you feel threatened by men? Do you fear for your security? Have you experienced threats or physical violence?
9) Have you ever heard of infections that can be transmitted sexually? (*Probe:* Specifically have you heard of HIV or AIDS?) *If yes:* From where? What do you know about it? What are the different ways people can protect themselves from HIV?
10) Do you know about ways to protect yourself from HIV/sexually transmitted infections? Do you have access to condoms? To health services for sexually transmitted infections and sexual and reproductive health? Has the conflict increased your risks of getting HIV? Why? Do single women in this area practice sex trade/work? To what extent?
11) Do you feel discriminated against? Are you subject to negative attitudes or behaviours? If yes, are you able to tell us who in the district discriminates against you? Why are there such attitudes?
12) Do you (or you children) receive any governmental assistance or support? Any community support?
13) What would help you the most in your situation? (*Probe:* Land? Health services? Direct support? School fees for children? Support group of other women?)

10. ADOLESCENTS AND YOUNG PEOPLE

1) How do adolescent girls and boys and young men and women in your community earn money? What kinds of jobs or sources of income do they have? What do they spend money on?
2) What type of interaction is there between adolescents/ young people that have moved here because of the crisis and the local population? How does the local population perceive the young displaced persons? (*Probe:* Are there any problems between these two groups?)
3) What challenges have young people in the community faced as a result of the crisis? (*Probe:* Disruption of services, lack of sources of income, reduced mobility, insecurity?)
4) What do most displaced adolescent girls and young women do here during the day? Do any of them have jobs earning money? If recently arrived: What would they do in normal times at home?
5) How many young women are here without their husbands/partners/male family members? What are some of the challenges that they face? Who assists them?
6) Has the crisis affected education services and access for adolescent girls and boys? What about young men and women? Have displaced young people the same rights as others?
7) Are there children/adolescents here without parents? How are they cared for? Are there separated children and/or orphans without host families?
8) Are there children here who are working for an employer? Where are they working? Why are they working?
9) Any specific activities for adolescents, eg…? Do displaced persons have to pay for services?

Would you mind if we talked about HIV and sexually transmitted infections?

1) Have you heard of HIV or AIDS? You don't need to tell us names, but do you know any young people with HIV?
2) Are young people in this community worried about getting HIV? What do they do to prevent it? What about other diseases that can be transmitted sexually?
3) What do young people do when they think they have a sexually transmitted infection or HIV? Can they get tests or get treated here?
4) Are there adolescent girls and boys, young men and women in the community who have sex who are not married? Do people think this is wrong for men or for women?
5) Have you ever heard of condoms? Is there a place to get condoms in this community? If yes, where? Are they easily accessible? What are some barriers to accessing them? Are they free? If an unmarried or young person wanted a condom, would they be able to get one?
6) Sometimes people take substances (marihuana, heroin, amphetamines, etc.) because they feel it helps them to forget about their problems for a while. Are there adolescents or young people in your community who take such substances? Or alcohol? Which substances? Are these substances ever injected? Are there any services available for people who have a problem with substance use? How common is alcohol consumption amongst young people? Has the consumption of alcohol or drug changed among young people as a result of the crisis?

I'd also like to ask some questions about violence against women and girls (sexual and domestic violence).

1) Do you know of young women and girls in this community who are forced to have sex when they don't want to? Do you know of young women who have sex for money, protection or food? With whom do these women have sex? What do you know and think about this kind of situation?
2) Do you know of young men or boys who are forced to have sex when they don't want to?
3) What do you know about husbands who are violent with their wives (e.g., beat, hit, threaten or cut them)? Do you think this has increased or decreased with the crisis? What is your attitude about husbands who hit their wives?
4) Where would young women or men get help if they had been raped? What does the community do? What services are available here? Is there treatment to prevent HIV? Pregnancy? Do young women or men look for help here when this happens to them? If not, why not?

