The Silent Emergency

HIV/AIDS in Conflicts and Disasters: An NGO Perspective

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Prepared by Lyn Elliott[1], Alistair Hallam[2] & [redacted] Ann Smith[3]

[1]HIV/AIDS Adviser for Save the Children UK

[2]Independent Consultant working for the UK NGO AIDS Consortium Working Group on HIV/AIDS and Emergencies

[3]HIV/AIDS Programme Support and Technical Adviser at CAFOD.

Abstract

Traditionally emergency responses are confined to water and sanitation, addressing basic needs such as food, shelter and fuel, immediate health provision through disease treatment/prevention, and camp management issues. A number of factors contribute to the spread of HIV/AIDS in emergency and displaced situations and it is clear that many of these factors will not be addressed, particularly at the preparedness and initial implementation of an emergency response. The problem then is that whilst emergency practitioners aim to protect refugees and displaced people and save lives, in negating to deal with the problem of HIV at the planning and initial stages of an emergency, they may well be perpetuating an epidemic with a catastrophic and ultimately fatal impact on the very populations they aim to protect.

The challenge to emergency practitioners is to consider their understanding of the interconnectedness of HIV vulnerability and emergency situations and to review their policies and practices and identify any changes needed in the light of the issues covered in this report.

Table of Contents

Biographical Details of Contributors

Maria Esther Artiles

Maria Esther currently works as a lecturer at the National University of Honduras in the fields of Preventative Psychology and the Psycho-sociology of groups. She is also a consultant for the Save the Children Fund, Honduras. Over the last three years, she has written a series of research papers on various aspects of sexual exploitation including sexual exploitation on the streets of Honduras and the social mapping of sexual exploitation, sexual tourism and child trafficking in Honduras. Prior to this, Maria Esther worked full-time for SCF, Honduras as the Information Officer.

Mary Blewitt

Mary is currently a Programme Co-ordinator for SURVIVORS FUND (SURF), a registered charity that represents AVEGA (an association of the widows of genocide in Rwanda) in the UK and supports survivors of genocide.

She has previously worked as a personal secretary to the Ambassador of Rwanda in the UK following eight months' volunteer work with the Ministry of Rehabilitation in Rwanda.

Matthew Carter

Matthew has spent the past twelve years working overseas in both humanitarian and development programmes. Matthew has specialised in programme management and co-ordination with special focus on working in complex emergencies and developing means to strengthen local capacity for disaster preparedness and response. Since March 1997 he has been employed by CAFOD as the Head of Emergencies Support Section. Prior to working with CAFOD, Matthew worked as Technical Advisor with ICRC in Somalia, Djibouti, Bosnia and Mozambique and with CONCERN Worldwide in Zaire and Bangladesh.

Lyn Elliott

In September 2000, Lyn began a PhD at Oxford Brookes University looking at health service delivery to teenagers in Oxfordshire. Prior to that she was the Global HIV/AIDS advisor at Save the Children Fund, UK for five years. Before joining Save the Children, Lyn worked

extensively in the field of reproductive health on an international level.

Alistair Hallam

For the last two years, Alistair has been working as a freelance consultant. During this time he has been involved in projects ranging from advising Save the Children (UK) on its review of emergency programmes to Team Leader of the UK Disaster Emergencies Committee's lesson-learning exercise in the Balkans. Alistair has previously worked at the ODI as a Research Fellow working on the evaluation of humanitarian assistance programmes and as an Associate Researcher for the Relief and Development Policy Programme. Previous experience with NGOs includes work in Mozambique, Sudan, Vietnam and Somalia.

Beverley Jones

After seven years working with Christian Aid in the Horn of Africa, Beverley is now CAFOD's Head of Africa Section. She began working in Africa 11 years ago when she took a VSO posting with the Ministry of Education in Sudan. Working as a teacher trainer within Sudanese and refugee communities, she then completed a Masters in Education and Development at Bristol before moving into emergency and organisational development work in Ethiopia, Eritrea, Somalia, Kenya as well as Sudan. Her new role has given her the chance to place the Horn of Africa experience in a wider African context.

Dr. Philippe Mayaud MD, MSc

Philippe is a Senior Clinical Lecturer at the Department of Infections & Tropical Diseases, London School of Hygiene & Tropical Medicine (LSHTM). His research primarily focuses on aspects of STD/HIV control in developing countries. He is the organiser of the MSc in STDs & HIV jointly run by LSHTM and the Department of STD, University College London. He teaches on aspects of STD and HIV in various other international courses. Philippe trained and graduated as a MD (GP) in France. He then successively worked in French Guyana, the Commonwealth of Dominica (West Indies), and was based for 6 years in the Mwanza Region, Tanzania, working on a large international STD/HIV intervention and research programme run by LSHTM in collaboration with an African NGO (AMREF) and the Tanzanian government. During this period, he and colleagues from AMREF established

Introduction

This Network Paper reports on the contents of a one-day seminar *'The Silent Emergency: HIV/AIDS in Conflicts and Disasters'* held in London on June 2nd 1999 and the wider preparatory and follow-up work related to that event. The seminar - organised by the UK NGO AIDS Consortium Working Group on Emergencies & HIV/AIDS - brought together emergency policy makers and practitioners and HIV/AIDS specialists from around the world and built upon the work of the 1996 seminar also organised by the UK NGO AIDS Consortium[2].

The aims of the seminar were:

- To outline the combined impact of emergency situations and HIV/AIDS;
- To identify factors in emergency situations that increase vulnerability to HIV and augment discrimination against those affected by HIV/AIDS;
- To develop awareness of existing policy and practice in emergency programmes which aim to prevent the spread of HIV and mitigate its impact, and to identify gaps in this regard;
- To enable participating organisations to explore future implications for their own policy and practice in regard to HIV/AIDS and emergencies.

Speakers and attendees came from the United Nations, donors, and NGOs, to present and discuss HIV-related concerns that pertain to emergencies, case studies from Asia, Africa, Latin America, and Eastern Europe that demonstrated the impact of HIV/AIDS in emergency situations and agency interventions to mitigate such impact.

As preparation for the seminar, a literature review was commissioned by the organising committee that included documentation on HIV/AIDS and emergencies, evaluations of HIV-related programmes that took place in emergency situations. Information was gathered on how and whether HIV/AIDS informed the policy of key emergency actors, and gaps in policy

were identified.

This Network Paper draws upon the work undertaken as part of the literature review, the presentations and discussions on the seminar and subsequent research. Section 1 describes the background to the issue as presented at the seminar. Global HIV statistics have been updated to reflect data available at the time of writing. In Section 2 a 'Problem Tree' model, used to structure the analysis of the problems of HIV/AIDS in conflict and disaster situations is described. The factors that make refugees and displaced people vulnerable to HIV/AIDS are examined in some detail. Case studies presented, which provide practical examples, lessons learnt and recommendations in the challenges of working with HIV/AIDS in conflict and disaster situations, follow in Section 3.

Section 4 outlines existing policies and guidelines and their relative strengths and weaknesses. The conclusions set out in Section 5 summarise the thinking of the participants of the seminar in terms of trying to address HIV/AIDS practically in agencies today. Finally, the recommendations also located in this section indicate some suggestions for the way forward for addressing HIV/AIDS in conflict and disaster situations.

Section 1: The Silent Emergency: HIV/AIDS in Conflcits and Disasters

1.1 HIV, Emergencies: An Overview of the Current Situation by Matthew Carter

HIV/AIDS has rapidly become one of the most alarming and devastating pandemics the world has ever seen. HIV is transmitted predominantly through sexual intercourse, though it can also be transmitted through blood, via shared needles of injecting drug users, through the use of unsterilised medical equipment, and from mother to child in the womb, during childbirth and through breast feeding. There is a growing recognition globally that AIDS is more than a health issue. It is a development and an emergency issue. It is now acknowledged that the spread of HIV/AIDS globally is associated with poverty, micro and macro economic issues, a breakdown in traditional social structures, gender status, cultural issues, migration and war.[3]

At the end of 2000, it was estimated[4] that at least 58 million people world-wide had contracted HIV, almost 20 million of whom had died. Some 5.5 million people are believed to have contracted HIV infection in 2000 alone, equivalent to nearly 16,000 new infections everyday. HIV touches almost every country in the world; however, the virus spreads very differently in different regions of the world. 90 per cent of people living with HIV are in the developing world. In some countries in sub-Saharan Africa, one fifth to one quarter of the adult population is HIV positive. Due to limited access to counselling and testing nine out of 10 people who are HIV positive do not know their status.

The impact of AIDS is systematically eroding the benefits achieved from development and health initiatives in the last few decades. In Namibia AIDS causes twice as many deaths across all ages as malaria, the next most common killer. Life expectancy in Botswana rose from under 43 years in 1955 to 61 years in 1990. With between 25–30% of the adult population infected with HIV, life expectancy is expected to drop back to levels seen in the late 1960s. Twenty five percent more babies less than 12 months old in Zimbabwe and Zambia are dying than would be the case if there were no HIV. By 2010, Zimbabwe's infant

mortality is expected to rise by 138% because of AIDS, and its less than 5 mortality is expected to rise by 109%.

HIV/AIDS is reducing the economically productive age group of people between 15-45 in many countries. There is no cure for AIDS. Retroviral drugs that mitigate the impact of HIV are benefiting many people living with AIDS in the North. However these are not accessible or affordable to people in resource poor countries.

The long symptom-free period associated with HIV/AIDS means that it has generally not been accorded a high priority in emergency operations, attention focusing instead on meeting basic needs, shelter and the treatment of diseases such as measles, cholera and dysentery. However, there is a growing body of evidence gained from the war zones of Rwanda, Bosnia and Sierra Leone that links war and forced migration to the spread of HIV/AIDS (The Bridge 1998)[5]. The impact of this is particularly acute on women and children, who constitute the largest proportion of refugee and displaced people. There are now approximately 40 million refugee and displaced people in the world, 75 per cent of whom are women and children.

HIV can be very difficult to combat in stable societies (DFID, 1996). The virus is associated with stigma and myth, and often not freely discussed. This makes it hard to provide care and support to people living with HIV/AIDS. Those affected may be discriminated against. In emergencies, the situation for people with HIV can be even worse. HIV positive people are particularly vulnerable to the higher levels of disease that often prevail. The associated reduction in healthcare provision results in reduced opportunities for treatment of opportunistic infections associated with HIV and AIDS[6].

1.2 Linkages between HIV and Emergencies, by Beverley Jones

I recently asked a colleague in Caritas Rwanda about the problem of AIDS in her country. She said that soon people would be facing the Second Genocide: the wave of people who will die from AIDS which resulted from the mass rape of women and girls during the 1994 Genocide - and perhaps, also, the wave of pregnancies which followed as people tried to

recreate families when women were already infected.

This brief overview will look at how conflict in Africa is becoming systemic and a state of normality - and asks in what ways this should influence our future AIDS programming.

At least five levels of conflict operate within Africa at this time:

These are the ones we are most used to associating with Africa:

- 'Ethnicisation' or intra-societal conflict, such as the Genocide of Rwanda in 1994, or Massacre of the Dinka in Sudan in late 1991, the attack of RUF rebels on civilians in Sierra Leone
- Intra-state or internal wars such as the war between the Sudan People's Liberation Movement and the Government of Sudan, or UNITA and the MPLA in Angola.

But since August 2nd, 1998, new conflict types have become more prevalent:

- Inter-state wars between nation states like the Democratic Republic of Congo and Rwanda, between the Eritrean and Ethiopian governments - some are assuming continental proportions
- International conflict, also dubbed a 'clash of civilisations', signified by the West vs. Islam - seen in the US missile attack on the Shifa Chemical Factory in Khartoum and the bombing of US embassies on African soil last year.

In addition, paid military force - one of the oldest professions in the world - is adding a fifth dimension to conflict in Africa as private military companies, linked to exploration companies seeking to extract resources from conflict-prone areas, nourish conflict in some of the continent's most vulnerable countries.

Yet these are not isolated or detached levels of conflict. Perhaps what has changed since August 2nd 1998 when the rebellion started in the eastern Democratic Republic of Congo, is

our awareness of the extent to which these conflicts form part of a conflict system. It is one which has greater links to regional and global systems of political and economic reorganisation than are visible from the perspective of a youth training programme for traumatised youth in Liberia, or a reconciliation meeting between the Nuer and Dinka in south Sudan - hopeful though these efforts may seem at a local level.

As we monitor the extent of regionalisation of the current Sierra Leone war which is illustrated in this map, we can say that there has been a significant shift in emphasis in the last year in Africa from 'intra-state' to 'intra-within inter-state' warfare. Or, more simply, that wars between countries are also being played out through wars within countries.

Whereas people have naturally moved between countries of West Africa for trade and other purposes, the forced movement of people through war, the extent of violent rape and other acts is leading to an escalation of HIV transmission and it is only a matter of time before the AIDS profile of this region matches that of Eastern and Southern Africa.

This second map was prepared in August 1998 and it is depressing to note how little has changed for the better. It illustrates the extent to which different types of conflict inter-relate in Africa at this point in time. It is simplistic and cross-sectional. Nevertheless, this snap-shot of military, political and economic relations from Eritrea to Angola, represents three overlapping geopolitical systems in operation, behind which lie the post-Cold War reorganisation of alliances.

The pre-Cold War colonial obsessions nevertheless remain: US superpowerdom, France's paranoia over Anglo-Saxon conspiracy, renewed British interest in central Africa, and Russian and Chinese resistance to total assimilation with Western 'Clubs' such as the UN Security Council.

Mediation is notoriously unsuccessful as a means of resolving conflict. Only 15% of the world's wars since 1900 (excluding anti-colonial wars) have been ended through negotiation - and many of those then broke out again. The chances of this current African conflict system

being resolved through mediation are slight.

On the face of it these scenarios appear unbelievably volatile and fickle - a shift of alliance in one part of the system will change every other part, operating through state, insurgent and private military structures. Sudan, which has been at low-intensity wars with both Eritrea and Ethiopia in recent years has re-opened relationships with Ethiopia now that Ethiopia and Eritrea are at war.

At the same time, this endless shifting of alliances can be regarded as a virtual state of normality.

