

UK Consortium on AIDS & International Development  
(formerly UK NGO AIDS Consortium)

## **Refugees, Displaced People and their Vulnerability to HIV/AIDS Report of the Seminar on NGO Action, 28-29 October 1996, London**

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The seminar was directed by the UK NGO AIDS Consortium Working Group on Refugees and Displaced People: Lyn Elliott (SCF) Ann Smith (CAFOD), Helen Elsey (ActionAid), Judy El Bushra (ACORD) Carole Collins (Oxfam), Gillian Wells (HelpAge International), Alexander Heroy (AMREF). Jane Cole was rapporteur, the report was edited by Sue Lucas.

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### **CONTENTS**

#### **SESSION 1: OVERVIEW**

Opening Address, Lyn Elliott, Save the Children Fund, London

Overview: Refugees and displaced persons: How coping strategies and circumstances increase the risks for HIV/AIDS. Judy Benjamin, Centre for Research on Epidemiology of Disasters, Belgium

An account of a personal experience Gifty Kinnah, Ghana

Discussion

#### **SESSION 2: THE UN RESPONSE**

UNHCR Kate Burns, Reproductive Health Officer, UNHCR, Geneva

UNAIDS Monica Wernette, Dept. of Country Support, UNAIDS, Geneva  
WHO Dr Takako Yasukawa, Division of Emergency and Humanitarian Action, WHO

Discussion

#### **SESSION 3: THE GOVERNMENT RESPONSE**

The government response to HIV/AIDS and its relationship to reproductive health in refugees and displaced people. Dr J Kashaija, Regional Medical Officer, Kagere, Tanzania

Responses to HIV/AIDS among refugees and migrant workers in Thailand and Burma. Jackie Pollock, Empower, Asia

An assessment of HIV prevention interventions with refugees and asylum seekers in the UK. Krishna Maharaj and Ian Warwick, Health and Education Research Unit, Institute of Education, London

Discussion

#### **SESSION 4: THE NGO RESPONSE**

HIV/AIDS, displaced/refugee populations and CARE Joan Schubert, CARE, USA

The NGO response: The African Medical and Research Foundation (AMREF) Rashid Mkanje, AMREF, Tanzania

Targeting the vulnerable: home-based care for HIV/AIDS in a refugee context in Tanzania Susan Mwita, Tanzania Red Cross Society

Discussion

#### **SESSION 5: THE HOST COMMUNITY**

NGO action to reduce vulnerability to HIV/AIDS among refugees/displaced people and the host community in Uganda Denis Nduhura, ACORD, Uganda

ACORD'S Programme in refugee affected area of Karawe, Kagera region, Tanzania, Donald Kasongi, ACORD, Tanzania

#### **SESSION 6: THE MILITARY AND GUARDIANS**

Vulnerability of displaced refugees to HIV/AIDS: the Liberian experience Anita Beyan, Save the Children, Liberia

The military and guardians Major R. Ruranga

#### **SESSION 7: REPORT FROM SMALL GROUPS on...**

1. People with HIV/AIDS
2. Women
3. Men
4. Children
5. Young people

#### **SESSION 8: SUMMING UP & RECOMMENDATIONS**

What have we learned and where do we go from here? Lyn Elliott, Save the Children Fund

Summing up: Sue Lucas, UK NGO AIDS Consortium and Calle Almedal, Norwegian Red Cross Society

Background document

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## Background

There are an estimated 15 million refugees in the world today. Three quarters of these are in Africa, and 80% are women and their children.

In addition, there are an unknown number of displaced people who have been forced from their homes but have not crossed country borders.

HIV is continuing to spread, and its impact is greatest in developing countries. In emergency situations of mass human movement, HIV often seems less important than food, shelter, water and emergency health care. But what are the long-term effects of not prioritising the risks of HIV transmission, and are displaced people at greater risk of HIV infection? If so, what are UN agencies and others who are responsible for refugees doing about this, and what can and should NGOs do?

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## Executive Summary

The aims of the seminar were:

- to look at the impact of displacement on vulnerability to HIV, and the effect of HIV infection on situations of displacement
- to consider what NGOs can and should do both immediately post-emergency and at later stages of displacement
- to share experiences between NGOs and other international and governmental organisations
- to raise awareness of the connections between HIV and displacement.

## Attendance

There were more than 90 people from 16 countries at the seminar, and there was very good representation from the south. Most participants had a background in NGO work but there were also representations from the UN, governments and universities. The seminar brought together people who were familiar with issues around HIV but had little experience of emergencies or refugee situations, and those who had emergency experience but knew little about HIV. Similarly there was experience in both emergency and development work.

The plan of the seminar was to look at the UN and government roles and then to look at how NGOs fit into this structure, what is being done and what could or should be done.

## The UN sector

UNHCR, UNAIDS and WHO presented their work in the area. UNHCR has prepared a field manual and UNAIDS guidelines. While all three agencies were clearly giving the issue the importance it deserved, there was some concern that if guidelines are seen as a major and final contribution from the UN, opportunities for more effective action may be missed. There was also a lack of clarity about the leadership role of the UN, especially UNHCR, in encouraging NGO response.

## The government sector

The session on government was probably the weakest, reflecting our stronger links with NGOs. The main point made, a valuable one which reinforces the experience of HIV work over the last ten years, is the importance of a supportive government attitude, illustrated by the contrast between work with Rwandan refugees in Tanzania and Burmese in Thailand.

The NGO session gave examples of what is being done, based on experience of CARE internationally, and AMREF and the Red Cross in Tanzania.

The second and third days were mainly in small groups, with fewer plenary sessions, and worked towards looking for practical action.

The discussions in both plenary and small groups brought out a number of controversial areas, areas where there are misconceptions, and areas where it is clear that not enough is known.

#### Controversial areas

##### The role of testing

There was controversy over whether voluntary testing and counselling should be a priority in camps, as suggested in the presentation from UNHCR. It is an area where there has been a great deal of discussion, especially through the Consortium's seminar and meetings on this issue. It was agreed that the complexities need to be fully recognised and that community development and community awareness including anti discrimination is as important in a refugee setting as in a more settled situation.

##### The role of community action and participation

Community development techniques and community-based work were clearly not well developed in refugee settings, even those where the population had been in the same place for a long time. The NGO work which had been described was based much more on the model of interventions and technical solutions than on community work. Those who had been working with HIV picked up this strongly.

##### The applicability of guidelines

While guidelines are valuable, there was controversy over whether guidelines could be applied to all circumstances, and whether the different circumstances which are relevant to displaced people can be covered by single set of guidelines, or whether each situation needs its own specific solutions.

##### The fear of stigma

For those who were unfamiliar with the work which has been done around discrimination and stigma due to HIV, the argument was still being put forward that working with HIV will only add to the problems people have and that therefore it should be a low priority. Those working with HIV stressed the importance of acknowledging that people are at risk and helping to change behaviour and attitudes in order to reduce this risk.

##### The tacit complicity with violence

Throughout the two days, the role of gender and the issues of violence against women were constantly brought out as being the most important cause of vulnerability to infection. One of the contentious issues was the role of UNHCR and other agencies in protecting vanquished forces, thus enabling them to continue to organise and carry out violence against the victors - or the perceived enemy. This has implications for justice, the rule of law and human rights, and needed much wider discussion than was possible in the seminar.