11. PREGNANT WOMEN AND LACTATING MOTHERS

Purpose:

a) PMTCT services people need; is access available?

b) What services were provided before?

c) What is their personal situation that might impact on access and or uptake?

1) Are you currently pregnant? How many months are you in your pregnancy (How many months have you been pregnant)? Is this your first pregnancy? How many children do you have?
2) For lactating mothers: How old is your baby now? Apart from breast milk, what do you feed your baby?
3) Have you seen anyone for antenatal care for this pregnancy since you have been displaced? *If no:* What are the reasons that you did not see someone? Did you see someone before you were displaced? *If no:* What were the reasons for not seeing someone.
4) Have you ever heard of HIV? *If yes:* From where? What do you know about it? What are the different ways people can protect themselves from HIV?
5) **I do not need to know the result,** but were you tested for HIV when you went for your ANC visit? Do you know where you could have an HIV test if you wanted to have one? If a HIV test would be offered (for free), would you consider to be tested?
6) If a pregnant woman was HIV positive, do you know where she would be able to access ARV drugs here?
7) Are there any reasons why she would not be able to access them? What about for her children?
8) Where you come from, what kind of support would be provided to HIV positive pregnant or lactating women? (*Probe:* nutrition, peer support groups, psychosocial, etc.). Which of those are available here?
9) How do you support yourself and the children? (*Probe:* What do you do if you do not have enough money to buy food or other essential items? Do you have working children? If yes, how old are they?
10) Before the conflict/crisis, were you or your children receiving any governmental assistance or support? Any community support? If yes, what? Are you still receiving this assistance? If yes, what are you receiving? Has it changed since the crisis?
11) Who in your family makes decisions on your own health care? Your children's health care? Has this changed from before the crisis?
12) Have you heard of HIV or AIDS?
13) Has the conflict/crisis increased your risks of getting HIV? Why?
14) Do you think that people might be more likely to get HIV due to this conflict/crisis?
15) If a member of your family got infected with HIV, would you want it to remain a secret?

Annex E. **Focus Group Discussions**

The topics listed are suggestions for thematic areas that could be covered during the focus group discussions, along with key elements, sample questions and suggestions for probing. These lists, however, should not be regarded as exhaustive. The focus here is on topics rather than specific questions *per se*; questions are given as illustrations, and should not be taken as the only way, or indeed the optimum way, of exploring the issue.

Guidance on focus group discussions*

**This tool has been adapted from reference 28.*

- Focus group discussions require an experienced moderator for creating an atmosphere that is considered natural and relaxed for the interviewees and a supportive environment for free discussion (i.e. establishment of ground rules, information on the way confidentiality and anonymity will be maintained, explanation of the process for taking notes and how this information will be used, etc.) This is critical for successful outcomes.

- Focus group discussions must be organised, well facilitated and properly documented in order to gain the type of in-depth information you need. Separate groups can be organised by age and sex, depending on what is appropriate in the context and what is likely to enable participants to be as relaxed and honest as possible.

- The list of topics and questions below may be too long for one session. Core questions for each topic are suggested as priorities. Each team must develop its own individual style of questioning in order to gain information in culturally appropriate and sensitive ways. Each team is expected to spend time in refining and agreeing on the final topic list depending on the particular context (based on information gleaned from interviews) and HIV risk behaviours of IDPs and affected communities.

- On organising focus group discussions:
  - Organise homogeneous groups of similar ages, sexes and experiences together.
  - Keep the groups small. They ideally consist of 5–10 participants, but can be bigger if the circumstances don't allow smaller groups. Choose the right facilitator for the group: men with boys/men and women with girls/women.
  - Limit the presence of onlookers to enable participants to speak freely.
  - Conduct the discussion in a place where participants can sit comfortably.

- On facilitating focus group discussions:
  - Warm the group up with energisers to make participants feel at ease and get them talking.
  - Assure the participants that everything said in the session will be kept confidential.
  - Do not rely only on what the well off, better educated and more vocal have to say.
  - Probe and crosscheck each question by listening closely to what is being said, challenging answers (where appropriate) and asking for more details.
  - Carefully lead up to sensitive questions. Keep sessions to a manageable length – around ten questions and lasting for 45 to 90 minutes, not longer than 2 hours.