At least three principles of warfare are consistently used by rulers within the system:

i) Your enemy's enemy is your friend,
ii) Border or faultline populations are to be instrumentalised in war, and
iii) In the absence of Cold War alliances and military muscle from Russia or the West, weak nation states will resort to private military companies and use their natural resources to pay for them.

There is a new Scramble for Africa taking place, a century after the last. In the comfortable locations of Victoria Falls, Lusaka, Paris and elsewhere, a new Berlin Conference is in session as African leaders decide how to carve up Africa's populations and resources. In the global market free for all, some companies will, literally, capitalise on the weak states' need for military muscle to influence the outcome of this Scramble - or, worse still, will engender further chaos in order to exploit resources without international or governmental scrutiny.

A recent book argues that with fraud and smuggling on a major scale, the plundering of natural resources, the privatisation of state institutions, the development of an economy of plunder and the growth of private armies, the state itself is becoming a vehicle for organised criminal activity. Further research argues that peace and war economies are becoming indistinguishable in Africa.

The wide-scale troop movements within and between countries in Africa at this time create easy routes by which HIV is spread in civilian populations where the disease may, through government and NGO intervention, have been brought slowly under control through health education and behaviour change. On the whole, this is a predictable consequence of offensive and defensive war strategies. However, there is concern in some areas that HIV infection has been added to the arsenal of weaponry. It is said that some troops, known to have high rates of HIV, are being instructed to rape and purposely infect unwanted sectors of society.

The conflict system we see here is not an aberration but the means by which planned objectives can be fulfilled. The pursuit of stability as a prerequisite for state development seems hardly viable when so many other interests are served by conflict. It is possible that some of the emerging political complexes in the South no longer need actual nation states to survive and prosper.

The legitimacy of the African nation-state is in crisis. The 1990s have witnessed the welfare role of African states diminish and wither under the combined weight of economic mismanagement, the accumulation of unsustainable debt burdens and some of the cost recovery programmes associated with structural adjustment reforms.

Many African countries have seen almost no return for the steps they have taken towards structural adjustment, debt repayments, deregulated markets and other demands made by the International Financial Institutions and their sponsors. Small wonder that the many African leaders are adopting other strategies for securing their uncertain futures.

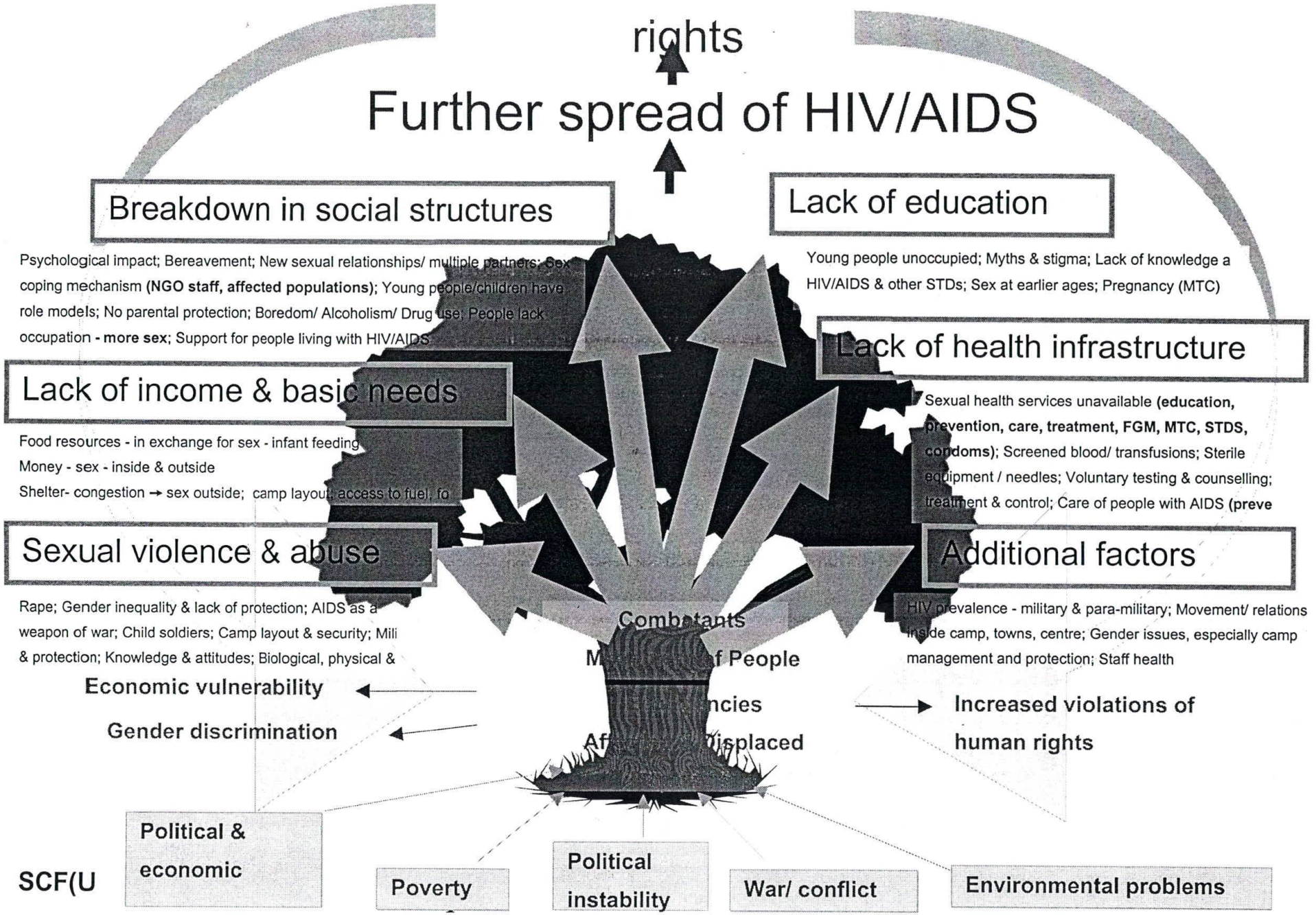
Even weak nation states can provide at least a framework within which active civil society can promote extensive HIV/AIDS prevention and treatment - as in the case of Guinea Bissau. However, with the demise of nation states, such opportunities for stemming the tide of HIV transmission in Africa, or the proper treatment of those who are already infected, will become harder and harder to find.

Yet so much of our NGO programming is argued on the basis that a normative state of peace is achievable in Africa through community development, reconstruction and peace and reconciliation programmes. We continue to adhere faithfully to the relief-rehabilitation-development continuum, in which AIDS work - be it palliative or preventative - is implemented in the rehabilitation and development phases. We continue to plan our work on models of 'complementary activity' which derive from our belief in the nation state as the framework within which different sectors play mutually reinforcing roles.

Surely, with the demise of nation states in an Africa which has become a Continental Complex Emergency it is time to rethink this approach - and to integrate our understanding of AIDS into all aspects of our programming - including very early stages of emergency response.

Section 2: The Factors that Contribute to the Spread of HIV in Emergencies

A problem tree analysis[7], presented by Matthew Carter, CAFOD, was used to analyse the factors that contribute to the spread of HIV/AIDS (see Figure 1).


Leads to further stigmatisation & increased abuse of huma
rights
Further spread of HIV/AIDS
Breakdown in social structures
Psychological impact; Bereavement; New sexual relationships/ multiple partners; Sex coping mechanism (NGO staff, affected populations); Young people/children have role models; No parental protection; Boredom/ Alcoholism/ Drug use; People lack occupation - more sex; Support for people living with HIV/AIDS
Lack of income & basic needs
Food resources - in exchange for sex - infant feeding
Money - sex - inside & outside
Shelter- congestion → sex outside; camp layout; access to fuel; fo
Sexual violence & abuse
Rape; Gender inequality & lack of protection; AIDS as a weapon of war; Child soldiers; Camp layout & security; Mili & protection; Knowledge & attitudes; Biological, physical &
Lack of education
Young people unoccupied; Myths & stigma; Lack of knowledge a HIV/AIDS & other STDs; Sex at earlier ages; Pregnancy (MTC)
Lack of health infrastructure
Sexual health services unavailable (education, prevention, care, treatment, FGM, MTC, STDS, condoms); Screened blood/ transfusions; Sterile equipment / needles; Voluntary testing & counselling; treatment & control; Care of people with AIDS (preve
Additional factors
HIV prevalence - military & para-military; Movement/ relations inside camp, towns, centre; Gender issues, especially camp management and protection; Staff health
Combatants
Economic vulnerability
Gender discrimination
Increased violations of human rights
Political & economic
Poverty
Political instability
War/ conflict
Environmental problems
SCF(U

The roots of the tree represent the factors that contribute to emergency situations in the first instance. Political and economic discrimination against groups of people, poverty and the search for resources and income, political instability, war and conflict, and environmental problems like drought and earthquakes all result in situations where emergency situations and displaced populations are created. Often as a result of loss of local or national protection displaced populations are vulnerable to increased violations of their human rights, economic and social vulnerability, and at increasing risk of gender discrimination. In emergency and displaced situations people move. Where war, conflict or protection is involved, combatants and military also move. In forced migratory situations these dynamics create populations that:

- Have lost access to basic needs like food, shelter, water and sanitation and income
- Have lost the protection of family, community and national forces and legislation that may protect them violence and discrimination
- Have lost access to basic services particularly health, education and social welfare
- are at increased risk of sexual violence, exploitation and abuse
- are exposed to populations that may harm, exploit or abuse them, for example combatants

These effects are depicted as the branches and leaves of the tree. All of these factors contribute to increasing vulnerability of displaced populations to the spread of HIV/AIDS as the following Table 1 indicates:

Table 1: Factors that contribute to the spread and impact of HIV/AIDS in Emergency and Displaced Situations

Lack of Basic needs & economic opportunities →	Women, girls and boys exchange sex for food, resources, shelter, protection and money
Breakdown in Social and Community Structures and lack of physical & legal protection →	Loss of spouse/partner and/or children therefore new sexual relationship(s)
	Sex and marriage at earlier ages owing to lack of leisure, education and employment opportunities & increased drug use due to boredom and lack of opportunities and loss of parental support and guidance on sexual issues for young people
	Loss of protection for women and young girls from rape and sexual abuse/violence and a lack of mechanism by which rape and sexual violence can be addressed. Abuse of power by camp leaders and military
	Gender insensitive camp layout and management that puts women and girls at increased risk of sexual violence and rape
	Lack of community support for people living with HIV/AIDS and for orphans
	Blood not screened and universal precautions on HIV/AIDS not applied
Lack of health infrastructure →	Women and men cannot access condoms for safe sex, sexually transmitted diseases are not treated. Drugs and supplements are not available to avoid mother to child

	transmission of HIV for pregnant women and girls No support services available for sexually abused women, girls and boys in terms of reproductive health care, psychological support. Personnel discriminate against people living with HIV/AIDS A lack of female trained staff in any temporary health infrastructure Lack of confidentiality and privacy in location and easy access Lack of voluntary counselling and testing facilities and treatment, care and support for HIV positive people Lack of education opportunities and skills development for women and children to decrease dependency on the exchange of sex for money and resources
Lack of Education and Skills training →	Lack of gender sensitive information on HIV/AIDS & sexually transmitted diseases, mother to child transmission/problems with advice on infant feeding Rape, sexual abuse, sexual harassment and violence
Sexual & Gender-based Violence →	Often high rates of HIV; Abuse of power and sexual violence and rape against refugee women and children Lack of knowledge on HIV/AIDS transmission and no use of preventive means during sex

The para-military, combatants, military and peace keeping forces, NGO and donor staff	Sex and intravenous drug use as a coping mechanism

Traditionally emergency responses are confined to water and sanitation, addressing basic needs such as food, shelter and fuel, immediate health provision through disease treatment/prevention, and camp management issues. The above table and problem tree illustrate the fact that a number of factors contribute to the spread of HIV/AIDS in emergency situations and many of these factors will not be addressed, particularly at the preparedness stage and initial implementation of an emergency response. The problem then is that whilst emergency practitioners aim to protect refugees and displaced people and save lives, in failing to take HIV into consideration at the planning and initial stages of an emergency, they may well be perpetuating an epidemic with catastrophic and ultimately fatal impact on the very populations they aim to protect. This is particularly the case when refugee populations are coming from low HIV prevalence areas and settling in high prevalence areas, and where rates of HIV are high among combatants and protectors. Particular regions of concern are sub-Saharan Africa, South East Asia, South & central Asia, and Eastern Europe.

It is clear from this model that to address the spread and impact of HIV/AIDS in emergency and displaced situations, a mutli-sectoral response is required that goes beyond the confines of traditional emergency responses. It is also clear that traditional emergency responses do not include crucial elements for addressing HIV/AIDS in existing sectoral responses. For example, the integration of reproductive health services in health responses at the early stages of an emergency situation would afford a structure to address both HIV transmission and gender-based sexual violence problems from the outset of a response. However, health responses in the early stages of an emergency traditionally focus on disease eradication and prevention, and mother and child health services.

Finally, it is apparent from the problem tree analysis that women and children are particularly vulnerable to HIV transmission through gender-based sexual violence, lack of protection, and exploitation and abuse perpetuated by gender insensitive camp management implementation and often by exposure to the presence of combatants and would-be protectors. Women and children constitute the largest and most vulnerable proportion of refugee and displaced people, however, emergency responses are rarely based on gender-sensitive assessments that reflect the problems and needs of women, children and young people.

The following sections describe in greater detail the vulnerability of refugees and displaced people to HIV/AIDS because of the factors named above. They incorporate some programmatic responses elicited in wider research carried out in connection with this seminar.

Lack of access to basic needs and economic opportunities

Many refugees in complex emergencies leave home with almost nothing - having lost possessions and the means of livelihood. The inability to maintain one's livelihood can increase vulnerability to HIV, largely as a rest of sexual bartering in exchange for basic goods and services. This is particularly true for single-female headed households, orphans and unaccompanied minors. It can take a long time to queue for relief commodities - time not always available to women with children who have lost their husbands. There is now a body of evidence to show that, unless care is taken in the design of distribution systems, women-headed households can lose out. For example, in 1991, while providing assistance to Kurdish refugees, UNHCR realised that women-headed households were receiving inadequate food rations, possibly as a result the fact that all of the food distributors were men. In recognition of this problem, WFP and UNHCR signed a joint Memorandum of Understanding (MOU) in 1997, which stated that women must be involved in all aspects of food distribution programmes. This intervention will help to resolve the fact that women often have to exchange sex to access food.