#### Areas where there are misconceptions

##### The progress of displacement

In speaking of refugees, there was a lack of clarity about whether the emergency or the later more settled phases were being discussed. As there was such a broad representation of people, for some the main issues were around refugees settled in a third country, such as the UK, and the different set of problems identified there. Displaced people may not be in an emergency situation, but there may be little prospect of their return to their homes or their resettlement elsewhere.

##### The composition of the refugee population

There is an oft quoted statistic that 80% of refugees are women and children. This is often seen as an unusual population distribution, prompting the question "where then are the men?". In fact, this reflects a normal population distribution in a developing country, where at least 50% of the population are typically under 18. In recognising this, it seems clear that the men have not disappeared, but although there they have become invisible.

The role of human rights

There is a lack of understanding of the basis of human rights, exactly what they encompass and how they can be used.

Inadequate knowledge

Identity and its relevance to vulnerability

The role of identity has not been much explored in relation to HIV. But its relevance to self-respect and the concept of belonging, both of which are crucial to enabling behaviour change and protection from HIV, are obvious. In addition, the presentation by Gifty Kinnah, herself a refugee from Liberia, underlined the protective - or destructive - role of identity, and how who you are can in an emergency situation mean life or death, rape or safety.

Distinctions and similarities between refugees and displaced people

The legal distinction between displaced people and refugees is clear enough - refugees must have crossed the border of their home country, displaced people have not. The legal difficulties facing them are different. But there may be greater similarities between long-term displaced people in their own country and long-term refugees in another country than between refugees at different stages of the process of flight and resettlement.

Different needs at different phases of an emergency and/or long term stable displacement

If the nature of the situation people find themselves in is different, their needs will be different

Different situations of displacement

We need greater clarity about what situations refugees are in at what stages of displacement, what the long-term implications are and how this affects what needs they have,

Gender issues and the role of militarisation on the sexuality of men

Gender issues were a constant theme of the seminar, and it is clear that not nearly enough is known about the reasons for violence against women in such settings, or how the training and militarisation of men affects the expression of their sexuality.

There were also "cross-cutting" issues which were brought up consistently throughout the seminar. It was clear that these are areas which have to be considered in all aspects of work with displaced people, but particularly in working in the areas of vulnerability to HIV/AIDS.

These are:

- balance between the needs of the host community and the needs of the displaced people
- balance between HIV as an emergency in ten years time and immediate emergency needs
- how to deal better with the military as refugees and how perpetuating violence adds to vulnerability

In beginning to consider future action, there were a number of themes which persistently emerged as the most serious and the most relevant to protection from HIV. These were used as the basis for thinking about future actions. They were

- the role of gender and age
- human rights
- community action
- access to information
- identity
- the military

As well as these areas of work, with their relevance to programme planning and design, the importance of work with adolescents was stressed in both plenary discussion and small groups. It was seen as part of the issues around gender and age, and the need for specific work with men, women, young people and older people, but the special needs of adolescents and their pivotal role in curbing the spread of HIV also needs to be recognised as an issue on its own.

The final stage of the seminar brought together a group of more than 20 people to look at what action can be taken in the future. These were summarised in three main groupings:

Advocacy: Human rights and identity

- planning early for long-term situations
- better UN co-ordination
- better UN/NGO co-ordination especially in recognition of needs and initiation of action
- specifically, lobbying at the UNHCR Steering Committee in October 1997 and feeding into the Steering Committee for Humanitarian Response Beneficiaries Charter

Approaches to work to reduce vulnerability

- gender training for NGO and other staff
- community based action
  - specifically, the piloting of Stepping Stones in a refugee camp setting
- training of staff in community development techniques
- work on access to information especially for women and adolescents
- dissemination of best practice in service provision and other areas including camp organisation and layout

Research on gender and the effect of militarisation

- male sexuality and the militarisation of young men/boys

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## **SESSION 1: OVERVIEW**

Opening Address

Lyn Elliott, HIV/AIDS Technical Adviser, Save the Children Fund, UK

It gives me great pleasure to welcome you all to this two-day seminar on the issue of NGO Action on Refugees and Displaced People and their vulnerability to HIV/AIDS.

We began to share our concerns on this issue through the UK NGO AIDS Consortium in 1995. A Working Group was set up to work towards the objective of bringing you all together to contribute to a seminar where experiences could be shared, gaps could be identified, and collaboration could be developed, in order that non-governmental organisations could plan and work more effectively towards reducing the vulnerability of refugees and displaced people to HIV/AIDS.

Among the participants, there is expertise on HIV/AIDS, reproductive health, sexual health, sexually-transmitted diseases, health, working with refugees and displaced people in conflict situations, military experience, gender experience, government experience, and experience of children in conflict situations. We are well placed to tackle the numerous issues relating to HIV/AIDS and the vulnerability of refugees and displaced people. I would like to give special acknowledgement to those participants who have experienced the hardships of conflict and have lived as refugees and displaced people, and to those of you who live with the virus. We cannot succeed without your contributions and are grateful that you have chosen to share them us.

One objective of the seminar was to involve participants from as many areas of the world as possible. We have participants from almost 20 countries globally. I think this is particularly important because as we all know too well HIV/AIDS is a global issue. An estimated 26 million adults and 1.5 million children have already been infected with HIV worldwide and it is estimated that approximately 10,000 new infections occur each day. Over 5 million adults, children and infants have died from AIDS to date. These figures have been reported from 193 countries globally. However, the lengthy invisibility of HIV infection has made the condition easy to ignore and this has helped the virus to spread virtually unchecked. Without the development of an effective vaccine or curative therapy in the near future, we must strive to work together collaboratively to endeavour to enhance current strategies and to develop new ones in an attempt to prevent HIV transmission, to care for people living with the virus and with AIDS, and to lessen the impact of HIV/AIDS on those affected by the virus.

Conflict and war are also global issues. A brief look at the world map indicates conflict in almost every region. Rwanda, Zaire, Burundi, Angola, Liberia in Africa; Israel, Palestine, Iraq and Kurdistan in the Middle East, the former Yugoslavia in Europe, Pakistan and India in South Asia, Burma in South East Asia to mention a few. Conflict and war result in the forced migration of people. As a result of conflict and war, there are approximately 40 million refugees and displaced people worldwide, the majority of whom are women and children. For agencies that respond to conflict situations, the most immediate concern is for people who are at the greatest risk of injury, starvation, exposure and disease. However, more recently HIV has become of increasing concern to agencies working with refugee and displaced people. The issue has been taken seriously and significant initiatives are underway:

- Ethical issues have been addressed. There are guidelines which advocate against the testing of refugee and displaced people for HIV/AIDS in order to avoid discrimination.
- Programmes on STD prevention have been set up to prevent the more efficient transmission of HIV associated with the symptoms of sexually transmitted diseases.
- Information, education and communication projects have been put in place in refugee camps, with displaced people and with the military, in order to provide knowledge on HIV/AIDS, how it is transmitted and how to prevent it
- Reproductive health programmes provide education and treatment on STDs and promote condom use.
- Health programmes provide treatment for women and children suffering from the effects of physical abuse and rape.
- There are a small number of projects which provide care of HIV positive people and people with AIDS.

We hope that the seminar will facilitate discussion on what has been achieved and whether there are any gaps that need addressing in our efforts to challenge the HIV/AIDS epidemic in the conflict environment.