- On documenting responses:
  - Assign one note taker to record what is being said and observed.
  - Record the responses of the majority of the answers provided by the group. Also note any important differences in responses between groups (eg. men and women, disabled).

All focus group discussion questions can be downloaded in MS-Word format at http://www.unhcr.org/cgi-bin/texis/vtx/search?page=&comid=4acda9f29&cid=49aea9390&keywords=HIV-bss-assessments and can be easily adjusted for the respective assessments and contexts.

Proposed topics are:

1) Displacement
2) Sources of information about HIV and sexual and reproductive health
3) Sexual and other HIV risk-taking
4) HIV and sexual and reproductive health services (incl. access to treatment and PMTCT)

Displacement

MEN AND WOMEN INTERNALLY DISPLACED IN THE LAST TWO YEARS (IDPS) AND MIGRANTS	
Topic focus	**Core questions**
	How many men/women have been forced to move/migrate because of the conflict? Does it affect more men than women?
	What were the main reasons for migration/displacement? General insecurity? Fear of recruitment or abduction? Violence? Harassment? Fear of (sexual) violence? Food scarcity? Degradation of local economy? Degradation of local services?
	Has the impact differed, depending on age, gender, ethnicity, and income?
	Where do people migrate? Other districts? Major cities? Other countries? For which reasons? Who takes the decision?
	How does it affect family structure? Are parents together? Are there more or fewer relatives in the households as a result?
	How did the change of residence or the conflict/crisis affect health, nutrition, and education?
	Additional questions
	Search for security, family and community members? Separation, isolation, destruction of family unit protection? Lack of social network? Increase in poverty? Exploitation?
	Have child labour or domestic labour increased or not? Why? Have women's roles changed? Have their responsibilities changed? Women's roles in the household and community? Women's control of assets and cash flow?
	Are there more family caretaker roles?

ADOLESCENT GIRLS, ADOLESCENT BOYS, YOUNG MEN, YOUNG WOMEN (ABOVE AGE 16 YEARS)	
Topic focus	**Core questions**
Migration or displacement of young people	How many young men/young women have been forced to migrate because of the conflict/ crisis? What proportion?
	What were the main reasons for migration/displacement? General insecurity? Degradation of local services? Degradation of local economy? Food scarcity? Fear of recruitment or abduction? Violence? Harassment? Is there a fear of sexual violence?
	Where do young people migrate? Major cities? Other districts? For which reasons? Who took the decision? How does it affect family structure? How does the crisis affect health, nutrition, and education?
	Child labour, domestic labour? Why?
	Additional questions
	Search of security, family and community members?
	Separation, isolation, destruction of family unit protection? Did this lead to more risk behaviours? Different impact on young women and young men? Different impact depending on ethnicity, caste and income?
	Lack of access to services? Disruption of services?
	Increase in poverty? Exploitation?
	Have young boys' or girls' roles changed? Have their responsibilities changed? More family caretaker roles?

PEOPLE LIVING WITH HIV (ORGANISED IN PEER GROUPS AND ACCESSIBLE)	
Topic focus	**Core questions**
	How many of your peer group have been forced to migrate because of the conflict? What proportion? Do you have new members in your group, displaced from somewhere else?
	What were the main reasons for migration/displacement? General insecurity? Degradation of local services? Degradation of local economy? Food scarcity? Fear of recruitment or abduction? Violence? Harassment? Fear of sexual violence?
	How does the conflict affect health, nutrition, work, and education?
	Additional questions
	What are the most difficult challenges faced by persons living with HIV in this community/ district? (Probe: Services? Discrimination? Cost of drugs?)
	Are there other people in your family or community that are aware of your HIV status?
	Search of security, family and community members? Lack of social network? Increase in poverty?
	Separation, isolation, destruction of family unit protection? Did this lead to more risk behaviours? Different impact depending on ethnicity, caste and income?
	Lack of access to services? Disruption of services?
	Increase in poverty? Exploitation?