Economic dependence on their spouses also places women at a disadvantage, making it more

difficult for them to refuse sex or negotiate safer sex. Income-generating activities for women and children are few and far between, with the result that many women end up resorting to prostitution as a means to provide for their families. Studies carried out among refugees in Eastern and Central Sudan in 1983 showed that 27% of single mothers became sex workers to earn a living[8].

Few programmes address HIV/AIDS in the commercial sex industry in and around refugee and displaced populations. Commercial sex establishments often appear around refugee camps, yet it has proven difficult to reach the vulnerable groups associated with these activities. More success has been achieved in the support of local women's groups as a means of empowerment. A variety of programmes have encouraged the development of women's support groups as a way of restoring some of the social support mechanisms lost during the displacement event, and of providing support to victims of sexual violence, care for families living with AIDS, training, basic education, and income generating activities for refugee women.

Breakdown in social and cultural structures

Many of the coping mechanisms and social support networks of individuals and communities are weakened or destroyed during population displacement. Traditional family structures may break down through loss or separation during flight, and new sexual relationships formed. There may be a desire to replace lost loved ones, either by having new children or through the development of relationships with new partners.

Orphaned and unaccompanied children are an especially vulnerable group, as a result of the loss of support and guidance from parents, and because they can end up in foster care or special institutions where they may not get the full attention needed to overcome the trauma of their experiences. Most of the current debates surrounding vulnerability of unaccompanied minors and orphans is related to how best to manage the child's basic needs, with little explicit reference found to increased vulnerability to HIV in the key policy documents related to placement and housing of unaccompanied children[9] [10].

Boredom is known to be a significant problem in refugee settings. Too much inactivity may increase the chances that individuals engage in more risky behaviour such as drug and alcohol abuse, and increased sexual activity. This is a particular problem for adolescents who in the absence of structure and good role models to influence behaviour might be more inclined to "experiment" with sex and drugs at a much earlier age.

One strategy that has shown to be effective in addressing the problem of boredom is the introduction of structured activities to refugee populations. A number of organisations provide schooling for refugee and displaced children. In addition to reducing idleness, the school environment provides an excellent avenue for promoting health education.

In another approach adopted by the AIDS Control and Prevention (AIDSCAP) programme in Ngara, Tanzania, sporting events were used to provide entertainment as well as to convey health education messages about HIV/AIDS. In between events, posters, performances, and songs were used to disseminate information about HIV[11].

2.3 Lack of education

Refugee and displaced populations often lose access to education. This has grave implications for the future of children and for adults where they may have otherwise gained access to adult education programmes. Refugee and displaced children not in school often become bored, and sometimes engage in sex at earlier ages therefore increasing their vulnerability to HIV/AIDS.

Many agencies carry out Information Education and Communication (IEC) and Behaviour Communication & Change (BCC) programmes to promote increased awareness about HIV/AIDS and STDs among vulnerable populations. Lessons have been learnt as a result of the experience already gained on how to improve the effectiveness of such programmes[12]:

• BCC can help create environmental conditions that facilitate personal risk reduction, i.e. a more supportive environment in which individuals receive encouragement from many sectors

to practise safer sex;

- Risk-reduction efforts need to address the behaviour of both partners in a relationship, but particularly the partner who has the most control;
- If peer educators are trained only to provide STD/HIV/AIDS awareness information, they may not be effective in influencing later stages of behaviour change;
- Well-planned and well-executed entertainment has proven to be effective in conveying serious behaviour change messages;
- Capacity building in BCC is critical, even for experienced health educators;
- Appropriate IEC materials should be developed in consultation with community leaders;
- Secondment of service providers to government or other facilities as appropriate should be encouraged in order to ensure project teams receive full training in a range of services.

While IEC programmes are certainly valuable as an initial awareness-raising tool, their limitations also need to be recognised. Programmes that rely solely on IEC will not be effective in enabling sustained behaviour change. Risk reduction strategies must also address the social and economic factors increasing people's vulnerability to HIV.
Community mobilisation has been used by many agencies as a strategy to promote awareness about HIV/AIDS and influence changes in individual behaviour. The 1996 UK NGO AIDS Consortium Seminar on Refugees, Displaced People and their Vulnerability to HIV/AIDS[13] made the following recommendations:

- Identify previous skills of refugees and Internally Displaced People (IDPs) before the displacement event & draw upon these skills
- Understanding refugee and IDP social structures is key, hence refugees/displaced people should be actively involved in planning and implementation where possible
- Refugee and IDP representatives should advocate for equal access to health care, including HIV/AIDS care as appropriate

Religious organisations can also be highly effective in influencing individual behaviour change[14] and in articulating wider concerns[15]. Church personnel are often the first (sometimes the only) groups able to access refugees or displaced people and they are likely to

continue their work long after international humanitarian response groups have left.

Targeting programmes to meet the specific needs of adolescents has proven to be difficult. Children that are having sex at younger ages may be unaware of the risks and ways to protect themselves. In 1994, the IRC initiated an adolescent health education programme for Liberian and Sierra Leone refugees living in the republic of Guinea[16]. The programme was integrated within the International Red Cross' general education programme through the use of formal health education classes. Additional activities included the formation of voluntary after-school "Health Clubs" and Young Women's Social Clubs that were involved in promoting positive reproductive and general health practices. Some of the participants reported that they felt more comfortable seeking information in this setting than from health centres or hospitals.

The IRC reported that given the chance to repeat the programme the following changes would be made:

- A needs assessment would be carried out to enable more efficient targeting of activities and messages;
- Programme activities would be initiated sooner after the arrival of refugees;
- the involvement of recipients in programme planning would be increased;
- better monitoring and evaluation of programme activities would take place;
- training for staff would be increased.

Save the Children Fund (UK) has also carried out adolescent education programmes on reproductive health and HIV in South East Asia[17]. A CAFOD review for DFID[18] looked at understandings of behaviour change with gender- and age-specific groups in programme in four countries of Africa. Although not specific to emergency response, some important messages emerged:

- personalise the AIDS problem so that all are aware of the fact that everyone is at risk in different ways;

• involve programme recipients in planning to ensure sustainability and accordance with certain rights of the child

• make the needs identified by intended beneficiaries the starting point for programmatic responses e.g. young women in Zambia saw education/skills training as their first priority (their only passport to economic independence and therefore control over sexual behaviours)

• no single authority figure can adequately represent the opinions and experiences of a community. Young people need to voice their own concerns and young women and men given gender-specific fora

• include components of self-esteem building based on the premise that "young people will only have protect themselves if they have a sense of their own worth";

• encouragement from and involvement of adults in programmatic planning is essential. Children are likely to confront HIV more effectively if not limited by adult restrictions. Adults have powers of decision over children and over programmes to be implemented in communities.

The link between general education and literacy and vulnerability to HIV needs to be more generally recognised. In September 1992, Oxfam developed a programme to tackle the problem of illiteracy among Bhutanese women in Nepal. A non-formal education programme was developed based on the National Literacy Programme in Nepal. Three components were created to provide basic reading and writing skills in Nepali, as well as basic arithmetic education for adults and children not served by the formal school system. Approximately 13,000 refugees participated in the programme over a 3-year period, the majority of whom were women[19]. General education not only promotes and increases overall awareness about HIV/AIDS but also helps to empower individuals.

2.4 Lack of health infrastructure

The impact of conflict and disasters on public health services can be severe, particularly in developing countries where existing infrastructures are already weak. The breakdown of the ability to provide screened blood for transfusions, and a lack of sterile equipment to safely handle and dispose of blood products can increase the risk of HIV transmission. Programmes

to reduce the number of injuries can be important, including those targeted at the problem of landmines. Essential programmes such as reproductive health services may also be disrupted during conflict and disasters. UNHCR, MSI, CARE and others belonging to the Reproductive Health Consortium have recently moved to introduce reproductive health into all emergency programmes.

STD Management

Despite efforts to strengthen access to STD information and services for the general community in the refugee camps in Tanzania in 1995, AMREF found that the commercial sex industry still thrived. A programme that involved the training of peer educators, the provision of condoms and on site STD treatment in brothels was only initiated quite late. Specially designed interventions need to be set up rapidly for this potentially large target group.

Condom Promotion

Condom promotion is an important strategy used to reduce HIV vulnerability in emergency settings. A number of factors that might inhibit the success of condom social marketing programmes include the resistance to use because of a desire by individuals to replace lost loved ones, misperceptions and fears about condoms, and in some cases political incentives, e.g. forcing women to bear enemy children. One of the main lessons to emerge from an AIDSCAP programme was that understanding the perceptions of the population about condoms is key to the success of any initiative. AIDSCAP found that NGOs were important partners for social marketing, which proved to be an enormous stimulus to the commercial condom market in general.

Pregnancy & Mother to Child Transmission

The UNFPA Reproductive Health Kit for Emergency Settings contains the following recommendations:

- the practice of safe deliveries by Traditonal Birth Attendants and health professionals through the use of "Clean Delivery Subkits"

- enforcement of universal precautions against HIV/AIDS to be incorporated into each kit
- planning for the provision of comprehensive reproductive health services

There is no mention of policies related to HIV positive women and childbirth, or the use of drug therapy to prevent mother-to-child transmission in most of the key policy documents concerning refugees and reproductive health. The WHO/ UNHCR/UNAIDS Inter Agency Field Manual recommends that breast-feeding continues to be encouraged under circumstances of high infectious disease prevalence and malnutrition. Provision of Voluntary Counselling & Testing (VCT) and information for pregnant mothers is encouraged to allow them to make informed decisions about this issue.

Treatment, care and support of people with HIV

Currently, very few HIV/AIDS programmes in complex emergencies have interventions that address the needs of care for HIV positive individuals. Only 3 out of the 13 reviewed in the Merlin study[20] provided care for terminally ill patients. The WHO/UNHCR/ UNAIDS Guidelines on HIV/AIDS Interventions in Emergencies recommend that care for opportunistic illnesses be given to people with HIV when relative stability is restored, the approach being predominantly biomedical.

The AIDSCAP programme in Rwanda in 1994 developed a home-based care component for HIV infected individuals. Volunteers recruited from the refugee community that were trained in home care regularly visited homebound refugees, bringing water, firewood and food. NGOs worked together to co-ordinate the distribution of clothing, blankets, cooking utensils and other items. In one case a group of refugee women was provided assistance in starting a kitchen to prepare food for those unable to cook for themselves. (Reference?)

Key lessons learnt through this programme included:

• the further stigmatisation of people living with AIDS - a serious problem among Rwandan refugees - was avoided by not singling out people living with AIDS; any ill or disabled person without family support could receive home-based care services;

• a high level of collaboration between agencies was necessary to carry out the home-based care programme.

Although the WHO/UNHCR manual on the Mental Health of Refugees provides a comprehensive view of the needs of refugee and displaced children, there is no mention of how to deal with the psychological stresses of HIV and STDs, including those caused by discrimination and stigma.

2.5 Sexual Violence and Abuse[21]

There are various forms of sexual and gender-based violence, rape being the most commonly referred to. In complex emergencies sexual violence has been used as a weapon of war, for example in Bosnia, Mozambique, Rwanda, Liberia, Sierra Leone, and more latterly Kosovo. Although data are not available for many conflicts, elevated rates of HIV infection followed the wars in Mozambique and Angola. During in the war in Bosnia 30–40,000 women were raped as a deliberate policy to force young women to bear the enemy's child[22].

According to a report by UNFPA[23], in Kosovo it was primarily young women who were abused. They were rounded up in towns and cities. Soldiers took groups of 5-30 women to unknown places in trucks or locked them up in houses where soldiers lived. Any resistance was met with threats of being burned alive. In the city of Berlenitz in Kosovo an eye witness testimony indicates that 30 young girls were rounded up and forced to follow soldiers into a house while mothers waited outside. For two hours mothers listened to the screams of the young victims who then came out one by one. Some were covered in blood, others were crying their heads hanging low. The same report indicates that: *'The denial of cases of rape by certain international and national medical personnel has made the work of reaching and dealing with the victims even slower and more delicate.'*.

In the camps in Tanzania, research with women in 1995 indicated that an increasing number of pregnancies were occurring among young women and girls who lived without the protection of their parents. In addition, the frustrations and idleness of refugee men in the

camp environment and their drinking habits contributed to more violence and sexual abuse against women. Most of the populations in the camps in Tanzania were from Rwanda where HIV rates were high prior to the conflict[24]. Many refugee women sold sex to people outside the camps and many refugee men visited local sex workers. Yet HIV/AIDS was not prioritised as an issue and very few interventions were developed.

Sexual violence also occurs in complex emergencies when refugees and displaced people are moving from one location to another. Girls and women are raped in this context and in camp situations where 'marauding groups' sexually abuse them; this includes those who are supposed to be guarding them[25]. In such situations, although military personnel are aware of the dangers, many do not use condoms as protection against HIV/AIDS.

In complex emergencies when systematic rape and sexual violence occurs it is difficult to respond when refugees are on the move and unprotected. Participants at the seminar recognised these difficulties, but also brought with them experiences of the types of intervention possible. One agency in Liberia lobbied the armed factions to try and reduce the levels of violence. Community leaders and church representatives had also been involved in efforts to raise awareness of women's rights as well as to offer counselling to those affected. Efforts had been limited, however, by the difficult political situation, and the possibility of violence against those speaking up about human rights abuses.

Fear of discrimination and stigma are major barriers to the adequate treatment of victims, who may, as a consequence, be reluctant to come forward for treatment. A lack of awareness amongst planners may also be an obstacle. Indeed, it is only relatively recently that guidelines on camp layout have explicitly considered the safety of women (see Section 4).

The presence of a camp perimeter may also significantly impact personal safety. One study showed that the construction of a thorn perimeter around a refugee compound in Northeast Kenya in 1992 significantly reduced the number of women and girls attacked[26]. In addition, the inaccessibility or lack of presence by UNHCR and other NGO personnel in the camps at night is thought to increase the risk of attack[27].