Of equal importance to work achieved to date, we have a greater understanding of the complexity of the issues involved with vulnerability to HIV/AIDS in conflict situations: We know that vulnerability to sexual transmission of HIV/AIDS is increased because:

- In situations of war, women and children are at increased risk of rape and violence. Rape can involve personal injury and tearing associated with violent sex, therefore increasing the possibility of HIV transmission. Forced and consenting marriage is common in conflict situations, where many people will have lost partners. There is not only the risk of infection through rape and new sexual partners but also through mother-to-child transmission.
- Men and boys are also known to have suffered physical abuse and sexual violation in conflict situations. There is a need to acknowledge that while women and young girls make up the majority of refugee populations, and are at the greatest risk of potential HIV transmission, men and boys are vulnerable too.
- Refugees and displaced people are often located in situations where they are deprived of the capacity to generate income. Women and young girls in camps often enter into sex work to earn income, food, and to gain access to other resources and may exchange sex for protection by the military in situations of violence. In local areas around refugee camps the sex industry becomes more evident.

- Children can be particularly vulnerable to HIV transmission in the camp situation and it is known that they become sexually active at a younger age. Children can become infected with HIV from their mothers who are HIV positive, either in the uterus, during birth or from breast-feeding.

We know that HIV vulnerability can be increased where there is lack of medical supplies and equipment permitting safe blood practices; lack of access to information on HIV/AIDS/STDs and to condoms; and lack of integrated service provision to address HIV/AIDS. Are we addressing this in our work?

Finally, we are learning that we must deal with consequences of HIV/AIDS and this promotes some more daunting questions:

- What about orphaned children in the refugee/displaced situation?
- What about the growing numbers of infected people?
- Should we be linking prevention and care?
- What happens when HIV positive people need to relocate to other countries from refugee and displaced situations?

It is hoped this seminar will generate many more questions. Through the wealth of experience gathered here today, we will explore, discuss and question fully, issues relating to vulnerability of refugees and displaced people in the hope that a comprehensive foundation for further action is developed. During the seminar, the proceedings will be documented and written up in a report to reflect the discussion and input. However, it is our hope that this collaboration continues long after this seminar and the final report.

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## SESSION 1: OVERVIEW

Refugees and displaced persons: How coping strategies and circumstances increase the risks for HIV/AIDS

Judy Benjamin, Centre for Research on Epidemiology of Disasters, Belgium

My presentation focuses on how displacement and refugee status increase the risks of HIV/AIDS and other sexually transmitted diseases. The case of Rwandan refugees living in north-west Tanzania provides the main example, and I will also touch on my recent experience with Somali and Sudanese refugees living in Ethiopia. Cultural and ethnic differences impact AIDS prevention programmes. We cross cultural boundaries when we promote behaviour change to reduce HIV. It is crucial to understand the cultural practices and beliefs of the affected group of refugees.

Key components to HIV/AIDS prevention for refugees include:

- to increase understanding of the conditions of refugee life which increase HIV/STD transmission;
- to add to understanding of HIV risk behaviour, including sexual and social networking for refugees in the context of geo-political events;
- to demonstrate the success and failure of HIV/STD interventions which seek to reduce the spread of HIV among refugees and socially-fractured populations.

This approach is founded on the premise that refugee existence—characterized by social disruption, family losses and separations, sub-standard, overcrowded living conditions and poor health—contribute to the spread of sexually transmitted diseases including HIV.

Gender and class dynamics play heavily in the risk factors associated with HIV transmission. The desire to replace lost members of the ethnic group is a major influence on the fertility picture in refugee camps and directly impacts the success of AIDS prevention programme design which relies on the use of protective condoms. In a densely inhabited refugee camp

the number and frequency of possible contacts with infected individuals is higher than in normal living situations.

The dynamic aspects of the social structure of refugee life and how this may increase HIV transmission needs to be examined. How does the social structure of refugee camps transform the individual refugee's behaviour into a collective outcome?

In Ngara Tanzania, over 400,000 Hutus fled following the devastating civil war and genocidal killings. Four months after the 1994 exodus began the AIDS Control and Prevention (AIDSCAP) Project contracted with CARE International to manage a broad-based HIV/STD prevention project for Rwandan refugees. The pilot intervention was a collaborative venture with Population Services International (PSI) handling condom distribution and promotion, and John Snow Inc. (JSI) providing assessment and evaluation support.

The primary objective of the project was to reduce the transmission of HIV and STDs among Rwandan refugees. The purpose was to reduce high-risk sexual behaviour among the sexually-active camp population. The target population was all sexually-active adults (70 per cent of the population under CARE's management, approximately 100,000 people). The strategy included four major components:

- increasing the availability of free condoms;
- providing community outreach education for HIV/STD prevention;
- promoting STD treatment, education and counselling;
- integrating prevention and care.

#### Methods

A total of 100 refugees were recruited and trained as AIDS Community Educators (ACEs) to provide AIDS/STD prevention education, 16 counsellors worked in each STD treatment site, and 20 peer educator/condom promoters were trained by PSI. Several months into the project a home-based care component was added to respond to the large number of people suffering from HIV-like illnesses. Home-based care services were not limited to people with HIV symptoms. The home-based care component was co-ordinated with other NGOs (International Rescue Committee and the Tanzania Red Cross Society) to cover different camps in the Ngara area.

An initial Knowledge, Attitude, Practice and Belief (KAPB) survey and community health assessment provided important data for project implementation. During the first 12 months of the project ACEs distributed over 1.5 million condoms and delivered AIDS/STD prevention messages in one-on-one encounters and group sessions to members of their own communities and made referrals for STD treatment. Free condoms were also distributed by PSI's condom promotion team at traditional and non-traditional outlets (kiosks, markets, bars, restaurants, and sports events).

Behaviour change communication strategies for sexually-active adults and adolescents were developed, drawing on findings from a series of focus group discussions held with youth, adult men and women, traditional healers, and unaccompanied women.

#### HIV prevalence and risk for Rwandan refugees

UNHCR reports nearly 40 million refugees and displaced persons worldwide—80% are estimated to be women and children. The World Health Organization estimates over 8 million cases of HIV infections in sub-Saharan Africa. Rwanda's HIV infection rate is among the highest in Africa. In 1992, more than 30% of pregnant women surveyed in Kigali were HIV positive. Sixteen per cent of men reported condom use during their last sexual episode in the baseline KAPB (the same 16 per cent was reported in the 1992 Rwandan Demographic Health Survey).

John Snow's KAPB showed a high level of AIDS awareness (87% knew at least two ways to prevent HIV infection), however, condom use was low and other high-risk behaviour was evident (frequent multiple partners, infidelity, low-risk perception and so on).

## Women and girl refugees face higher risks than men

Their survival coping strategies often include behaviour which greatly increases their exposure to HIV e.g. exchanging sex for food, water, or protection. The harshness of refugee life increases the strenuous labour so familiar to African women. Many Rwandan women on both sides of the conflict were beaten, raped and tortured. The sexual violence continued inside the refugee camps. Self-appointed water monitors often coerced women into exchanging sex for the scarce water. Young girls were raped while collecting firewood or when they went to latrines.

Single women, especially unmarried mothers, are particularly vulnerable to sexual violence. Many unmarried mothers in the camps became pregnant as a result of rapes during the fighting and exodus. Naive rural teenagers quickly adopt the ways of street-wise urban adolescents, or become the prey of older men seeking "safe" sex partners. New social units are formed when orphaned adolescents join others to set up households. It was common to see groups of young men setting up households together to maximize their rations.