Sources of Information

General sources of information about sexual reproductive health (contraception, pregnancy, HIV/sexually transmitted infections).

MEN AND WOMEN INTERNALLY DISPLACED IN THE LAST TWO YEARS (IDPS) AND MIGRANTS	
Topic focus	**Core questions**
Main sources of information about HIV **Most frequently used and most important sources of information on HIV**	How many of you know about HIV or AIDS? What have you heard about the ways HIV is transmitted or prevented?
	What are the usual sources of information through which HIV/sexually transmitted infections/ contraception information reaches men and women? What about young boys and girls?
	Are there any other ways/sources of information that could be used to reach them with HIV information (or supplies)?
	How did the conflict affect sources of information about HIV?
	Additional questions
	Do you know people affected by HIV? ***(DO NOT QUOTE NAMES)*** Is AIDS a concern in the community? Among particular groups?
	Are people living with HIV supported by the community or ostracized?
	Let us make a list of the different ideas people have about the ways that HIV is spread person-to-person. Probe about ways HIV is transmitted (sex, blood, mother-to-child transmission).
	Mediated channels (television, radio, newspapers, etc.) versus interpersonal channels (contacts of community-based counseling, peer education and group sessions?
	Role of insecurity? More difficult access to information on HIV and sexual and reproductive health? Less attention to sexual and reproductive health? Is there a need for improved skills in condom use? Negotiation and communication skills?

ADOLESCENT GIRLS, ADOLESCENT BOYS, YOUNG MEN, YOUNG WOMEN (ABOVE AGE 16 YEARS)	
Topic focus	**Core questions**
Main sources of information about HIV **Most frequently used and most important sources of information on HIV**	How many of you know about HIV? What have you heard about ways to get HIV?
	Whom or what do young people rely on for information?
	Do young people of your age talk openly to other people about sex and related issues?
	Is there anyone that young people don't talk to? Don't like talking to?
	Whom or what are the most important sources of information to young people? Role of parents, siblings, friends, teachers, religion, role of the media (magazines, TV, videos, etc.).
	How did the crisis affect sources of information about HIV in the district?
	Did the conflict/crisis affect school sex education? Were schools running as usual? What alternative sources of information were used? Role of insecurity? More difficult access to information about HIV? Less attention to sexual reproductive health
	Additional questions
	Let's make a list of all the different ideas people have about the ways that HIV is spread.
	How do young people of your age usually find out about relationships, sex and contraception?
	Probe about correct ways of HIV transmission (sex, blood, mother-to-child transmission). Probe about misconceptions about HIV (incorrect modes of transmission). Do the sources of information vary for young men and women?
	How do you feel about the sex education that is provided in school? Differences in the teaching of young men and women? Is it useful? How could it be improved upon? Is there a need for improved skills in condom use? Negotiation and communication skills?

PEOPLE LIVING WITH HIV (ORGANISED IN PEER GROUPS AND ACCESSIBLE)	
Topic focus	**Core questions**
Main sources of information about HIV **Most frequently used and most important sources of information about HIV**	Whom or what do you rely on for information?
	Do you talk openly to other people about HIV and related issues?
	Is there anyone that you don't talk to? Don't like talking to?
	Whom or what are the most important sources of information to the people? Role of parents, siblings, friends, your peer group, teachers, religion, role of the media (magazines, TV, videos, etc.).
	How did the conflict/crisis affect sources of information about HIV in the district?
	Role of insecurity? More difficult access to information about HIV? Less attention to sexual reproductive health?
	Additional questions
	Probe about correct ways of HIV transmission (sex, blood, mother-to-child transmission). Probe about misconceptions about HIV (incorrect modes of transmission). Do the sources of information vary for men and women? What information about HIV is missing? What information should be disseminated in the current situation?
	How do you feel about the sex education that is provided in school? Differences in the teaching of young men and women? Is it useful? How could it be improved upon? Is there a need for improved skills in condom use? Negotiation and communication skills?