Involving the refugees, especially women, at a very early stage in planning emergency interventions has been shown to be an important strategy to address the problem of security, and can also help increase accessibility to health and other emergency services[28].

2.6 Additional Factors

2.6.1 Presence of the Military/Paramilitary

The relationship between the role of combatants and HIV transmission is complicated. Military and paramilitary forces can play an important role as protectors ensuring the personal safety of vulnerable populations. At the same time, they can also be perpetrators of sexual violence.

A large number of soldiers are known to be HIV positive. As of December 1998, UNAIDS estimated that STD rates were between 2-3 times higher among armed forces than in comparable civilian populations. Studies carried out in 1995 in Zimbabwe show that the HIV infection rate for soldiers was 3-4 times higher than in the civilian population. According to senior personnel in the French Army Health Services, tours of duty overseas multiply the risk of infection for French military personnel by a factor of 5[29].

Other threats to the wider community acknowledged by UNAIDS[30] include:

1) the impact of HIV/AIDS on infected individuals and their families. Because of the long symptom-free period, there remains a high likelihood of transmission by infected individuals who are unaware of their status to their spouses.

2) the risk of transmission to civilian populations through mixing and heavy use of the local sex industry. The case of the UN Transition Authority in Cambodia (UNTAC) provides a clear example that there is an ever-increasing need to consider this issue more seriously.

The UNTAC mission carried out in Cambodia from 1991-1995, brought some 20,000 soldiers from a variety of countries – US, Western Europe, Bulgaria, Uruguay, India, Pakistan, Bangladesh, Thailand, Indonesia, Korea, and several African states. The peacekeeping operation was the first of its kind and was, at that time, one of the most ambitious UN operations ever launched. The majority of these soldiers were young men with a relatively low level of education. According to Beyrer (1998), "they walked into a country long closed to the outside world, starved for cash, and full of people eager to take their dollars." Needless to say, the commercial sex industry flourished.

Local authorities in Phnom Penh were quick to attribute the rise in HIV prevalence and the growth in the sex industry to UNTAC. Although there is no concrete evidence to support this claim, local NGOs working with sex workers in the area did report that sex workers on average doubled their nightly number of customers, from 5 to 10 during the UN mission. The prevalence of HIV among blood donors in Phnom Penh during this 5-year period increased dramatically, indicating a corresponding rise in prevalence among the general population.

Studies of returning UNTAC soldiers in Uruguay and the USA show that those who carried the disease were mostly infected with a particular subtype E of HIV, found only in Southeast Asia and Central Africa. It was estimated that 15% of the Indian soldiers that served with UNTAC came home infected[31].

There is a clear need to address the issue of HIV/AIDS and the military. Burke (1993) suggests that this reluctance to acknowledge this problem has been attributed to the fact that HIV is not an acute, wartime concern. Additionally, military forces are hesitant to disclose information that may reveal their weaknesses.[32]

According to UNAIDS, one of the main characteristics of the armed forces that makes it a strong candidate for change is the nature of discipline and education that exists within the system. Consequently, military institutions are an excellent target for education programmes. The decisiveness and energy exerted by the military when faced with a serious and clearly defined mission, if channelled appropriately, could be a highly effective mechanism for

change.[33] This applies not only to efforts made to influence behaviour within the armed forces, but also within the wider community.

Examples of HIV/AIDS interventions for soldiers that have been successfully introduced in a number of countries including Botswana, Chile, Thailand, Zambia, and many NATO member States include:[34]

- Improved or expanded prevention education
- Condom education and distribution
- STD prevention, screening, and treatment
- Provision of voluntary counselling and HIV testing

At the same time, implementing measures that address risk behaviour is not enough on its own. Efforts need to be made to change factors that increase the group's vulnerability to infection. Change at this level will have to take place at a much higher level within the military institution. UNAIDS has highlighted three key areas:

- Changing posting practices
- Changing the military culture
- Changing military attitudes towards civilians

In 1993, the Civil-Military Alliance to Combat HIV and AIDS (CMA) was established as a UNAIDS collaborating centre when it was realised that peace keepers and military personnel at home were a population at special risk for STD and HIV infections. It was recognised that one key to successful programme development in STD/HIV prevention and control was close collaboration and integration of the prevention programmes of the civilian and the military sectors.

Since mid-1998, the Civil-Military Alliance to Combat HIV and AIDS has brought a new orientation to its work as a technical support agency, an orientation that is called Crisis Prevention and Response (CPR). It places particular emphasis on recognising

that HIV/AIDS is a priority issue in refugee, emergency, crisis, conflict and post-conflict situations. Two additional elements, both critical for success, involve:

- the enhancement of civil-military co-operation and co-ordination of efforts
- inter-country co-operation in both planning and response.

2.6.2 The Child Soldier

Child soldiers are especially vulnerable to HIV either through sexual violence by older officers or through peer pressure that encourages risk-taking behaviour. The week of April 26th 1999 marked the beginning of a recent initiative by Save the Children UK to combat the problem of the child soldier. Other organisations such as Human Rights Watch and the Coalition to Stop the Use of Child Soldiers are heavily involved in advocacy.

2.6.3 Staff Health

A recent survey by the International Committee for the Red Cross found that 1 in 10 aid workers were HIV positive.[35] This has important implications for humanitarian response. Careful attention needs to be given to the degree of training given emergency responders. Many expatriates that work in the field come from areas of low HIV prevalence and may never have had to deal with the problem before. Several individuals consulted in this review cited the need to sensitise aid workers about the reality of HIV: ways to prevent transmission; how to recognise and care for people living with HIV/AIDS, and the need to advocate against discrimination of them.

Section 3: Case Studies on Conflict and Disasters and HIV/AIDS

The following case studies were presented at the seminar. They indicate how selected agencies have approached HIV/AIDS in conflict, disaster and as a result of migration.

Case Study I Sexual Violence Against Women: Experiences from AVEGA's work in Kigali, Rwanda by Ester Mujawayo and Mary Kayitesi Blewitt

This case study highlights the perspective of a local Rwandan organisation - AVEGA -an association of the widows of genocide, in the area of HIV/AIDS.

1. Introduction

The ideal situation would be to prevent sexual violence from happening in the first place, but this falls outside the mandate of humanitarian agencies. Campaigning and advocacy work to include sexual violence and rape as a category I crime against humanity would deter or reduce sexual violence against women.

Increasingly during conflict women are raped and humiliated. AVEGA has a membership of 12,000 widows. Over the last five years, as many as 2,000 opted for voluntary HIV testing. Nearly 80% of those who have been tested are positive. Although Rwanda was ranked highly among countries with HIV levels pre-genocide, indications are that most HIV-positive women in AVEGA may have contracted the virus as a result of rape and sexual violence during genocide because of the following reasons:

- Many are young girls who were not sexually active before genocide.
- The majority has the high CD count and have to date maintained good health. In spite of poverty, rape, trauma, isolation, destitution, high levels of stress and inadequate/bad diets experienced by those infected by HIV.

HIV/AIDS is a universal reality, be it caused as result of rape or other forms of transmission. In the context of Rwanda most people were aware of the virus's existence and its effects. Many people may have the virus or have lost someone or know a friend who is positive. Externally promoted/resourced HIV awareness raising meetings and workshops in isolation of addressing other problems experienced in emergency situations may be inappropriate. What is essential is to improve people's lives through the provision of food, clean water/sanitation and the meeting of other basic needs. The prevention of communicable diseases/opportunistic infections and common viruses during such situations is another crucial area of intervention.

2. How can we be prepared to play a useful role in responding to the HIV/AIDS realities in a humanitarian situation?

A change of attitude is the first step towards understanding how to deal with the HIV/AIDS situation in a humanitarian context.

A starting point to engage with the issue of HIV is for us to examine our own attitudes, and the universal and culturally specific components of stigma, etc. There is a need to examine how we relate to People with AIDS (PWAs), and whether we are comfortable with the virus ourselves. Because of the stigma and indifference given to HIV/AIDS in many communities and sometimes among health professionals, it is essential that our response be well informed, this can be greatly assisted by learning from those who have managed to reconcile themselves to being either HIV positive or having AIDS.

Using their services and involvement to reach many people who may be frightened to seek support is a key intervention strategy that can bring significant benefits. Identifying and committing to work with such individuals in an emergency setting is more easily said than done. For this reason we should always try to set up structures and systems that can at a minimum be sensitive to local realities and thereby able to be supportive of HIV/AIDS affected individuals/ families during emergencies.

3. What sort of early interventions are possible in a humanitarian situation?

- Supporting local structures to deal with HIV/AIDS.

Humanitarian workers should not just wait in conflict/emergency situations for the effects of HIV and AIDS to become utterly self-evident. A lot of effort and resources should be put into developing local leadership, existing communal practices, that can provide the necessary information, and support to women who have experienced sexual violence and may have subsequently contracted HIV.

- The setting up of health clubs which would assist in addressing the issues of:

a) the provision of practical information
b) understanding and being supportive of the role of local remedies
c) advice on dietary provision
d) education around safe sex and the use of protective methods
e) stress reduction through dialogue with affected groups, looking to identify causes of stress and working to minimise these.

- Tackling Alcohol Excesses

Alcohol excesses look for employment or income generating alternatives in emergencies to reduce destitution and despair.

- Symptoms and opportunistic infections

Raise awareness among health professionals of common symptoms of immune deficiency that may manifest themselves as opportunistic infections.

4. AVEGA's experience in the area of HIV/AIDS and emergencies

5 years on the widows who survived genocide are still living with insecurity, significant economic challenges and psychological and physical disabilities. The period of transition post emergencies is a crucial one to be engaged in looking for local creative options to support the area of HIV/AIDS.

a) Breaking the circle of stigma and negative attitudes

AVEGA is using the services and the knowledge of PWA to break the negative circle of stigma. PWA with practical experiences have brought courage, confidence and richness to members of AVEGA. At the same time, this has allowed PWA to provide a positive contribution to the future strategies of AVEGA when taking forward work in the area of HIV and AIDS.

Finding someone to talk to about HIV has helped to reduce stress and anxiety levels. Many people prefer to talk to non-family members until a later stage. AVEGA has been able to provide a supportive environment in which those who may suspect being positive or who are HIV positive and living with AIDS learn to manage the virus until such a time when they are ready to speak openly about it and seek appropriate support.

b) Listening and providing a supportive environment

"Not separating out HIV/AIDS from other health issues". A key policy position of AVEGA.

HIV/AIDS has become a household word in AVEGA - "it is okay to be positive". The illness is dealt with in the same way as malaria, headaches, diarrhoea and coughs. Healthy Women seminars are run in which many topics are generally discussed: prevention methods, symptoms and treatment, good diet and stress free environment are emphasised as the best treatment for any infection. Some people may prefer to listen and make no comments, others may participate and ask questions. This builds trust and confidence which is essential to

break the stigma about communicable diseases including HIV.

Women who have begun to live comfortably with the virus are used to talking about their feelings of being HIV positive, their first reactions when they were diagnosed are typically fear, isolation, and anxiety. The great emotional stress linked to the virus in any cultural context highlights need to find appropriate mechanisms to share the burden.

c) Providing practical help

Raising the levels of income

In many households, poverty is the prime cause of stress. Not being able to meet basic needs for families can result in negative practices such as involvement occasionally in prostitution to sustain the family. The provision of credit for income generating activities has enabled some women survivors to access basic family requirements and reduce stress and destitution.

Supplementing the diet

AVEGA realises that in the Rwandan context, raising awareness about staying healthy and having a good diet is not enough, consequently the organisation provides a range of high protein foods in support to those who have tested positive. This programme has been ongoing since 1996 but is vulnerable to erratic donor support.

Providing medical support

AVEGA runs a clinic with a full time nurse and a doctor visiting weekly. Opportunistic infections are dealt with seriously whether a member of AVEGA is positive or not. This integrated approach is seen as critical in providing a supportive health care service to survivors. AVEGA also tries to meet the medical bills for members who are HIV positive and affected by opportunistic infections, it also offers to pay for HIV testing provided through the private sector and provides a regular health monitoring service for the survivors.

Counselling support

Healthy women seminars are run by the survivors themselves, they provide a listening ear for

those who may be experiencing symptoms. They provide emotional support and information about how to plan your life and your dependants' future. AVEGA also provide outreach when PWAs are sick.

HIV testing services

This is voluntary and women survivors are totally free to opt for testing in their own time. In most cases they have proved themselves ready and willing to live with HIV. In the absence of guaranteed medication or a cure, women explore the time limit they have through testing and monitoring their health. This gives them an opportunity to plan for their dependants.

5. Tentative Conclusions

- Recognition of the limits of the humanitarian mandate, and the need for further legal measures to protect women in conflict and to mitigate infection through this route.
- Humanitarian agencies need to examine their institutional and individual attitudes associated with HIV and AIDS.
- Local structures and organisations alongside government heath services provide very effective avenues to supporting HIV/AIDS affected individuals and families.
- The involvement of PWA in service and information delivery is a very important factor in reaching potentially affected groups/individuals.
- Humanitarian agencies should aim to ensure that basic needs are met in a way that empowers local people (such as credit schemes). Reducing stress associated with meeting basic needs plays a crucial role in providing a supportive environment for those who are affected by the virus.
- Given the protracted nature of humanitarian situations (in Rwanda the humanitarian situation still remains 5 years after the genocide), there is a need for transition strategies beyond the humanitarian phase, however this is defined.
- Most of AVEGA's work is on a modest scale and with very constrained resources. The interest and resources of donors to support this area of work is very constrained and has a fundamental effect on what can and cannot be achieved.

Case Study II Forced Migration, The Military and HIV/AIDS in Burma by Jackie Pollock

To mark World AIDS Day 1998 (December 1st) Daw Aung San Suu Kyi issued a statement saying: "The battle against AIDS is not merely a health issue, it is a battle against ignorance, poverty, indifference, prejudice and callousness. So many of our people in Burma, especially the young, are vulnerable because of the poor quality of our health care and social services, and because the authorities are not prepared to recognise the enormity of the problem and come to grips with it."