## Social and political context

The majority of refugee situations in sub-Saharan Africa are the result of conflict. Complex power relationships shape social interactions, permeating every facet of camp life and affecting the outcome of project efforts. The Rwanda tragedy is intertwined with political, moral, and ethical issues. Their importance and effect, both on field AIDS educators and health service providers to refugees, as well as their effect on recovery and development efforts in the home country, should not be underestimated. Young Hutu men in the camps boasted of their efforts to impregnate as many women and girls as possible to help replenish the population. Rumours circulated that condoms contained HIV. Project staff members were physically threatened on some occasions. These larger agendas overshadow conventional health belief models and social cognitive theory while providing new ground for theory building and future research.

## Innovative approaches are needed in refugee settings

Refugee populations have special needs which go beyond the traditional prevention programming. The conditions of refugee life increase exposure to infectious diseases including HIV and other STDs. The destruction of families, deterioration of old social structures, and the formation of new social units, loss of income, over-crowded, unsanitary living conditions, boredom and increased alcohol consumption are just some of the factors which increase refugees' risks of HIV and other diseases.

Programme interventions must maximize scarce financial resources by focusing efforts on those most at risk. The experience of this project suggests that visual medium (videos, street theatre, comic posters) is more cost-effective, and popular than printed educational material. The refugees were given opportunities to write scripts, video tape and critique their performances.

## Special efforts are needed to reach young people and vulnerable groups

Cultural barriers pose special challenges to creating prevention programming for younger refugees. Sports events were the most effective medium for reaching young people with prevention messages. PSI helped construct a community sports complex with a soccer field, volleyball, handball and basketball courts. The weekly events drew crowds of several thousand. Condoms were demonstrated and distributed. Traditional dance groups performed special anti-AIDS dances.

## Aggressive STD management is crucial to success

The project collaborated closely with African Medical Research Foundation (AMREF) to promote STD treatment through syndromic management. CARE trained counsellors gave health education sessions to patients awaiting treatment at outpatient clinics. Counsellors aggressively followed-up on partner referrals and medication regimes. Graphic slides and videos drove home the messages.

What were some results of the programme?

An effective network of free condom distribution is now in place making condoms available throughout the camps. Approximately 26,000 AIDS educational sessions are held monthly. The follow-up KAPB showed that: while condom use had not significantly increased, lower risk behaviour was reported; a decrease in numbers of multiple sexual partners was reported; access to health services for adolescents had increased; social support groups had been formed for people with AIDS and for unmarried mothers; women reported less social isolation feelings (58.9 per cent felt isolated at baseline; 38.4 per cent at follow-up); and exposure to AIDS messages in the camps rose from 5.2 to 83.5 per cent.

#### Conclusion

Refugee populations are at great risk for the transmission of HIV and other STDs. Women and adolescent refugees are especially vulnerable. Sexual violence which is most often directed towards women and girls increases HIV risk. Women may be powerless to exert any choice in practicing safer sex and may be subjected to violence, coercive sex, and rape. Interventions need to target women and youth along with the generally sexually-active population in programme design.

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#### SESSION 1: OVERVIEW

An account of a personal experience

Gifty Kinnah, Ghana

I will be addressing this topic from the perspective of a person who had to flee for dear life from Liberia where I had lived for nearly twenty years. Indeed, my recollection of my childhood and adolescent years come from that country. When war broke out, I got separated from my family and I had to make my way to safety with my daughter who was just a toddler. I will also limit myself to issues as they affect African refugee and displaced women.

I want to spare you the horrific details of my trek across the length of Liberia to safety in Cote d'Ivoire and then to Ghana, where my parents come from and where I was born. Personally, I have not been able to deal with the trauma enough to go into much detail anyway, so it will be a sanitised version, but relevant to the topic and issues it raises. My aim is to use my experiences to demonstrate how refugees and displaced people, especially women, are vulnerable to all sorts of abuse, particularly sexual abuse and thus to HIV and other STD infections.

During my flight, an interesting problem that arose for me was that of identity. I was born in Ghana of Ghanaian parents but raised in Liberia (my mother's father who is still alive, incidentally is Welsh). To all intents and purposes I was Liberian, although I did not have any legal documentation attesting to that. When I fled from Liberia, I was mixed up because I had to make my way to a place called Ghana, which as far as I was concerned was a foreign country. I spoke very little of my parents' language, Fanti, and did not really identify myself as someone from that Ghanaian ethnic group. On the other hand, I could no longer identify myself with Liberians, whom until then I had come to think of as my people, because of the atrocities I witnessed throughout my flight to safety. There were instances during this journey when my life depended on whether I identified myself either as a foreigner, or a Liberian from a particular ethnic group. I learned to read and sum up situations quickly to know how I would identify myself and my daughter. Against this background of conflicting situations, I could not even admit to myself whether I was a displaced Liberian or a Ghanaian refugee.

Whatever my label, the reality was that I was a young African woman fleeing a conflict situation with a toddler, without the protection of a male relative. How more vulnerable can one be?

Call it luck, or the hand of God sheltering me, but my greatest hardships during my flight from Liberia were due more to witnessing people's inhumanity to others than anything else. My

companions - mostly Ghanaians, who had also been living in Liberia and Mandingos, a large ethnic group who can be found in Liberia, Sierra Leone, Guinea and some parts of Cote d'Ivoire - with whom I had trekked the length of the country - were shot dead simply for being foreigners. It was even more tragic because we were just within a half-day's trek to safety in Cote d'Ivoire. My life and that of my daughter was spared because I did not speak the Liberian language with an accent like my erstwhile companions. I found refuge in a Catholic convent in Danane with my daughter; since I did not speak much French, I still remained in contact with the Liberians in the local refugee camp, where I noticed and learned from the women how circumstances and events laid them open to abuse.

The geographic layout at the refugee camp did not take women's security into consideration when it was being set up. Often women's makeshift shelters were located at the edges of the camp, laying them open to theft, personal attacks and other atrocities.

When food and clothing were being handed out, they were often elbowed out of the way by men and either got very little or nothing at all. So they had to go to the men or soldiers afterwards to get some more or better stuff. With the chips stacked against her like that, a woman in that position can only bargain from a position of weakness, laying herself open to abuse. I am not saying that all the men or soldiers were, or are brutes, but in conflict situations, because people can be incredibly cruel, one has to guard against such situations arising in the first place.

It is generally agreed that due to biological reasons, transmission of HIV to women is more effective. For cultural and societal reasons—such as polygamy, social acceptance of a man having relationships outside a marriage, widowhood rites, female genital mutilation, to name a few—an African woman runs a very high risk of infection with the HIV virus and other STDs. War and civil unrest increases her vulnerability even further because of the possibility of rape and other atrocities and no access to medical care and legal redress. When you consider this scenario against the background of a continent where there are currently a lot of internecine conflicts, and where HIV is already wreaking havoc on the socio-economic fabric of life generally, the outlook is pretty dire. It is tragic that not much is being done by way of targeted, strategic HIV prevention campaigns. Certainly not in Liberia, and not much in Ghana either.

I find it very disturbing that although the most effective known barrier to transmission of HIV and other STDs is the use of condoms, no one is informing the men of this. If the problem is where to start from, I suggest they begin the HIV prevention campaigns with soldiers - be they rebels or government troops - because they are easily identifiable as a social unit with a predilection to act and respond in fairly similar ways almost everywhere on the continent.

This may be open to debate, but whereas most men are known to be sexually promiscuous, soldiers seem to surpass them all, even during peacetime. In war situations their predilection is multiplied several times over.

There may be underlying factors for this. They move from place to place quite frequently. In conflict situations, they may be separated from their families and perhaps work out their insecurities and trauma by going with many women. Unfortunately, they exploit their power (stemming from the barrel of their guns), to sleep with as many women as they can. It is also not unheard of for them to rape women and young girls.