Sexual Activity and Sexual Risk Taking (HIV Risk Behaviours)

MEN AND WOMEN INTERNALLY DISPLACED IN THE LAST TWO YEARS (IDPS) AND MIGRANTS	
Topic focus	**Core questions**
	How has the conflict/crisis impacted on sexual behaviours of men and women? Has the conflict changed the context of sexuality (norms of sexual abstinence, age at first sex, fidelity, etc.)? How has displacement affected the sexual behaviour of IDPs?
	Are you aware of women and/or girls having been forced to have sex against their will or going abroad against their will (e.g. to work in entertainment places?) Is it an increasing issue? What evidence do you have?
	Is risk-taking in sexual relations or in drug use more prevalent because of the conflict/crisis? More commercial/transactional sex? More partners? Or the contrary? More non-regular relationships? Less formal marriages? More cohabitation? Are drug use or drug injecting use behaviours affected by the conflict/crisis? Is sharing of needles and syringes different, due to the conflict situation?
	Additional questions
	Have there been changes in sexual norms? Disruption of families? Sexual violence? Who are the men/women most at risk of sexually transmitted infections and HIV in this community? Why?
	Who are the HIV-vulnerable populations in the district? Widows? Migrant men? Married women left alone? Mobile men? Soldiers? Youth? Others?

ADOLESCENT GIRLS, ADOLESCENT BOYS, YOUNG MEN, YOUNG WOMEN (ABOVE AGE 16 YEARS)	
Topic focus	**Core questions**
Commencement of sexual activity	Has the conflict/crisis changed the context of first sexual relations? How?
	To what extent do you think militias have pressured some women of your age about sex *(in case of conflict)*?
	Are young men/women able to avoid pressures by armed forces *(in case of conflict/crisis)?* Are young men/women able to avoid pressures by any people with power (eg. leaders, NGO workers etc.)?
	Have many girls have been sent away as a result of fear of sexual pressures and forced sex?
	Has sexual violence increased or stayed the same? Are rapes of young girls/boys more common or the same?
	Has sexual exploitation or trafficking increased or stayed the same?
	Do adolescents and young people use condoms during sex?
	What do young people think about same-sex activities? What do others think?
	Additional questions
	What proportion of young men/women of your age do you think are sexually active? Does it vary for young men and women?
	At what age would you say young people start having sex? Is abstinence actively promoted?
	Is it generally acceptable for young people to have sexual relations when they are not married?
	What are the financial pressures/gains from sexual intercourse for poor young girls?
	How do people react if a young woman becomes pregnant or a young man becomes a father? Feelings and reactions amongst parents, elders and other relations, young people themselves?

ADOLESCENT GIRLS, ADOLESCENT BOYS, YOUNG MEN, YOUNG WOMEN (ABOVE AGE 16 YEARS)	
Risk perceptions	
Topic focus	**Core questions**
Risk taking	To what extent do you think that people of your age take risks of any sort during sex?
	Is drug use and injecting drug use an issue among young people?
	Is risk-taking in sexual relations or in drug use more prevalent because of the conflict? More commercial sex? More partners? Or the contrary? More non-regular relationships? Less formal marriages? More cohabitation? Early marriage?
	Do you know any people living with HIV ***(DO NOT QUOTE NAMES)***? Do you know people who have had HIV tests?
	Additional questions
	To what extent do you think people your age are aware of sexual risk-taking? Why do they take these risks?
	To what extent do you think HIV is a risk to young people of your age?
	Do boys and girls take the same or different risks? Are young people more worried/concerned about pregnancy or HIV and other sexually transmitted infections?
	Do you think people take the risks seriously?
	Are people living with HIV accepted among peers? Any concerns linked with conflict?