Burma has all the ingredients for an explosive HIV/AIDS epidemic – 44 million vulnerable people and a military dictatorship, which refuses to acknowledge the problem. In reference to the hostile relationship between Burma's military junta and its own people, and the lack of community involvement in government-led programmes, Dr Peter Piot, executive director of UNAIDS said "In Myanmar, at the moment, this is not a strong point because there is the government and then there is civil society". In addition, there are over 150,000 refugees from Burma in neighbouring countries, up to one million illegal migrant workers in Thailand, and between 2 and 4 million internally displaced people. Their right to self-determination is seriously restricted, their access to information is dangerously limited, and they have received only negligible health care and education services before being displaced. All live in fear. Security risks are high for the internally displaced, the refugees have very little guarantee over their safety and the migrant workers can be deported at any time.

Such conditions are far from conducive to HIV education and care. Health reports from Burma point to the inadequacies of implementation of programmes inside the country. More important than economic backing and infrastructure they point to the lack of political will: the impossibility of reaching the young people through schools and universities which have been closed for much of the last ten years, constant forced relocations of communities and whole villages and security concerns.

Burma has the second worst HIV/AIDS epidemic in Asia, after only Cambodia where an

estimated 4% of the adult population is infected. UNAIDS estimates that there are at least 440,000 cases of people infected by HIV. 86,000 adults and children have already died, and 14,000 orphans exist because of AIDS. Rates among intravenous drug users are among the highest world-wide - 74% in Rangoon, 84% in Mandalay and 91% in Myitkyina, capital of the Kachin State on the border with China.

Women in Burma face considerable health problems because of poor living conditions, inadequate health services, and lack of basic education. Health care is even more deficient in the ethnic minority regions, where constant relocations and the heavy loss of men's lives have left women with the complete responsibility of raising their children. Maternal mortality rates are 580 per 100 000 live births, as compared to 80 for Malaysia and 10 for Singapore.

The Universal Child Immunisation (UCI) programme, which is done with UNICEF's support, reaches less than 60% of children nation-wide, and an even lower proportion in some areas. Higher immunisation rates have been hindered by security concerns, transportation problems, lack of electricity, and shortage of health workers, especially in remote areas. As in many other developing countries that lack potable water and sanitation, major causes of children's morbidity and mortality in Burma are intestinal and respiratory infections, malaria, malnutrition, and vaccine-preventable diseases. One million children are reportedly malnourished, 9-12% severely so.

The situation for those people living with HIV in Burma is unknown, except for the fact that health care for the civilian population is negligible, medicines being used exclusively for the army. HIV positive people are not having symptomatic diseases treated. TB is one of the major diseases related to HIV in Asia and requires stable medical facilities, which can regularly supply the drugs over a long period. Even if the drugs are available, it is unlikely that medical services can provide the necessary encouragement and stability to ensure that patients take the drugs for the whole period. Without such services resistance to the drugs will increase and have disastrous effects on the whole region.

The first major influx of refugees from Burma arrived in Thailand in 1984. This group of

some 9,000 people were ethnic Karens fleeing fighting between the Burmese central government and members of the KNU. Since 1988, when nation-wide pro-democracy demonstrations took place in Burma and the SLORC took power, the nature of human rights abuses in Burma increased in intensity. The new military government doubled the size of its armed forces and was able to establish a permanent presence in territory formerly held by the ethnic armed groups.

In the course of the fighting, countless villagers either fled to Thailand or hid in the jungles of Tenasserim Division. By the end of May 1997, 114,800, Karen, Mon and Karenni refugees were in camps along the Thai/Burmese border. UNHCR is unable to carry out its mandate along this border, since Thailand is not a signatory to the Convention on Refugees. UNHCR has, therefore, had no permanent presence in any of the refugee camps nor any role in their administration.

From June 1997 onwards a new policy was implemented by the Thai army to permanently close the border to all new arrivals, thus effectively denying asylum to all those fleeing Burma. By November 1997, both Thailand and Burma had new governments. In Thailand, the SLORC's ally, Gen. Chavalit Yongchaiyudh, was replaced as Prime Minister by Chuan Leekpai. Chuan headed a coalition, which expressed support for human rights. In Burma, the SLORC was unexpectedly replaced by the new State Peace and Development Council (SPDC). Although the top four positions in the SPDC remained the same as in the SLORC, fourteen government ministers were sacked and replaced by younger army officers. In Thailand, the Chuan administration, with Foreign Minister Surin Pitsuan, took a new attitude towards the Burmese government and towards the refugees on Thai soil. In February 1998, the government invited UNHCR to give a presentation on its work with a view to considering a UNHCR presence on the Thai/Burma border. When refugee camps were attacked in March, the government immediately responded with enquiries to the Burmese embassy.

Cross-border aggression, the influx of refugees and illegal immigrants, and the political situation across the border have become a serious threat to local stability in Thailand. As a result, the Chuan government has attempted to introduce a greater degree of flexibility in its

by people known to the family. Frequently an inability to talk about it directly to the child but able to create situations which helped the child and provided protection. Significance of the role of other women to provide assistance and sometimes parenting.
Recognition that women's responses to protection of their children are not always logical/rational. Normal responses to an abnormal situation - but may not always be able to fully assess the circumstances. Importance of opinions and discussion by others to address some of these misjudgements. Consideration should be given to the vulnerability of children in the host community particularly to drugs, alcohol abuse and propaganda.

5. Community's Attitudes to Sexual Violence/attitudes to sex

Righteous outrage by the civilian and military authorities at what was happening to women was most often used to give legitimacy for the same revenge. Apparent ambivalence of many community leaders and service providers. Public statements contrary to provision/facilitation. Sex as a negotiating tool for economic, bureaucratic or survival (life and death). No community has to deal with mass rape and sexual violence in normal situations so cultural patterns do not exist. Wide range of attitudes exist but generally it is suggested that pre-conflict experiences/conditions and geographical isolation were more significant contributors to a women's vulnerability than the fact that she had been raped during the conflict. Denial by some individuals in aid agencies to accept that people have sex in extreme physical and emotional circumstances and, therefore, a lack of provision of basic services.

What does this have to do with HIV/AIDS programmes in emergency situations?

Why in mid 1999 do we still need to 'sectoralise' HIV/AIDS programming?

It is impossible to see what can be done about HIV/AIDS prevention/protection when there is systematic rape as part of a military strategy. This and the presence of dis-inhibitors mitigate against any measures. Aside from trying to stop the conflict perhaps all that can be done is to provide basic medical care to the abused after the event. However, sexual violence prevails in emergency situations for many additional reasons.

There may be a reluctance to integrate HIV/AIDS programming in emergency situations for fear of 'over loading' or compounding people's vulnerability and stigmatisation. Yet people have a right to be informed and they are survivors as well as victims.

Psychological support programmes address ignorance, stigma and myth in order to assist people to understand and cope with their experiences. This appears to be a good starting point for HIV/AIDS programmes.

Basic reproductive healthcare and trauma programmes provide opportunities for HIV/AIDS programming to be integrated from the start. The programme described here did not know whether we were working with HIV positive women and children. However, it is suggested that a number of the responses would have been appropriate for beginning to address the needs of people living with HIV/AIDS and for community prevention programmes.

Case Study IV: Prevention and Care in an Emergency: STD/HIV/AIDS Programme in Rwanda Refugee Camps in Tanzania by Dr Philippe Mayaud[a]

Background:

During April 1994, an estimated 350,000 Rwandan refugees established themselves in 2 large camps in the Ngara district, North West Tanzania. Given the camps' living conditions, the nature of the crisis and the known high prevalence of STDs and HIV in the Rwandan and Tanzanian populations, STD/HIV measures were urgently needed. It was first decided to undertake a rapid STD/HIV situation analysis to inform international and local organisations about the needs and nature of the required STD/HIV intervention programme.

Methods:

The initial STD rapid assessment consisted of 5 components: (i) a literature review of the epidemiological situation of STDs and HIV in Rwanda and NW Tanzania, with particular reference to Ngara district; (ii) a review of facilities providing care in the camps to assess provision of STD/HIV care; (iii) a review of the health information system and STD statistics in the camps; (iv) a rapid STD survey conducted among 100 antenatal clinic attenders, 40 men randomly selected from each of the 6 camps' outpatient clinics (total 240) and ~300 men living in the community selected through a multistage cluster sampling frame; and (v) a rapid Knowledge Attitudes Beliefs and Practices (KABP) survey, conducted among men and women.

The STD/HIV programme was launched 4 months after the start of the Rwanda crisis in 1994 and had 5 components: (A) *IEC*: health learning materials (posters, leaflets, etc.) were produced in Kinyarwanda and 14 refugee health behaviour promoters (HBPs) conducted regular mass STD/HIV education campaigns. (B) Peer educators were trained among bar and brothel workers. (C) *Condoms* were supplied through various outlets: at clinics, during

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[a] In collaboration with: AMREF, Mwanza, Tanzania: Wences Msuya, Rashid Mkanje, Frexon Lisekie; LSHTM: Beryl West, James Todd, Debby Watson-Jones, Heiner Grosskurth, David Mabey; NIMR, Mwanza: Godfrey Kaatano, Jan Cornelissen; UNHCR-Ngara: Genevieve Begkoyian,Thane-Toe; Other agencies: AEF, CARE, IRC, ICRC, MSF-Spain, MSF-Holland, MSF-France, Red Cross-TZ

campaigns and by peer educators. (D) The *STD intervention* consisted of training and supervision of health workers (HWs) in syndromic STD case management at all outpatient clinics and provision of STD drugs; screening for syphilis was introduced at antenatal clinics and supported by a TBA training programme; and prevention of ophthalmia neonatorum at birth. Clinical efficacy of algorithms was monitored as well as drug susceptibility of *Neisseria gonorrhoeae* and quality control of syphilis testing. (E) *Community education and support programme for AIDS patients* consisted in home-based care and counselling provided by a network of approximately 100 AIDS community educators (ACEs) recruited from the refugee population.

Impact of the STD/HIV programme was assessed through a repeat of the rapid STD and KABP surveys 18 months after initiation of the STD/HIV programme and review of other programmatic process indicators.

Results:

The review of the epidemiological STD/HIV situation indicated a high potential for epidemic spread given the refugee population mix, with higher HIV rates among urban Rwandan populations (35%) compared to rural Rwandans (5%) and host populations of the Ngara district of Tanzania (7%); STD rates were known to be high in both countries prior to the exodus. The pattern of *N gonorrhoeae* drug susceptibility was also different between the two countries, with widespread resistance to a larger panel of antibiotics in Rwanda.

The health facility survey confirmed the absence of STD guidelines and basic training among health staff operating in camp clinics; the rapid STD and KABP surveys as well as observations confirmed the presence and widespread utilisation of alternative STD care providers (traditional healers and market vendors).

At baseline STD and KABP surveys, men and women reported frequent experience with STDs and risky sexual behaviour prior to the exodus, with, however, a marked reduction of sexual activity during the period of exodus and establishment of camps. Despite high levels of knowledge of HIV risks and prevention measures, and self-assessment of risk, only 16%

of men admitted to using condoms during casual sex. Predictably, high levels of STDs we recorded: over 50% of ANC attenders were infected with vaginal pathogens and 3% were infected with gonorrhoea; the prevalence of urethritis was about 10% in men of whom 3% had *N gonorrhoeae* or *C trachomatis* infections; the prevalence of active syphilis was 4% among women and 6% among men.

Following the intervention, the number of self-reported STD cases at clinics increased from 20 (estimated annual incidence 0.6%) to about 250 per week (estimated annual incidence 7.5%) and over 11,000 STD cases were treated in the first 12 months of the programme. Syphilis prevalence among ANC attenders remained low at around 4 to 5%. Presence of multi-drug resistant gonococcal strains was observed: 98% of strains were resistant to tetracycline, 60% to penicillin and 15% to cotrimoxazole.

120 IEC campaigns were conducted in 18 months, reaching about 230,000 sexually active persons. Condom demand increased substantially, and about 1.5 million condoms were distributed in 12 months (~50% through peer educators).

Results from the 18-month follow-up STD survey showed little decrease in the levels of urethritis among men in the community and in the levels of cervical infections among women attending ANC clinics. However, the prevalence of vaginal infections had decreased and the prevalence of syphilis remained at low levels. The results were consistent with a mitigation of impact of the STD epidemic given the circumstances.

Sexual behaviour patterns did not appear to have changed much in this population, with even perhaps an indication of increased levels of paid/transactional sex and widespread levels of (sexual) violence particularly against women and young people.

Conclusions:

Refugee populations are often exposed to increased risks of STDs including HIV. Reproductive health issues should be addressed early during a refugee crisis. STD case detection and management should be improved by training health workers using the WHO

syndromic approach, and through IEC campaign encouraging attendance at clinics, but algorithms and choice of highly effective drugs should be tailored to circumstances and monitored. Efforts should focus also on reaching vulnerable groups in the community such as young people, women, and people living with AIDS. Rapid situation analysis methods may provide quick and useful information at low cost in refugee camps but should be refined and combined with other programme indicators measuring process and quality of services. Impact of specific interventions on the health status of refugees is not easily measured and this area needs further research.

References - See notes [2] [3] [4] [5] below.

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[2] *AIDSCaption Suppl* on refugee situation (J Benjamin's paper on Rwanda), 1997 and AIDSCAP/FHI electronic library, 1997.

[3] Mayaud P, Msuya W, Todd J, *et al.* STD rapid assessment in Rwandan refugee camps in Tanzania. *Genitourin Med* 1997; 73: 33-8.

[4] Msuya W, Mayaud P, Mkanje R, Grosskurth H. Taking early action in emergencies to reduce the spread of STDs and HIV. *Africa Health*, 1996; July: p24.

[5] Mkanje R. STD/HIV programme in Rwandan refugee camps in Tanzania. In: UK NGO AIDS Consortium. Refugees, displaced people and their vulnerability to HIV/AIDS. London 1996.