Also in conflict situations, they control who goes and comes in a geographical area, and may thus have access to as many women as they want. Even if women do not want their attentions, with law and order broken down, who can they complain to and seek redress from?

Usually, in war situations, soldiers are the ones who have control over material and monetary resources. And as an African woman's role as provider of food and shelter to her dependents never ceases, indeed is more important than ever in war, her quest for basic items for her dependents more than ever lays her vulnerable to abuse. Sometimes she can only barter with her body for these items, for continuous provision, or even for security from harassment from other men.

Furthermore, in a situation where soldiers have the money, one of the few things available for purchase may be sex with women.

I do not have figures for Liberia, but it is estimated that in Angola, HIV prevalence in both the MPLA and UNITA armies is 50 per cent compared with 10 per cent for the civilian population. The Ugandan army has a sero-prevalence of about 35-45 per cent; and in Zimbabwe, sero-prevalence is estimated at 50 per cent compared to only 10-20 per cent for the civilian population. The mortality rate due to AIDS stands at 34 per cent in the Congolese army.

For these and other reasons, soldiers seem to be a high HIV prevalence group in Africa and their high mobility rate—in geographic terms as well as in terms of their predilection for multiple relationships—has serious implications for the sexual health of refugee and displaced women in Africa. For an African woman refugee, it is not only the deprivation of food, shelter, water, and security that she has to contend with, but also the risks that an encounter with a soldier might pose for her.

Life in refugee camps can also be so mind-numbingly boring and aimless that many women and men especially the young ones, seek sexual liaisons as a means of relieving the boredom and coping with trauma. After fleeing gunfights and other horrific experiences, it can be very reassuring to confirm your existence by cuddling up with someone else; thus it is inevitable that such relationships occur. For some women also, liaisons resulting in pregnancy may be a means of filling the void left by a dead or missing child or children.

In the course of fleeing a conflict situation, one is so intent on preserving one's life that one tends to overlook the need for health care. Indeed, people have been known to just wrap something around a gunshot wound or other injuries requiring urgent care and carry on until they reach safety. HIV transmission is not immediately obvious and with woefully inadequate and ill-equipped health care systems in most African countries today, an HIV positive refugee or displaced person is under a death sentence at short notice. The quality of life as a refugee or displaced person would accelerate the onset of AIDS.

Considering all of the above, including the health risks that soldiers pose to the community at large, it is a serious oversight that more HIV prevention campaigns have not been run with them. At the very least, if such work is targeted at this fairly homogenous group, it can then be evaluated and used with the necessary modification for men in the wider community.

African refugee and displaced people run a real risk of HIV infection and this needs to be acknowledged by the UNHCR and other bodies who are responsible for policies and service delivery to refugee and displaced people, particularly in Africa. There is an urgent need to work out effective strategies to deal with the issues which make refugee and displaced women vulnerable to infection and other ills; and I propose that they start some prevention education campaigns with the soldiers.

Otherwise, being a refugee or displaced woman in Africa is tantamount to laying yourself open to HIV and other STD infection. Please don't let us die because of other people's ignorance and misuse of their power.

#### Discussion points

- Should the military be in different camps from the refugees? This arrangement would be possible in a settled situation, but difficult to implement in an emerging conflict situation, as has been evident recently in Rwanda.
- Protection of women from male violence in camps should be a priority issue. The problem is immense, particularly in an emergency situation. UNHCR have developed Guidelines which define the need to protect women and children against violence, especially sexual violence.
- What is the role of church ministers in refugee camps? UNHCR reported that they had received requests to provide counselling training to ministers.

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## SESSION 2: THE UN RESPONSE

### 1. The United Nations High Commission for Refugees:

Kate Burns, Reproductive Health Officer, UNHCR, Geneva

In June 1995, more than 50 agencies attended the Symposium on Reproductive Health in Refugee Situations. At that time, Mrs. Ogata, the High Commissioner for Refugees, and Dr. Sadik from UNFPA committed their respective agencies to ensure that all persons in conflict and emergency situations have access to quality reproductive health services.

What do we mean by Reproductive Health and what is the relationship between reproductive health and HIV/AIDS? I think you will agree that HIV/AIDS fits within the comprehensive definition developed at the International Conference on Population and Development in Cairo, and subsequently into the constellation of reproductive health services. The definition of reproductive health states: "Reproductive health is a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity, in all matters related to the reproductive system and to its functions and processes". It goes on to say that: "Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when, and how often to do so."

The component parts of reproductive health are:

- safe motherhood;
- prevention and response to sexual violence against refugees;
- prevention and care of STDs including HIV/AIDS;
- family planning;
- management of other reproductive health concerns e.g. complications of unsafe abortions and female genital mutilation
- meeting the special needs of adolescents.

But whether HIV/AIDS fits into reproductive health is not really the issue here. We recognize the need to integrate HIV/AIDS into all facets of our work with refugee populations, just as we should integrate reproductive health into Primary Health Care and other sector programmes, such as education, protection, and community services. And this we have started to do, but much more is needed.

A major lesson of the AIDS pandemic so far has been that HIV spreads fastest in conditions of poverty, powerlessness and social instability—conditions that generally prevail for refugees and displaced persons. We know that in 1992, the HIV prevalence in Rwanda in prenatal mothers in rural areas was up to 4.5% and in urban areas 19-35%. Obviously we have at least that prevalence, if not higher among refugee populations. How high is not the issue.

Since joining UNHCR, I have visited more than 20 camps in five countries and spoken to many UNHCR and NGO partners. Let me share with you some of my observations on our work in HIV/AIDS, both successes and weaknesses:

- HIV testing of blood for transfusion is routinely being carried out in all refugee areas I visited.
- The means are available to undertake universal precautions in all our health facilities.
- Condoms are available, and groups are trying to increase the distribution points.
- Syndromic case management of STD services is in-place in many places
- Strengthening of these STD services is needed.
- Good examples of small-scale prevention programmes are evident in selected places, such as Ngara, Tanzania; Kakuma, Kenya; and Guiglo, Cote D'Ivoire. These are implemented by NGOs who have led the way, usually receiving financial resources from outside sources. Obviously more needs to be done, but we have started.

- On the issue of care for people with AIDS, on the medical side we are able to provide treatment for opportunistic diseases. Some limited home-based care has been integrated with other programmes - but we only have scratched the surface.

We have no services available for voluntary counselling and testing. This I believe is the big need for the future. In places like the Great Lakes we know National AIDS Programmes are accelerating their work in providing voluntary counselling and testing services and we need to do the same.

What are we doing to prevent situations in which people are vulnerable to HIV? As I said earlier - HIV/AIDS programmes have to be integrated into all facets of our work. For UNHCR that means such sectors as education, skills-building community services and protection. Each of these areas must incorporate AIDS into their work in order to remove or lessen the vulnerability of people. We support schools though usually only at primary level. We support skills building, but only a few benefit, and not usually the young people who are most at risk. Community services have special programmes for "vulnerable groups", which usually include unaccompanied minors, single-headed households, elderly, disabled etc. These are important at-risk groups and I think we do try and reach out to them, but more could be done.

I truly see the need to mobilize all our efforts to target young people. I think we all agree that they are falling through the cracks of our system. Men, too, who in refugee situations have lost their standing as the bread-winner of their family, lose their self-esteem as decision-makers, and sit around with time on their hands, often taking their frustration out on women, either in the home or outside.. We need to involve these two groups in all aspects of our work.