ADOLESCENT GIRLS, ADOLESCENT BOYS, YOUNG MEN, YOUNG WOMEN (ABOVE AGE 16 YEARS)	
HIV risk prevention	
Topic focus	**Core questions**
HIV risk prevention and practices	Has sexual exploitation (e.g. selling sex) increased among adolescents? Among young people? Has drug use increased among adolescents? Among young people? Has injecting drug use increased? Have casual relations increased?
	Have abortions increased? Have out-of-marriage pregnancies increased? Have sexually transmitted infections increased?
	Additional questions
	Who should be responsible for protecting against any risk during sex? Pregnancy? Sexually transmitted infections? HIV?
	Who is normally responsible for contraception and protection?
	What do people of your age expect to happen about contraception? Is it expected to be used?
	How do young people feel talking about contraception with partners?
	Core questions
Condoms	What does safe sex mean to adolescents? Young people? Have you received recent information about faithfulness, reduction in the number of sexual partners in relation to HIV prevention?
	Is condom availability or access more difficult?
	From where do adolescents or young men and women generally obtain their condoms? Ease of obtaining condoms? Barriers to obtaining condoms? Are they free?
	What do you think would make people of your age adopt safer sex practices?
	Additional questions
	What do young people think about condoms? What are their advantages and disadvantages? Should men/women carry them around?
	To what extent do prices affect condom use, cleaning of injection needles and other behaviours? Are prices of condoms within the „ability to pay" range of young people? Are organizations making condoms available for free?

PEOPLE LIVING WITH HIV (ORGANISED IN PEER GROUPS AND ACCESSIBLE)	
Risk perceptions	
Topic focus	**Core questions**
Risk taking	Is drug use and injecting drug use an issue? Is risk-taking in sexual relations or in drug use more prevalent because of the conflict/crisis? More commercial sex? More partners? Or the contrary? More non-regular relationships? Less formal marriages? More cohabitation? Early marriage?
	Additional questions
	To what extent do you think HIV is a risk to everybody?
	Do men and women take the same or different risks? Are people more worried/concerned about pregnancy or HIV and other sexually transmitted infections?
	Do you think people take the risks seriously?
	Are people living with HIV accepted among peers? Any concerns linked with conflict/crisis?
HIV risk prevention	
Topic focus	**Core questions**
HIV risk prevention and practices	Has sex work increased among people? Has drug use increased among people? Has injecting drug use increased? Have casual relations increased? Have abortions or out-of-marriage pregnancies increased? Have sexually transmitted infections increased?
	Additional questions
	Who should be responsible for protecting against any risk during sex? Pregnancy? Sexually transmitted infections? HIV?
	Have you changed your precautions of sexual risk taking, since you know your status?
	How do you feel talking about contraception with partners?

Sexual and Reproductive Health Services

MEN AND WOMEN INTERNALLY DISPLACED IN THE LAST TWO YEARS (IDPS) AND MIGRANTS	
Knowledge and access to services	
Topic focus	**Core questions**
Awareness and use of services	Can you list services where you visit and talk about sexual health, contraception, sexually transmitted infections, HIV?
	Do you have easy access to these services (as IDPs or migrants)? Are there specific services for women who have been raped or beaten?
	Is there difficulty in access, insecurity, lack of personnel or lack of supplies (because of the conflict)? Do you know where to be tested for HIV?
	Do you know which services for HIV exist in the next health facilities? *Probe for ART, PMTCT, pediatric treatment*
	Additional questions
	Lack of peer organizations and education? Lack of social activities? Lack of networks?
	Are there barriers to attendance?
	Do you know where to be tested for Hepatitis B&C?
Need for services	
Topic focus	**Core questions**
Need for HIV and sexual and reproductive health services	What do you think are the most important features of a sexual and reproductive health service? Or programme activities for HIV prevention?
	How do you think the current services/programmes in your district could be improved upon?
	What do you think are the best ways of advertising and promoting services for HIV prevention?
	Additional questions
	Who is the most in need of such programmes/services for HIV?
	Who should provide the information and advice about HIV and sexually transmitted infections?
	Are there differences in the needs of men and women? Do you think that needs have changed because of the conflict/crisis?