Case Study V: Socio-economic issues of HIV and emergencies in Honduras by Maria Esther Artiles

POVERTY

Before tropical storm MITCH in October 1998, Honduras was already one of the poorest countries in Latin America. According to the Economic Commission for Latin America (CEPAL) (Inforpress, Guatemala, January 1999) damages to the country were valued at more than US$ 5 billion. This figure is double that sustained as a result of Hurricane George earlier in 1998, and five times that sustained by the country as a result of Hurricane FiFi 25 years ago. It is also more than twice the damage sustained by all of the other affected countries in the region, which suffered damages of US$2 billion altogether. The President of the Central Bank has stated that the country is in economic recession and estimated that the GDP for the next few years will be -1%, thus positioning Honduras as one of the poorest countries in the continent. The government estimates that during the first two months following MITCH, Hondurans received USD 300 million of humanitarian aid, in food, clothing, medicines and basic infrastructure repair (for shelter provision and telephone, water, electrical services etc.), as well as a financial aid worth more than US$ 5 million. Both donor agencies and international organisations in Honduras have noted the extent to which the government made important steps to manage these resources with transparency.

Honduras has a population of 5.8 million people. It has been estimated that approximately 560,000 people have been severely affected. Save the Children Fund (UK) estimated that at least 280,000 of these are children and young people. According to Tegucigalpa's City Major's Office, at least 40% of women (most of them single mothers) working in the informal sector of Tegucigalpa and Comayaguela lost their patrimony, with a total loss of 800 million Lempiras (more than US$ 5 million). Throughout the country, the disaster has left many Hondurans without housing, employment, land for cultivation, and infrastructure with which to transport goods from one area to another. The impact of the disaster upon the large numbers of urban poor has been particularly significant: the marginal areas in which they traditionally live - around bridges, in areas corresponding to the natural paths of rivers,

on land prone to landslides or seismic activity - were particularly vulnerable to the effects of the storm and the widespread flooding that came with the rains. At the time of writing (6 months after the event) more than 5,000 families (approximately 30,000 people) are still living in overcrowded communal shelters, having lost everything. Still, today, one can clearly see the effects of MITCH throughout the country in all sectors of activity and among all strata of society.

Although not as visibly, however, MITCH has had an impact on conditions which promote the spread of HIV/AIDS in Honduras. Before MITCH, Honduras held the third place for HIV/AIDS prevalence in Latin America, after Haiti and Brazil. It also had the highest number of cases of people living with HIV/AIDS of the Central American region (57%). Epidemiologists have estimated that, so far, 39,000 people are HIV positive in the country, with a concentration of impact in the age range of 15 to 29 years with a heterosexual pattern of infection. The Ministry of Health reported 13,252 cases of HIV/AIDS for March 1999, with an asymptomatic population of 2, 978. At least 3, 041 of these cases are concentrated in the city of San Pedro Sula. The latest figures show 502 accumulated cases in children of 0-4 years of age (4.8%) and 350 cases in the age range of 15-19 (3.5%). The General Report of the Impact of Hurricane MITCH on People Living with HIV/AIDS, issued by UNDP in Tegucigalpa, indicates that 440 children younger than 15 have developed AIDS, 95% of whom acquired it via perinatal transmission. So far, 33% of the infected population is made up of women showing a tendency to reach a one to one proportion in relation to the men infected (1.8:1). Mortality associated with AIDS among women of reproductive age for 1997 was 25/100,000 WRA compared to 5/100,000 WRA reported for 1990.

According to the Foundation for Health Promotion, a national NGO partly funded by Family Health International, one of the immediate effects of the emergency is a 30-50% underreporting of cases due to the damage suffered by the health infrastructure and the displacement of people from one region to another. This is also associated with the initial concentration of the medical staff on epidemiological surveillance as the emergency demanded. The number of cases post MITCH cannot be ascertained until the window period ends in May, and the quarterly report is produced in July. It is expected to be considerably

higher than the reported figures before the event.

Although the use of child labour as a survival strategy is not new to the families in the country, an increase of it was observed almost immediately after the emergency. Children are at risk by exposure to toxic materials while involved in cleaning activities and selling of goods. While on the street they are threatened by sexual violence and exploitation. School attendance is a problem for most children living in the shelters due to displacement and lack of resources, and as a result, they remain on the streets of the city. Dr. Donald Kaminsky of the national NGO FUNDAR, reported 200-260 new children on the streets of Tegucigalpa due to the impact of the emergency. Covenant House estimates that as a consequence of MITCH, 5,000 children will be in this condition in addition to the 5,000 accounted for in 1995. Street educators at this institution indicated that at least 20% of these are expected to be girls.

The two main markets in the neighbouring city of Comayaguela were completely destroyed and with them a place used by the children as makeshift shelters before MITCH. These were also places traditionally used by them to obtain money for their basic necessities through selling goods or helping shoppers carry their bags.

The Fraternidad Sampedrana del Niño in San Pedro Sula reported an increase of girls involved in sexual exploitation or at risk of it. This institution reportedly has opened an office to specifically handle the prevention of sexual exploitation in this city.

Migration associated with the loss of housing and employment is critical from one community to another and it is happening nation-wide. The most attractive areas are those at the north coast, mainly Cortes, where the assembly factories for export (maquilas) are a promising source of employment but where the epidemic has the highest number of cases. For example, a mother in Choluteca (a town in the southern part of Honduras where the impact of the emergency was very high) reportedly left her children in the charge of her oldest daughter to go to the northern coast in search of employment. Her children now live off the good will of people from the community.

The borders show a very busy traffic of persons involved in commerce, an activity where the returns of investment can be obtained in the short term. This increases the potential for dissemination of HIV/AIDS. Furthermore, the mobility of risk groups (i.e. commercial sex workers) is taking place due to the search for new customers at places where sexual tourism is high such as San Pedro Sula, La Ceiba, Comayagua and Tegucigalpa.

Sexual Violence

An increase in domestic violence and sexual violence is evidenced in the continuous reports made by the press of the country. The victims, most of which are women and children, are therefore at higher risk of HIV/AIDS.

Limited Access to Education and Health Services

The response capacity of the health and education sectors was severely diminished as a consequence of MITCH. The school year was suspended and the education infrastructure used as shelter facilities around the country. The Ministry of Health conducted a 3 month emergency intervention to attend the population affected and to cater for the needs of HIV positive or people with AIDS and other opportunistic illnesses. This also includes HIV positive children who had initiated treatment with anti-retroviral medication.

In spite of very significant efforts to provide Hondurans with an education for HIV/AIDS prevention through the media, this has been unsuccessful in modifying their behaviour towards the promotion of sexual health. In general terms, the impact of MITCH is not perceived as a threat to the problem of HIV/AIDS in the country. According to the STD, HIV/AIDS Division at the Ministry of Health, one of the most critical areas and challenges to address the problem of HIV/AIDS in the country is associated with the lack of empowerment of civil society in the fight against the epidemic. Furthermore, a gap is apparent between its evolution and the national institutional response due to administrative and political limitations.

Through INTERFOROS, civil society has pointed out that the central efforts are placed heavily on the physical reconstruction of the country, which makes up for most of the National Reconstruction Plan presented at Stockholm, at the expense of incrementing the social vulnerability of the people. Areas of vulnerability such as the threat of HIV/AIDS posed by the emergency are not considered of critical importance.

The Central American Meeting of Women for Reconstruction "Exercising Power for Equity" demanded the governments "to guarantee women the right to health, taking into consideration their vulnerability to HIV/AIDS as a cause of mortality" as well as an Equal Opportunity Law effective in all states of the region.

An official emergency plan, funded by international co-operation agencies, was devised in order to face the impact of MITCH on STD HIV/AIDS with preventative action taken as well as direct assistance. It involves the private sector and the population in shelters to educational efforts. Working in co-ordination with other sectors will be attempted in order to avoid duplication of efforts and maximise use of human and financial resources.

At the NGO level, most international co-operation agencies attempted without success to face the emergency in a co-ordinated way. For the most part, each agency managed the needs of their own target population with a considerable loss of the potential geographical and social impact expected. The majority of those consulted for this presentation reported the paralysis of activities for STD HIV/AIDS prevention in favour of provision of food, shelter and medical care for the first few months after the event. This was also reflected in the STD HIV/AIDS prevention project, which SCF is implementing with Plan International in 10 provinces of Honduras. The health staff involved in the project could not continue with the regular STD HIV/AIDS prevention activities because they were called to participate in the National Campaign for the prevention of epidemics such as cholera, malaria and dengue. The teachers were involved in activities within the shelters and since the school year was cancelled by the Ministry of Education the student counsellors on HIV/AIDS prevention were not able to conduct prevention activities independently of the facilitator. However, the

organisation level achieved by the project is responding and the Committees Against HIV/AIDS made up by students, teachers and health staff are implementing their action plans. It is very important that agencies do not redirect funding originally planned for this area but that on the contrary, more aggressive strategies are devised to address the problem on a mid-term basis.

CASE STORY: WENDY

Mine is a troubled life. My story is about living on the streets. I don't have help from anybody in my family. They are very strict. My parents don't help me because I have a drug problem. I have been on the street since I left my house when I was 12 years old because my cousin tried to rape me. Then I stole a gold chain and I was sent to jail but I escaped. While on the street I got into a fight that put me in the hospital with a fractured neck. I was wounded by a thief who stole my hat and 200 Lempiras three days ago. That had never happened to me before. I followed him until I fainted because I was losing so much blood. I was picked up by the Red Cross and taken to a hospital.

I fell in love with a guy. I hadn't even had a period when I got involved with him. The only thing I knew is that blood came out of the body. He made a home for me and we lived together for a while but then we broke up. I realised I was pregnant when I had the morning sickness. I didn't suspect anything until my mother-in-law told me I probably was with child and took me to the health centre. I was very worried about it. I was 15 then, I didn't know what it meant to have a child. That first pregnancy ended up in abortion. Now I have two children, a 4 year-old boy and an 8 month-old baby girl. I abandoned the boy because his father used to beat me up a lot. I stayed with him as long as I did because my mother-in-law was very good to me, she treated me like a mother. She still treats me well but she doesn't let me see my baby even for a day. I am grateful to God because he has protected him. When I have money I buy things for my children. She makes the mistake of not letting me see my son. She should let me see him as she did before.

I have had many different jobs. I work for my food and I work for my drugs. I worked in

'maquila' factories in San Pedro, in restaurants and markets, but I was not able to keep those jobs because I got sick and took up drugs. I have not been able to get ahead because I sniffed glue, smoked marihuana, took pills, smoked cigarettes and drank alcohol. When MITCH came my boyfriend and I lost 2 'chicleras' - a stand used to sell candy - worth 300 Lempiras each. We almost drowned near the river by the Juan Ramon Molina bridge where we were renting a room. The owner yelled for us to get out of there but we did not pay attention. Next thing we knew we had the water up to our chests. That's when I told him to get me out of there, I felt we were going to die. My boy saved me but in doing so he almost drowned. He held on to some things in the water and he managed to get out an hour later. He swallowed a lot of that water. Every thing we owned was taken by the river.

My blood test came out positive for HIV. I am ashamed of it and all .... It is a sad thing .... It was explained to me here that I got this because I had sex without using a condom. Men don't like to use condoms, I don't know why; some say that one doesn't want to have their children. I don't know who I got it from, maybe it happened because two of my boyfriends were inmates at the penitentiary; they live with many women.... Once I went with a man who gave me 50 Lempiras to be with him... My boyfriend knows I am infected, but he doesn't like to use condoms. Now I don't have sex with him or others, because I don't want to infect anybody...

What Wendy wants most in life she leaves in the hands of God. She would like to stay away from bad company, away from drugs and from the street to get ahead in life. She wants to have her parents back and live within her family in the company of her children. She wants the man who attacked her to be put in jail. She feels that at the Covenant House she is well taken care of. While she recovers from her wound she receives the benefits of the programme. She has been doing some art work, which she shows with pride. At 18, she feels she will be able to get the education that her family couldn't provide.

What Wendy has not told us is the amount of guilt she feels about her diagnosis. It is strongly suspected that she has been involved in sex with multiple partners. The HIV/AIDS status of her baby girl is unknown.

LESSONS LEARNT

The emergency raised many issues within the international co-operation, the community, women's groups, government and civil society in general.

- **Emergency preparedness.** The extent of the emergency surpassed the country's possibilities. In spite of the existence of government structures especially created for this purpose, these went into crisis and within a month were substituted by privately managed ones, which could carry out information management and emergency related activities. Since the country, and especially the cities of Tegucigalpa, Comayaguela and Choluteca are very vulnerable to disasters, contingency plans need to be devised within the organisations working with vulnerable populations such as women and children and the elderly.

- **Child rights promotion, particularly the prevention of child violence and HIV AIDS work, needs to be undertaken at the same time as the provision of basic necessities takes place.**

- **Access to information.** Validated information was not available from government sources due to problems of isolation of certain communities and lack of communication. An Information and Communication Strategy with messages directed to children in psychological distress needs to be devised. The shelter population needs to be screened in order to provide better attention to the needs of those infected. The population needs to become aware of the threat that HIV/AIDS poses to their lives and how the consequences of the emergency aggravate the vulnerability of the country to the epidemic.

- **National and International NGOs as well as government agencies need to achieve the organisational level required to work in a co-ordinated way in order to achieve greater impact.** Strategic alliances need to be made in order to achieve this. When possible, funding allocated for HIV/AIDS prevention should not be redirected to immediate needs of the population. UNAIDS, PMA, UNPF and the Programme for Action on HIV/AIDS of

Central America have initiated co-ordinated action. Support needs to be provided to the co-ordination of the national response to the epidemic.

- **In order to achieve the stabilisation of the epidemic in the country, prevention activities must be accompanied by attention to the needs of the infected population.** The development of community mechanisms of action in case of disasters and the attention and prevention of HIV/AIDS spread in the affected communities is an urgent need.

- **Development projects must have an HIV/AIDS prevention component in order to achieve long term sustainability.**

- **Community organisation efforts are an urgent necessity in order to conduct prevention, awareness raising and promotion of non-discrimination towards infected as well as affected people.**

- **The process of empowerment construction among women needs to be strengthened and this should involve working with men in order to reduce the vulnerabilities the country is facing at the present.**

- **The transparency efforts in humanitarian aid management proved to be beneficial for the country's eligibility for humanitarian aid.** Efforts need to be applied in order to avoid discrimination in the assignation of benefits among both the infected and affected population.