In closing, I would like to highlight that the Field Manual, jointly developed by many agencies, gives clear guidance on the nature and scope of how we should be undertaking HIV/AIDS prevention and care programmes. The question is how long will it take us to act? By "us" I mean everyone involved in responding to emergencies today, and everyone who has been working for years in HIV/AIDS. We need expertise and commitment to accelerate efforts to extend support to refugee populations. We need to breakdown the iron curtain that divides development from relief and emergency assistance.

## 2. UNAIDS: Monica Wernette, Department of Country Support, UNAIDS

Until recently, HIV/AIDS prevention has not been seen as a priority in emergencies, especially in the early acute phases, because it is not an immediate threat to life. The Rwanda crisis, two years ago, very clearly identified the need to include HIV interventions on the emergency and humanitarian relief agenda. Never before, had there been an emergency of such magnitude, in a country with such a high HIV prevalence. It was clear that the epidemic posed a threat, that could not be ignored until the return of relative stability. The nature of the emergency led the inter-agency advisory group on AIDS to mandate the development, of an essential minimum package on the prevention of HIV/AIDS (STDs) and provision of care, during emergency situations.

The Guidelines for HIV Interventions in Emergency Settings was developed in collaboration with UNHCR and WHO, and is currently being printed. The purpose of the Guidelines is to enable governments, UN agencies, and NGOs, at the earliest opportunity, to adopt measures to prevent the rapid spread of HIV in emergencies, and to care for those already affected. The Guidelines address five stages of an emergency, and recommend HIV/AIDS prevention activities that are indicated and feasible during each of the five stages.

The essential minimum package identifies what HIV/AIDS interventions are called for, as basic elements of a response to any emergency. These interventions are:

1. Prevention of HIV transmission through blood transfusion
2. Prevention of HIV transmission through universal precautions
3. Prevention of HIV transmission through provision of condoms
4. Prevention of HIV transmission through provision of information
5. Prevention of HIV transmission through STD care

Additionally, HIV/AIDS-related human rights and ethics during emergencies are seen as part of meeting people's basic rights to life, health, education and information.

In the context of the activities described in the Guidelines, emergency and refugee populations addressed include: women, children, minorities, indigenous people, migrants, illiterates, the poor, men having sex with men, sex workers and injecting drug users. Women, children, the elderly, detainees and prisoners are particularly vulnerable. Comprehensive care for people with HIV-related illnesses is seen as an essential component of basic curative care in any refugee situation.

According to UNHCR, roughly 75-80 % of the world's refugees are women and children. Currently, half of the 7,500 people world-wide who become infected daily are women and over nine out of ten infected women live in a developing country. We are aware of the biological vulnerability (male-to-female transmission, the physiology of younger women, untreated STD's, etc.) and the social and economic vulnerability (inaccessible services, socio-economic circumstances, lack of education, economic dependence) of women to HIV infection. How can women, especially those displaced and/or refugee women become less vulnerable to HIV? Four areas are considered below:

- **Combat ignorance**

Improve refugee/displaced women's access to information about their own bodies, education about AIDS and other STDs, and the skills to say "no" to unwanted or unsafe sex. UNAIDS is testing and comparing different approaches to skills-building so best practices in this area will be made available and shared.

- **Provide friendly services**

Ensure access to appropriate health care and prevention services, at places and times convenient for women. Make condoms and STD care available where people can go without embarrassment. UNAIDS is helping to ensure that women's family planning options help rather than undermine their ability to avoid HIV and balance the procreational and recreational aspects of human sexuality within a woman's life.

- **Build safer norms**

UNAIDS supports groups and community organisations in questioning traditions which are deadly in the era of AIDS such as tolerance of child abuse, rape, and sexual coercion. It also supports groups and organisations to educate boys to respect girls and women, to engage in responsible sexual behaviour, and to share the responsibility for protecting themselves, their partners, and their children from HIV and conventional STDs. UNAIDS speaks out for safer, egalitarian norms and supports concrete efforts to build these in all situations.

- **Reinforce women's economic independence**

There is a need to multiply and strengthen existing training opportunities, and co-operatives, and link them with HIV/AIDS prevention activities. UNAIDS will support these efforts.

It is clear that the epidemic is still progressing faster than we are. Infected women outnumber men in sub-Saharan Africa, and in other places the situation is heading in the same direction. Furthermore, in just a few years' time, at least 90% of the world's infections will be located in the developing world and the actual AIDS caseload will be triple what it is today.

In many cases sexually transmitted death is due to lack of proper reproductive health care. Many such deaths are caused, directly or indirectly, by unwanted or exploitative sexual relations. So, given the constraints, how can we move forward?

UNAIDS will act directly through its six co-sponsors (UNDP, UNICEF, UNESCO, UNDP, WHO and the World Bank) and with NGOs and other partners to strengthen risk-reduction strategies and decrease the consequences of HIV/AIDS on marginalised and especially vulnerable populations.

Activities that UNAIDS is focusing on are as follows:

- **Refugee and indigenous populations**

UNAIDS will conduct research, and design and evaluate HIV/AIDS prevention support and care pilot interventions, as part of larger reproductive health programmes for refugees and indigenous populations (especially women).

- Education of peace-keeping forces

UNAIDS will advocate for educating UN peace-keeping forces concerning the vulnerability of populations in war-torn countries, especially rape and other forms of physical violence. UNAIDS supports the civil-military alliance on HIV, and has a professional focal point on its staff specifically addressing -military-related HIV/AIDS issues.

- Programmes for adolescents

Acknowledge adolescent girls and boys as vulnerable populations among refugees and displaced people, and collaborate with other agencies (WHO's Adolescent Health Programme, UNHCR's Reproductive Health Group) to design broader interventions for adolescents that address both their development and health needs. (UNAIDS, in collaboration with UNHCR's Reproductive Health Group, is developing the HIV Prevention Among Young People Project in a country hosting large numbers of refugees).

The path ahead is difficult. Time and again, advances in development are erased or reversed with a change in political regime, or due to war, or a natural calamity. AIDS is one of those calamities.

UNAIDS will play its full leadership role in global advocacy, over and above what we are able to do directly and with partners, to keep its voice raised on behalf of vulnerable groups in all possible situations.

### 3. World Health Organization (WHO)

Dr Takako Yasukawa, Division of Emergency and Humanitarian Action, WHO

I should like to begin my presentation by clarifying the structure of WHO with regard to dealing with refugee issues and HIV/AIDS.

Within WHO, the Division of Emergency and Humanitarian Action (EHA) is responsible for responding to emergencies, both natural disasters and complex emergencies, including refugee situations. The Division has two preparedness and prevention units and four response units. EHA functions as a focal point in WHO vis-à-vis other United Nations agencies and non-governmental organisations in emergency management, and depending on the expertise required, EHA will work together with the technical divisions concerned.

The Office of HIV/AIDS and Sexually Transmitted Diseases (ASD) was created in WHO to liaise with UNAIDS and to serve as a focal point in relation to HIV/AIDS and sexually transmitted diseases.

Under the overall co-ordination of UNAIDS, the areas WHO focuses on are:

- STD control (prevention, treatment and case management) integrated into primary health care and reproductive health settings
- Blood safety
- Comprehensive care for persons with STD/HIV/AIDS in the health care system
- Integration and continuum of care for STD/HIV/AIDS persons in the health system, including discharge plan from hospital to home
- Epidemiological surveillance systems for STDs, HIV and AIDS. Let me emphasise that for surveillance purpose, WHO supports unlinked anonymous testing
- Health promotion, advocacy and networking in the health sector and with other sectors/agencies

In order to achieve their objectives, ASD has established close collaboration with other divisions within WHO, which enables HIV/AIDS control activities to be included in the particular programme areas.