ADOLESCENT GIRLS, ADOLESCENT BOYS, YOUNG MEN, YOUNG WOMEN (ABOVE AGE 16 YEARS)	
Knowledge of services	
Topic focus	**Core questions**
Awareness of sexual and reproductive health services	Can you list places and people that adolescents and young people are able to visit and talk to, to find out about sex, contraception, sexually transmitted infections including HIV?
	Is there counseling available for people who have experienced sexual violence? Do you know what Post Exposure Prophylaxis is? Is Post Exposure Prophylaxis available? Do you know where to get HIV tests?
	Additional questions
	How do young men/women usually find out about services? (Health centres, young clubs and organizations, etc.) Lack of peer organizations and education? Lack of social activities? Lack of networks? Do you know where to get Hepatitis B&C tests?
Adolescent and young people's use of services	
Topic focus	**Core questions**
Awareness of sexual and reproductive health services	Do adolescent young men and women of your age visit the local services for contraception and sexual health advice? If not, why not?
	Are there difficulties in access, lack of personnel, and lack of supplies? Are they reluctant to provide services to adolescents? Do you have access to HIV treatment (ART), if it is needed?
	Barriers to attendance: is insecurity a key factor? Acceptability of services
	Are there particular issues for IDPs, young men or young women, in accessing these services? What would improve acceptability of services for young men/women?
	Additional questions
	Why do young men/women usually access services? What brings them there?
	Do IDPs have easy access to services?

ADOLESCENT GIRLS, ADOLESCENT BOYS, YOUNG MEN, YOUNG WOMEN (ABOVE AGE 16 YEARS)	
Impressions of services	
Topic focus	**Core questions**
Programmatic development in sexual and reproductive health and other services	What are the most important programmes/services that need to be created or developed in the district for sexual and reproductive health?
	Who is the most in need of such programmes/services?
	Have conditions and quality of district services changed since the conflict has occurred?
	How do you think the services/programmes in your district could be improved upon?
	What do you think are the best ways of advertising and promoting HIV prevention services?
	What services would help people who inject drugs to decrease needle sharing? Are there any programmes for young people who inject drugs in the district? *If yes*, what type of programmes? (*Probe:* Needle syringe exchange, peer outreach, education on safe injecting practices, drug substitution therapy?) Is anybody on a Methadone programme?
	Additional questions
	What do you think are the most important features of a sexual and reproductive health service for young people?
	Are there differences in the needs of young men and women?
	Who should provide the information and advice on HIV and other sexual and reproductive health issues?
	Where do you think young people's sexual health services should be held (location)?

PEOPLE LIVING WITH HIV (ORGANISED IN PEER GROUPS AND ACCESSIBLE)	
Use of services for People living with HIV	
Topic focus	**Core questions**
Use and access of HIV-related services	What services are available for persons living with HIV in this district/community? Has the conflict/crisis affected your access to health services?)
	Are there specific problems for people under antiretroviral therapy who have moved or who will return to their district? Are ARV still available or are there stock outs? Have newly arrived people (displaced) access to ARV treatment?
	Do people living with HIV receive nutritional support or extra food? Do you receive some form of livelihood support? *If yes:* What kind of livelihood support?
	What care and treatment services/programmes are needed for people living with HIV? How should they be provided and by whom?
	Do you have to pay for services? If yes: For which services and how much?
	Are there difficulties in access, lack of personnel, and lack of supplies?
	Barriers to attendance: is insecurity a key factor? Acceptability of services
	Additional questions
	Have newly arrived people (displaced) access to ARV treatment?
	Probe: Access to voluntary counseling and testing, to antiretroviral therapy, to social services? Where are the services available? Do you access these services? If not, why not?
	What services/programmes should be in place to prevent HIV transmission?
	Do IDPs have easy access to services?

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