Section 4: Current Policies & Guidelines

Research carried out in advance of the seminar revealed that many agencies do not have written policies on HIV/AIDS in emergencies. For those that do, such policy often focuses on the immediate causes of vulnerability to HIV rather than on the underlying forces that lead to such vulnerability. This leads to an approach that is largely biomedical, addressing issues such as safe blood transfusions, universal precautions for health workers, health education to promote a reduction in risk-taking behaviour, condom social marketing and prevention and management of sexually transmitted diseases (STDs). However, some guidelines produced by agencies do address the underlying vulnerability of refugees to HIV/AIDS by outlining approaches to increase the protection of women and children for example.

4.1 A Brief Review of Policies of various UN Agencies

UNHCR updated its policy on HIV/AIDS in 1998. The policy statement indicates that:

"HIV/AIDS must be addressed within the refugee environment in the earliest stage of an emergency situation and throughout the stabilisation period....HIV prevention and strategies should have a multi-sectoral approach, and integrate well with all areas of refugee assistance and protection including education, protection and security, health/reproductive health, and community services.....UNHCR should co-ordinate with the national AIDS programme and establish open and collaborative communications with host country authorities to ensure effective HIV programming.....Voluntary counselling and testing (VCT) can be considered if existing preconditions will allow complete compliance with all guidelines that are crucial in conducting VCT...however UNHCR strictly opposes mandatory HIV testing of refugees because of the risk of indirect violation of human rights through discriminatory consequences...resettlement of refugees living with HIV are difficult and must be given special attention to avoid placing these persons at greater risk of discrimination, refoulement and institutionalisation"[36]

4.1.1 Guidelines on HIV/AIDS in Emergency Settings. UNAIDS/WHO/UNHCR

UNAIDS in collaboration with WHO and UNHCR produced Guidelines on HIV Interventions in Emergency Situations[37], that set out recommended interventions for what it defines as the five stages of an emergency (destabilising event; loss of essential services; restoration of essential services; relative stability; relative normality).

During the destabilising event, the Guidelines recommend:

- ensuring an HIV-free blood supply for transfusion;
- ensuring basic information is available on the HIV and STD situation for relief workers and others going into the field.

During this stage, efforts should be focused on planning and assessment for future events.

During the acute stage of the emergency, where there has been a loss of essential services, and a breakdown in the political and social order and in the physical infrastructure, the Guidelines recommend the implementation of the Essential Minimum Package (EMP):

- adherence to universal medical precautions. These consist of: hand washing; use of protective clothing including gloves; safe handling of sharp instruments; safe disposal of medical waste including sharps; and decontamination of instruments and equipment.
- measures to ensure safe blood transfusions, for example, using blood substitutes wherever possible.
- provision of basic HIV/AIDS information; where existing health care structures have broken down or do not exist for refugee populations, there is a need for appropriate and basic information on prevention of HIV and care for those with HIV. Methods of dissemination should be culturally sensitive.
- provision of a free supply of condoms – in the AIDS era, condoms should be considered to be an essential item in emergency relief supply. Agencies also need to consider the means of distribution, taking into account the need to ensure that the most vulnerable populations have access to them.

According to the guidelines, the most urgent task in the acute phase is to ensure that condoms are available to all that seek them.

Once essential services have been restored, the Guidelines suggest that agencies can begin to develop more sophisticated and proactive HIV/AIDS interventions. This will include:

- gathering further information on HIV and STD situation in affected areas prior to the emergency;
- understanding existing risk behaviour and attitudes and designing interventions to reduce risk behaviour and discrimination against people with HIV/AIDS;
- produce information and undertake educational and condom promotion activities aimed at encouraging safer sexual behaviour among refugees and surrounding community;
- establishing a programme for the control of STDs including treatment;
- providing care for people with HIV and AIDS, through clinical management and early diagnosis, nursing care, counselling services and the development of social support

It is recognised that these guidelines are slightly health oriented and that the social and economic problems associated with HIV prevention and care are not fully addressed, for example gender issues, support for young people, gender-based sexual violence and so on. There are plans to update the guidelines in the year 2000.

4.1.2 A Field Manual for Reproductive Health in Refugee Situations

The Interagency Field Manual for Reproductive Health in Refugee Situations[38] was developed by UN, governmental and non-governmental organisations and technical experts at a symposium in 1995, and updated in 1999. The manual recommends the provision of a Minimum Initial Service Package (MISP) for reproductive health in refugee settings at the initial stages of an emergency situation. This incorporates most of the Essential Minimum Package described above, but also includes:

- prevention and management of consequences of sexual and gender-based violence;
- planning for provision of comprehensive reproductive health services, integrated into primary health care as soon as possible.
- A focus on the reproductive health of young people

Special programmes need to be developed to mitigate the physical, psychological and social consequences of sexual violence. Recommendations to address the problems experienced by victims of sexual violence include: the use of emergency post-coital contraception; the provision of voluntary counselling and testing for pregnant women; and, the use of same sex medical staff to treat victims.

The manual recommends that the MISP should be followed by a more comprehensive intervention after the acute emergency period is over.

4.1.3 Guidelines for the Protection of Refugee Women. UNHCR

The Guidelines for the Protection of Refugee Women produced by UNHCR in 1991[39] provide guidance for practitioners that address many of the problems associated with factors that perpetuate the spread of HIV in emergency situations especially in the context of gender-based sexual violence, access to health care, education and skills training, economic activities, access to food, water and fuel, and legal and protection procedures. The guidelines include a framework for assessment and planning. The adoption of such guidelines at the planning stages of an emergency response would address many of the vulnerabilities to HIV/AIDS by women and girls in camp situations. However, the response in displaced populations outside a camp environment is less clear.

4.1.4 Sexual Violence against Refugees: UNHCR Guidelines on Prevention and Response

The Guidelines on the prevention and response of sexual violence against refugees[40] examine the situation of sexual violence in refugee settings, outline preventive measures, address practical guidelines on responding to incidents, and cover legal aspects including

international law.

4.1.5 UNHCR's Guidelines on Women and Sexual Violence (1995)

These define four elements related to camp design that may increase the vulnerability of individuals to attack and sexual coercion:

1. **Geographical Location:** if the camp is located in an area that has serious crime or is geographically isolated from the local population;

2. **Design and Social Structure:** Overcrowding; unrelated families may have to share communal space (which may force them to live in close contact with individuals traditionally considered enemies);

3. **Poor design of services and facilities:** Factors such as lighting, and the location of latrines, fuel, and water can increase the vulnerability of women and girls to attack and rape;

4. **Lack of police protection and general lawlessness** where police officers or military personnel are involved in acts of sexual abuse or exploitation or are unable to maintain control.

4.1.6 Action for the Rights of Children: A Training and Capacity-Building initiative on behalf of Refugee Children and Adolescents[41]

Action for the Rights of Children (ARC) is a collaborative initiative between UNHCR and the International Save the Children Alliance. ARC aims to increase the capacity of UNHCR, government and NGO field staff to protect and care for children and adolescents during all stages of refugee situations from emergency interventions to durable solutions. ARC is a compendium of training materials that uses an innovative, participatory approach to cover a range of critical issues affecting children and adolescents using an age-gender perspective to ensure that girls and boys equally benefit from all protection and assistance efforts. Issues covered are unaccompanied children; child soldiers; education (including land mine

awareness and girls' education); child and adolescent preventive health (including HIV/AIDS and STDs), disability; exploitation and abuse; and durable solutions.

4.1.7 Untapped Potential: Adolescents affected by armed conflict

This publication produced by the Women's Commission for Refugee Women and children, covers reproductive health, HIV/AIDS, gender-based sexual violence, protection, child soldiers, health, education, livelihood and social issues in relation to young people. There are examples of programming practice and review of policies.[42]

4.1.8 Meeting an urgent and unmet need: making reproductive health services available and accessible to forcibly displaced young people. WHO

This publication by the Department of Child & Adolescent Health & Development, WHO, covers why young people are forcibly displaced and what are their circumstances. It then looks at sexual violence and strategies for the provision of reproductive health services to displaced young people.

4.2 Agreed Minimum Standards and NGO Policies

4.2.1 The Sphere Project

The Sphere project is a programme of the Steering Committee for Humanitarian Response (SCHR) and interacts with VOICE, ICRC, and ICVA. The project was launched in 1997 to develop a set of universal minimum standards in core areas of humanitarian assistance. The second edition includes HIV/AIDS and gender issues.[43]

4.2.2 NGO Policies

As mentioned previously, many NGOs have not addressed HIV/AIDS and conflicts and disasters at a policy level. Save the Children UK has an overall HIV/AIDS policy with one section devoted to emergencies, children and young people and HIV/AIDS. MSF has developed an AIDS Policy Paper, which defines a general framework for their interventions,

applicable to emergency situations and longer-term projects. It outlines 10 priority interventions, the first seven of which are medical interventions concerned with safe practices for transfusions and injections, sterilisation and disposal of medical waste, protection of health workers, medical management of AIDS cases and STD control. These are compulsory and must be implemented by all MSF missions from the start. Promotion of safer sex and patient counselling/social support are also essential and should be developed progressively, according to local needs, resources and capacities. A number of agencies have produced HIV/AIDS policies for staff that set out the organisation's position on employment, prevention, testing, care, insurance, confidentiality and support.

In the period since this seminar, CAFOD has developed a leaflet setting out guidelines for those working in emergency situations[44]. Intended for use in the first instance by CAFOD programme staff and by partner organisations supported by CAFOD, this resource is being piloted with eight partner organisations worldwide and it is hoped to have a revised version more widely available by November 2001

4.3 Practice within NGOs

Information on 13 HIV/AIDS programmes for displaced people, carried-out by 7 NGOs was collected during research by Merlin. Many of these programmes were initiated after the initial emergency period was over:

- **AMREF** and **CARE** (the latter in conjunction with **AIDSCAP**, **JSI** and **PSI**) have carried out HIV/AIDS programmes starting approximately four months after the refugee crisis began in Rwanda in 1994.
- **SCF (UK)** have carried out programmes for refugees in Liberia, Nepal, Sudan and Uganda.
- **CAFOD** supports local NGO partners who have programmes for refugees in Liberia, Rwanda and Burma.
- Other NGOs carrying out activities in Tanzania in 1994 include **ACORD** (East Africa Regional AIDS program) and the **Tanzanian Red Cross**.

Table 1: The major types of intervention in the above programmes

Rank	Type of Intervention	Number of programmes
1	Promotion of safer sexual behaviour	13
2	Distribution of condoms	8 -10
3	Strengthening and support of health units -- STD services, equipment, training	6
4	Home based care for terminally ill	3
5	Income generation activities to support orphan care takers	1

Section 5: Conclusions & Recommendations

5.1 Conclusions

Group discussions in the seminar revealed that a number of agencies have included consideration of HIV/AIDS in their response to emergencies. Although the actual nature of the interventions varied according to the context and to the agency concerned interventions with an HIV/AIDS component have included:

- a rapid STD assessment in Rwandan refugee camps in Tanzania;
- the provision of clean needles at all medical units, and the use of sterile techniques;
- care in the location of latrines and water points to reduce the possibilities of sexual violence (through the inclusion of women in the camp planning process);
- the establishment and support of women's groups;
- the provision of safe abortion kits;
- the provision of treatment and counselling for women who have suffered from sexual violence;
- Education and the supply of condoms to local peacekeeping forces.
- Reproductive health services for young people

Despite these examples, participants observed that the response to date has been limited and all too often confined to narrowly medical issues like e.g. providing safe blood for transfusions. HIV/AIDS does not occupy much attention of the policy makers in emergency organisations. Reasons for this included:

- the difficulties in obtaining data on the HIV/AIDS situation. Such information was often difficult to collect in a 'normal' setting, let alone in a context of violent conflict and mass displacement;
- the difficulties of understanding the context in which HIV/AIDS infection is

occurring, especially when societies are undergoing crisis;

- the lack of 'visibility' of the problem. The effects of increased vulnerability to HIV/AIDS may only become apparent a long time after the immediate crisis;
- the lack of staff capacity, busy responding to other emergency needs;
- the scale of the problem and the difficulties in knowing how best to tackle issues associated with HIV/AIDS;
- the difficulties of accessing women, due to existing male-dominated power structures;
- the lack of proof of the effectiveness of HIV/AIDS interventions;
- the difficulties of ensuring confidentiality for those tested;
- the lack of prioritisation of the issue by local decision-makers;
- the 'compartmentalisation' of HIV/AIDS as a health issue, and not something for wider discussion;

Where agencies have most experience of HIV/AIDS and emergencies is in longer-term programmes, implemented after the initial crisis had abated. Such programmes include interventions aimed at reducing the levels of sexual violence, the provision of support for vulnerable groups, the provision of condoms and care of those with AIDS and tuberculosis. Many participants noted that teams responding to the immediate emergency too often believe that HIV/AIDS considerations do not apply to their work and should be left to those who follow with longer-term programmes.

5.2 Recommendations

5.2.1 Develop an HIV/AIDS Policy or Integrate HIV/AIDS into existing Policy and increase staff capacity

Too often field workers are concerned about HIV/AIDS but are not aware of their organisational position on the issue, do not know how to deal with it or how to integrate it into to everyday work. If Aid agencies are truly committed to the saving of lives, then HIV/AIDS must be addressed at the policy level. In order to encourage this, more discussion

with and between agencies should be fostered [through initiatives such as the seminar].

Donors could ask to see policies on HIV/AIDS integrated into emergency programmes and could monitor what is being done in practice.

Resources will need to be made available to train staff and to provide support for existing and future interventions. HIV/AIDS must become an integral component of emergency preparedness and programming. There is a need to include relevant indicators to reflect the impact of HIV interventions in the monitoring and evaluation process of programmes. There is also a need to provide training on international instruments that exist to support HIV/AIDS programming, for example the UN Convention on the Rights of the Child and the Convention on the Elimination of Discrimination Against Women.

By not providing HIV prevention, care and support, or treatment and counselling of women who have been sexually violated, agencies are denying refugee and displaced people their basic rights. International organisations need to monitor the implementation of these international instruments alongside practitioners and draw attention to gaps and lack of implementation.