For example, the Global Tuberculosis Programme (GTB) has been implementing pilot projects of tuberculosis (TB) management integrated with HIV/AIDS community care scheme and also it has published the TB/HIV clinical manual.

The EHA Division has also included AIDS control activities in some of its emergency operations, which are often undertaken during the post-conflict/rehabilitation phase(s). However, some of these activities are of direct assistance to internally-displaced persons (IDPs) and refugees. For example, in 1994 WHO sent a technical mission, which consisted of AIDS and family planning specialists, to Rwandan refugee camps. There, the team had discussions with UNHCR and NGO representatives, identifying gaps and making proposals for action plans to implementing partners.

Unfortunately, WHO was not able to follow-up these proposals. During the discussion which will follow my presentation, I should appreciate sharing your experiences on the implementation of these proposed activities and your opinions on whether or not these proposals are practical; or feasible.

Priority activities to control HIV/AIDS in refugee settings, in order of importance, are as follows:

- Accessibility, availability and use of condoms
- Blood safety
- Care of symptomatic cases of STDs
- Advocacy and education
- Care of AIDS patients, including patients with tuberculosis

There is one crucial question, "How can protection against HIV/AIDS and protection against pregnancy be tackled together in one comprehensive method?"

Health workers who are so accustomed to the traditional contraceptive method, namely, pills or long-acting hormone implementation, which achieve high levels of protection against pregnancy with rather low consultation and limited compliance by the users find it embarrassing to deal with condoms. On the other hand, advocacy of the use of male condom without intensive consultation or strong compliance by users will just fail.

Also family planning providers might think that a barrier contraceptive method is not natural. It is true that more than 90% of the currently available contraceptive devices are hormonal. However, it is foreseen that within a couple of years, donors and major agencies in the reproductive health areas will promote more strongly the use of barrier contraceptive methods. Female condoms are also promising, but still a lot of work is needed.

Finally, I would like to raise the question of how and in what areas WHO could effectively collaborate with the UN and NGOs. At the last World Health Assembly in May 1996, Member States requested that WHO reinforce the "partnership approach" in emergency management in the planning, implementation and monitoring of emergency, rehabilitation and recovery programmes. As a result, EHA/WHO conducted a survey to determine what NGOs expected WHO's role in emergency management to be. The findings showed

1. The WHO essential activities expected by NGOs
  - Support MOH in strategy establishment, technical advice, identifying supplies required and improve communications with NGOs (but not co-ordination).
  - Standardization of the emergency health management and health relief supplies, by providing guidelines and reference materials, and by designing health kits.
  - Establishing and managing an information system by conducting surveys, consolidating available information and dissemination to concerned people.
  - Undertake and supervise assessment and research on health problems and unmet needs in the emergency situation, by involving implementing partners.
2. The WHO essential activities expected by NGOs, but with some prerequisites
  - Technical co-ordination in general

- Pre-requisites:
  - The field capacity building by WHO
  - Clear decision and instruction among UN agencies on who co-ordinates the health issues
- 3. Back-up support by WHO to NGOs and local health authority
  - The following activities are under the primary responsibility of NGOs and local health authorities but support by WHO is needed and welcomed as a back up.
    - Special programmes
    - Training activities
    - Supply issue
  - The nature of the WHO back-up support includes:
    - Identification of the gaps;
    - Facilitating the involvement of NGOs and local health authorities;
    - Standardization of the activities implemented by NGOs/local health authorities.

The control of HIV/AIDS will fall under the aegis of the Special Programme. Moreover, the survey showed that NGOs expect WHO to act in a supportive role rather than taking the primary role in terms of identifying gaps and making recommendations on technical standardisation.

WHO's biggest constraints are lack of funds and field presence to ensure and follow-up its technical input. In major complex emergencies, we have emergency staff on the ground. Hence, that person could provide the necessary WHO input. In some emergency situations, we are not there. In order to cover this lack of presence, we identify an emergency focal point in the WHO country office, and assign a role and responsibilities and provide training to them. This activity has just started, and although the outcome is not yet satisfactory, progress is being made, I hope today's valuable opportunity will lend to strengthening the partnership approach in STD/HIV/AIDS control in refugee settings. We will pursue the partnership approach in a normative and technical way.

#### Discussion points

##### Dissemination and evaluation of UNHCR/WHO Guidelines

- UNHCR distributes a library kit, including these UNHCR/WHO Guidelines and other relevant information, as part of the package of emergency supplies for refugees. UNHCR, WHO and UNAIDS all distributed copies of the Guidelines to their respective country offices, as well as to NGOs globally.
- WHO uses the Guidelines during training courses and workshops aimed at Ministry of Health personnel, however, in future these courses were being extended to other target groups, including NGOs, and UN staff.
- NGOs, especially the larger ones, also have a responsibility to supply materials to their field operators.
- UNHCR plans to evaluate the Guidelines after 12 months of use in the field and revise them accordingly. They will then be distributed through the same channels as mentioned above.

##### Displaced persons and floating populations

- UNHCR can only get involved with people who have been displaced from their country of residence, and not people displaced within their own country. Local NGOs should identify the needs of displaced persons and find resources, for example through UN country offices.
- the present Guidelines should be adaptable to suit different social contexts.
- WHO/GPA has implemented projects on street children, men who have sex with men, prostitutes and intravenous drug users, and UNAIDS is building and extending these projects.
- The UN is still deciding which UN agency should be responsible for programming support to internally displaced people. Internally displaced people are the mandate of national governments, sometimes with the assistance of donors. Often there was a lack of

incentive for them to return home as they might have lost everything and have little to return to.

#### Provision of care and support services

- As a minimum standard, people should have access to the care and counseling they previously had in their own countries.
- This requires collaboration between UN agencies and host countries National AIDS Control Programmes
- There are still discrimination issues to be faced.
- For UNHCR, HIV/AIDS programmes for refugee populations are not happening at present. The UN was working with governments and integrating refugee services into their national programmes. Refugees tended to be in remote areas which were also the least served by existing services.

One participant expressed concern that even after several years, a refugee camp may lack basic services, and wondered what chance there would be of setting up an HIV/AIDS programme? There is an opportunity here for NGOs to put pressure on UNHCR under such circumstances.

#### Refugee and local populations

- UNHCR may provide health services in refugee camps that are better than the health care provided to local people, which raised certain ethical dilemmas. There was the potential to provide good reproductive services in camps, these may be costly, and improvement was needed in this area.
- In some situations, HIV/AIDS prevention services were being targeted at the refugee population without providing information to the local communities living around the camp. It was suggested that the UN should persuade governments to carry out a joint HIV/AIDS prevention programme, since there was little point in protecting only the refugees, especially in view of the mixing that occurred between the two groups.
- One question related to whether any attempts were made to integrate the refugee community with the host community when camps became long-term. Once the emergency situation became stable, many NGOs wanted to work both with refugees in the camps as well as with the local populations outside, which was welcomed, especially as HIV is prevalent in both groups. This has provided the opportunity to break down the barriers between refugees and local populations.