Review existing Policies & Guidelines, and distribute up to date resources

Many policies and guidelines are not updated to integrate HIV/AIDS issues. As HIV/AIDS is a relatively new subject, and a sensitive one, there is often a reluctance to update policies and guidelines. However, new materials are becoming available all the time and there needs to be a concerted effort by international agencies to prioritise, fund and distribute useful guidelines and policy to organisations and field practitioners (see 3.3 below). Agencies need guidance in reviewing their policies and need updating on what resources are available.

Seminar participants commented that despite the existence of an HIV-related UNHCR policy many personnel in emergency and displaced settings do not put the policy into practice. UNHCR must ensure that all staff are aware of its HIV/AIDS policy. In the execution of its

co-ordinating role in emergency and displaced situations UNHCR should ensure that HIV/AIDS is put on the agenda at the planning stages and that NGOs take responsibility for putting initiatives into practice.

5.2.3 Evaluate what works well in HIV/AIDS programming in emergency and displaced situations and develop documentation on how to integrate HIV/AIDS into different sectoral areas

The case studies presented in this report indicate lessons learnt and make recommendations for future programming. However, more generally, there is a lack of analysis to date on what works and what doesn't in planning and programming with HIV/AIDS in conflict, disaster and migration situations. Information and evaluations have not been synthesised and analysed to recommend on good practice.

This publication has looked at some of the current policies and practice; however, further research is needed to bring together documentation and analysis on interventions to date to further inform good practice. Often policy makers and practitioners are required to integrate HIV/AIDS into existing sectoral work. However, many organisations do not have the capacity or know-how to do this. Further guidance and documentation is necessary in user-friendly handbook form to address this.

5.2.4. A multi-sectoral & integrated response

To avoid the increase in vulnerability to HIV/AIDS in emergency and displaced settings it is necessary to have a holistic response and address all the factors that contribute to the spread of HIV in emergencies (for example, aspects as diverse as blood safety, tuberculosis, sexual violence, security, reducing boredom, decisions about who controls basic resources etc). In many responses it is tempting to address one or two aspects of the problem and feel confident that the situation is dealt with. However, by doing this agencies will only deal with HIV/AIDS issues in a cosmetic fashion: unless the problem is dealt with comprehensively by addressing causal factors, agencies are simply dealing with the symptoms. Core to this holistic approach is a multi-sectoral response involving:

- protection of legal rights and human rights issues for refugees and displaced people;
- gender-sensitive layout of camp or other temporary accommodation provided;
- gender-sensitive planning of access to food, water, fuel and resources;
- the provision of reproductive health services, including gender sensitive HIV/AIDS education and condom distribution, and care for people living with HIV/AIDS;
- improvement of overall health provision;
- the adoption of universal precautions for *all* instances of contact with blood or clinical waste;
- Increased training of staff to help them overcome fears and prejudices towards people affected by HIV;
- An integrated approach to provision of health- and social services;
- education, skills training and social and economic opportunities directed at women, children and young people;
- guaranteed respect for the rights to medical care of people with HIV or AIDS;
- an approach that overcomes the difficulties of identifying people with HIV/AIDS without increasing stigma and prejudice;
- the separation of the military and combatants from civilian populations where possible;
- the active participation of host country/community and incorporation of local resources whenever possible to ensure that any HIV/AIDS initiatives taken are sustainable. Efforts should be made to overcome the resistance of some church groups or other local actors to addressing HIV;
- The active participation of displaced people/refugees as far as possible and depending on available skills and capacity;
- Documentation of more case studies and experiences of good practice;
- the integration of HIV/AIDS into existing programme work where agencies are already working in affected areas. This can be started by doing a needs assessment (see below).

5.2.5 Carry out a needs assessment that integrates HIV and that is gender sensitive

It is imperative that the issue of HIV is addressed at the needs assessment stage of any agency response. In so many instances agencies start to deal with HIV after basic needs have been met. This lack of preparedness makes it more difficult to set up a relevant response and to obtain funding for it. The issue of gender needs to be addressed within this context to reflect the fact that the majority of refugees are women and children, and women and girls are particularly vulnerable to HIV both biologically and socially in an emergency context.

Even before a needs assessment is completed, in any new refugee situation agencies should:[45]

- ensure universal precautions are applied in every situation involving contact with blood or clinical waste;
- guarantee the availability of free condoms
- identify a person responsible for co-ordinating activities

As a general rule field staff should act on the assumption that sexual and gender-based violence is a problem unless they have conclusive proof that this is not the case.

The needs assessment should include the collection of information on the following issues:[46]

- the prevalence of STDs and HIV in the host and home country, area, region;
- specific risk situations within the refugee settlement which should be targeted with specifically tailored interventions;
- the cultural beliefs, attitudes and practices concerning sexuality, reproductive health, STDs and HIV/AIDS through formative (qualitative) research using focus groups and interviews;
- whether illicit drugs used and if so how and by whom
- what forms of sexual and gender-based violence are occurring, in what circumstances and who the perpetrators are

- Whether women, children and young people have the opportunity to develop skills and educational opportunities.
- Whether there are any ways of earning an income except by exchanging sex for money and resources

5.2.6 Ensure a greater focus on gender-based sexual violence

This is one of the most sensitive areas of work in emergency situations. International and national agencies often deny rape is an issue in emergency situations and this hampers any intervention to support victims. International and national staff need training on the rights of refugees and displaced people to support in event of rape and sexual violence. Human Resource Departments of organisations need to incorporate pertinent questions on HIV/AIDS, gender, ageism, disability and attitudes to sexual violence when recruiting staff to work in emergencies. Emergency programming should address sexual violence at the level of policy and practice.

5.2.7 Encourage greater focus on the military and combatants

The military and combatants play a major role in emergency conflict and post-conflict situations. Earlier sections of this report describe some of the factors that perpetuate the spread of HIV/AIDS in relation to the military. National infrastructure needs to make sure that military personnel have access to HIV prevention initiatives and knowledge of violations to international law where rape and sexual violence are concerned, particularly with children and young people. Military and peace-keeping forces must be made accountable for any sexual misconduct and any crimes of sexual violence they commit. The rules of war should be enforced.

International agencies using peacekeeping forces need to employ the same approach. Combatants are often hard to reach and are often beyond caring when it comes to HIV prevention.

5.2.8 An increased focus on children and young people, with particular attention to child soldiers

Women, children and young people make up the majority of refugee and displaced populations. However, very often children and young people are denied their rights to HIV prevention, care and support.

Young people are not often targeted well in emergency situations and as illustrated in this report are vulnerable to sexual abuse and exploitation, boredom, isolation, trauma and forced into fighting. There is a need to target children and young people's vulnerability to HIV/AIDS and to provide care and support where they are affected by HIV/AIDS in future emergency interventions.

5.2.9 Staff training

Staff of humanitarian response agencies need to be aware of HIV/AIDS, to have a thorough understanding of how it is transmitted, the need for protection, and the specific vulnerabilities of all refugees and displaced people to HIV/AIDS but in particular those of women and girls. Staff need relevant guidelines and policy within which to respond; they also need to be aware of the role played by the military, combatants, camp leaders and guardians in possible violations of protection.

Staff also need to be aware of their own personal vulnerability to HIV/AIDS as many may be dealing with blood, skin-piercing implements and clinical waste. Humanitarian response postings are frequently unaccompanied and unsupported. Sexual relationships are quite common and the sexual health of workers should be taken into account. The traumatising effect of emergencies on workers needs to be acknowledged and a support system provided that minimises the risk of them seeking unsafe sexual relations as a coping mechanism.

If all these factors are addressed in emergency and displaced settings then it is more likely that the transmission of HIV/AIDS will be challenged significantly in these situations and that refugee and displaced populations will be in greater possession of

their rights to HIV/AIDS prevention, care and support. Equally, aid agencies and international organisations are more likely to fulfil their mandate to save lives.

Notes

[1] UK NGO AIDS consortium. Refugees, Displaced People and their vulnerability to HIV/AIDS. Report of the Seminar in NGO Action. 28th and 29th October 1996.
[2] Ibid.
[3] UNAIDS Report on the Global HIV/AIDS epidemic, December 2000
[4] Ibid
[5] Migration & HIV: War, oppression, refugee camps fuel the spread of HIV' in *The Bridge* no 5, 3 July 1998, pp 4–5.
[6] Young H. "MERLIN Discussion Paper: HIV/AIDS Interventions in emergency Situations; Past, Present and Part of MERLIN's Future?" Feb 1999
[7] Adapted and developed from an analytical tool used in participatory learning approaches (PLA)
[8] WHO-Emergency & Humanitarian Action – Violence and Injury Prevention: violence and health. http://www.int/eha/pvi/infokit/gender.htm. March 1999.
[9] Williams, JP. Developing & Implementing Alternatives to Institutional Care Outside the Extended Family & Establishing a National Policy Framework for Policy and Practice. Paper presented at the SCF(UK) Social Policy meeting on the Social Impact of Poverty, HIV/AIDS, and Conflict on Children. Swaziland, 2-4 November 1996.
[10] Refugee Children: Guidelines on Protection and Care. 1994, UNHCR, Geneva.
[11] Benjamin, J. AIDS Prevention for Refugees: The Case of Rwandans in Tanzania. *AIDScaptions*, 1996, 3(2)
[12] Taken from 'AIDS Control and Prevention Project. Family Health International. Final Report, Volume 1'. December 31, 1997 and from discussion with Marie Stopes.
[13] UK NGO AIDS Consortium Seminar on Refugees, Displaced People and their Vulnerability to HIV/AIDS. Report of the Seminar on NGO Action, 28th-29th October 1996, London
[14] Friedman G.S. AIDS Prevention & the Church. *AIDS & Society*, Jan/Feb 1995. P:4
[15] HIV and Development: A Church-Based Development Agency's Perspective. Trócaire/CAFOD publication, in press, Spring 2001.
[16] How to Guide-Reproductive Health in Refugee Situations. Reproductive Health Education for Adolescents. IRC. February 1998. Guinea.
[17] Tewari, R. HIV/AIDS Prevention Strategies for School Age Children in South Asia: Examples and Possibilities. Save the Children.
[18] Described in *Safely through the Night. A Review of Behaviour Change in the context of HIV/AIDS*. Article by Ann Smith and John Howson, CAFOD, published in PLA Notes 37, February 2000
[19] Rahmam T. Literacy for Refugee Women: A Case Study from Nepal. *RPN*, April 1996, 21:28-29.
[20] Young H. "MERLIN Discussion Paper: HIV/AIDS Interventions in emergency Situations; Past, Present and Part of MERLIN's Future?" Feb 1999
[21] Most of this text has been published in *Gender, HIV/AIDS and Emergencies, a paper prepared by L. Elliott for Relief & Rehabilitation Network*, Overseas Development

Institute, Regents Park, London, NW1. Newsletter, Number 14, June 1999

[22] 'Migration & HIV: War, oppression, refugee camps fuel the spread of HIV' in *The Bridge* no 5, 3 July 1998

[23] Assessment Report on Sexual Violence in Kosovo by D. Serrano Fitamant consultant to UNFPA. April/May 1999

[24] 'Community Participation in a Refugee Emergency – focusing on community mobilisation, women and youth', a report from the Rwandan camps in Kagera Region of Tanzania, Radda Barnen, Stokholm 1995.

[25] 'Migration & HIV: War, oppression, refugee camps fuel the spread of HIV' in *The Bridge* no 5, 3 July 1998

[26] Bissland, J. International Protection for Refugee Women – A Case study of Violence against Somali Refugee Women in Kenya. Paper presented at the international conference on uprooted Muslin women. United Arab Emirates.

[27] Reproductive Health Consortium, 5 Day training programme. 1998.

[28] Palmer C, and A. Zwi. Women, Health, and Humanitarian Aid in Conflict. 1998. ODI, Blackwell Publishers: Oxford.

[29] General Jacques Abgrall, Deputy Director, Scientific and Technical Action, Centre Directorate of the French Army Health Services. UNAIDS Point of View: AIDS & the Military. May 1998.

[30] UNAIDS Point of View: AIDS & the Military. May 1998.

[31] Beyrer, C. War in the Blood: Sex, Politics, and AIDS in Southeast Asia. Zed Books. London. 1998.

[32] Burke, D. International Military Issues. From a report on the Berlin Seminar on HIV/AIDS in Military Populations 1993. Taken from *AIDS & Society*, July/August 1993: 4-6.

[33] UNAIDS Point of View: AIDS & the Military. May 1998.

[34] Ibid., 1998.

[35] Newspaper article by Caroline Lees circ. 1995. Undated and unsourced article entitled 'One expat. aid worker in ten picks up HIV.

[36] UNHCR Policy regarding Refugees and Acquired Immune Deficiency Syndrome, 1998, UNHCR/IOM/78/98, UNHCR/FOM/84/98

[37] Guidelines for HIV interventions in emergency settings 1996, UNAIDS/WHO/UNHCR, Geneva, Switzerland

[38] Reproductive Health in Refugee Situations: an Inter-agency Field Manual, 1999, UNHCR, Geneva, Switzerland

[39] Guidelines on the Protection of Refugee Women, 1991, UNHCR, Geneva, Switzerland

[40] Sexual Violence against Refugees: Guidelines on prevention and Response, 1995, UNHCR, Geneva, Switzerland

[41] Action for the Rights of Children: A Training and Capacity-Building initiative on behalf of Refugee Children and Adolescents, 1998, UNHCR and International save the Children Alliance

[42] Untapped potential: Adolescents affected by armed conflict. January 2000 Women's Commission for Refugee Women & Children, 122 East 42nd Street, New York, NY 10168-1289, USA.

[43] **The Sphere Project, 2000, PO Box 372, 17 Chemin des Crets, CH-1211 Geneva 19, Switzerland**

[44] **The Silent Emergency: HIV/AIDS in Conflicts and Disasters. Issues and Recommendations for those working in Emergency Situations.CAFOD. 2001**

[45] ***Reproductive Health in Refugee Situations: An Inter-Agency Field Manual*, 1995, UNHCR Geneva.**

[46] **Taken from a combination of *Reproductive Health in Refugee Situations: An Inter-agency Field Manual,* 1995, UNHCR Geneva, and *Guidelines on the Protection of Refugee Women*, 1991, UNHCR, Geneva, and filling in gaps.**