#### Long-term refugee camps

- Concern was expressed at the long-term stay in camps for many refugees. For example, the Ethiopian civil war had lasted 30 years, but although repatriation had started three years ago, many refugees had remained in the camps.
- The UN had no desire to build infrastructures to last for years since the hope was that refugees would soon have the opportunity to return home. Long-term camps have major implications for the provision of social and health services.
- There were also political considerations, as host governments did not always want the refugees there. UNHCR wanted to make the refugees as self-reliant as possible, but this was difficult given the situation.

#### HIV prevention

- Knowledge about HIV in camps was limited even in areas such as Zaire where two years before the emergency, knowledge about HIV/AIDS had been good. A recent study in The Lancet showed that prevention programmes aimed at refugees and displaced persons were not succeeding.
- One UK NGO working with an African community had problems encouraging men to use condoms. It appeared that condom use among refugees in Africa was no better than among the local populations, and probably worse.

#### HIV testing

- When the emergency situation was stable, the UN was strongly recommending voluntary testing and counselling to the affected population to the extent that it was available for the

local community. Many governments e.g. Tanzania and Uganda, wanted HIV testing. Many doctors insisted on testing before providing treatment and counselling to people. Moreover, testing enabled people to plan for the future, especially where children were involved.

- This is controversial: In many countries a policy of testing explicitly or implicitly meant that those people with HIV infection had more of an obligation to stop the epidemic than those without the virus, a position which is ethically questionable. A person who had, or thought he/she had the HIV virus had a responsibility not to pass it on. But equally, those who were, or thought they were HIV negative also have a responsibility not to get the virus
- The Consortium has discussed issues of testing, and suggests that testing alone, with community involvement and well designed care and support programmes, will not lead to reduction of transmission.
- One UK NGO has also examined this issue thoroughly and after consulting widely decided not to recommend testing, even in a country with a good health system and where treatment and care were available.

#### Sexual violence

- It was acknowledged that sexual violence among refugees was an immense problem but that inroads were being made, especially regarding protection and community services.

#### Resettlement

- In response to a question on the role of the three UN agencies regarding the resettlement of displaced persons, it was made clear that national governments were responsible. The services available to those resettling should be the same as those for the existing local community.

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### **SESSION 3: THE GOVERNMENT RESPONSE**

The government response to HIV/AIDS and its relationship to reproductive health in refugees and displaced people

Dr K. J. J. Kashaija, Regional Medical Officer, Kagera Region, Tanzania

There is no doubt that HIV/AIDS is a major cause of concern with great potential for future harm in the civil war stricken populations of Rwanda and Burundi and the neighbouring countries in Eastern Africa and Zaire. The Rwanda genocide between the Tutsi and Hutus forced a massive influx of about 700,000 refugees in Tanzania over a brief period. On 28 and 29 April 1994, nearly 200,000 Rwanda refugees poured across the Kagera river into Ngara and Karagwe districts of Kagera region in North-West Tanzania. This was one of the biggest ever refugee exoduses in a 24-hour period. Since then more than 500,000 refugees have continued trekking into the camps in the two districts.

Although the Refugees Relief Service Organization and many donor communities immediately started giving material support for the refugees, there were obviously instances where material assistance was not available to them at the right time and they died. Some, who are still alive today, have remained to tell the story. They remember and know much more than we remember and know.

The refugee problem is still with us<sup>1</sup>. They are repatriating at a small rate. The bitter experience at home makes them fear to return. Revenge is at heart, dialogue and forgiveness are not a priority for most of them at the moment. We will stay with them for a long time

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<sup>1</sup>In December 1996 and January 1997 the Tanzanian Government closed the refugee camps and escorted the refugees back to Rwanda. This was carried out in an orderly manner. The consequences in terms of HIV are unknown.

The feudal bloody conflicts have become a permanent feature in Rwanda and Burundi - and they have attained a permanent genocide state of affairs. Together with the ethnic origin of these civil wars, I believe in the curse of poverty - with its many causes poverty has attributed much to the whole environment. Rwanda and Burundi and the surrounding countries (Tanzania inclusive) are among the poorest countries in the world, with a per capita income of less than US\$300. More than 90% of the labour force is predominantly engaged in a subsistence agricultural economy, working on land with a relatively limited crop production potential.

The population density in Rwanda is 280/km<sup>2</sup>, the second highest in Africa. Fertility rate is the highest in Africa and in the world. These demographic factors forecast a stimulus to domestic political strife.

HIV/AIDS in Rwanda (and Burundi) and the exodus region, Kagera

In 1992, WHO reports showed that the ten countries worst affected by HIV/AIDS in Africa were all sub-Saharan: Uganda (34,611 reported cases), Tanzania (34,605), Kenya (31,185), Malawi (22,000) Zaire (18,186) Zimbabwe (12,514), Cote d'Ivoire (10,792), Rwanda (8,483), Zambia (6,556), Burundi (6,052). The countries constitute the exodus zone for the refugees of Rwanda and Burundi.

Kagera region, is well known for its high prevalence rates of HIV. In 1987 Bukoba town had a rate of 27% while the surrounding rural areas had a rate of 12% with an overall prevalence for the whole region of 9% among adults of 15-54 years. Before the war, Rwanda had one of the highest rates of HIV in Africa. In the capital Kigali, one third of pregnant women and 50-70% of STD clinic attendees were HIV positive.

The war has let these populations with high HIV prevalence rates mix.

The Benaco camp with approximately 500,000 refugees forms the second largest city in Tanzania, after its capital Dar es Salaam. As one would expect in a city, there are shops, markets, hairdressers, bars, guesthouses and brothels. The sex industry is certainly flourishing.

Thousands of unaccompanied women are forced into selling or exchanging sex for economic reasons. Rape and forced marriage are common. Young people's cultural structures are broken down and they lack traditional family guidance, which together with the boredom in the camps and restrictions on movement within a limited radius means they easily end up with sex practice on the rampage.

The massive financial energy that has gushed into the area has turned camps into economic centres, attracting traders from across Tanzania, Kenya and Uganda and making the sex industry spring up in the towns of Ngara/Karagwe and all along the truck routes to the camps. The prices of consumer goods have hiked up making life in these districts relatively difficult, not only for the refugees alone, but also for the local population. In such circumstances, the spread of HIV has been enhanced.

The Government's response to HIV/AIDS control in refugee/displaced people in Kagera Region

Tanzania is one of the countries worst affected by the HIV/AIDS epidemic, not only because of the high prevalence rates of the disease, but also because it is one of the world's poorest countries. The National AIDS Control Programme was one of the first to be set up in Africa.

The efforts to control the epidemic have been dependent largely on the donor community. Local efforts to repress the epidemic have invariably not been adequate to cope with the increasing numbers of the affected population. The epidemic can be seen as annihilating the society. This fragile situation has obviously been made worse by the influx of the refugees.

What then has the Government of Tanzania offered in the control of HIV/AIDS to the refugee/displaced population? All endeavours have been made by the Government to bring back hope to the refugees and to offer a life in a near tranquil state so that various

intervention programmes could be instituted to the population, including an HIV/AIDS control programme. The Government has accomplished this in close collaboration with the international community agencies working on the refugee problem. Furthermore, since the Government has offered asylum to refugees, it has had to provide guides and other organizational requirements to the international community working with the refugees to facilitate their work.

The local community has also provided different services to the refugees e.g. health, education etc. Moreover the local community has exchanged food for labour with the refugees as the food customs (banana culture) are alike.

The Government has allowed the refugees to make use of the wood in the area as the only fuel (energy) source available, running the risk of deforestation which is becoming evident. In addition, the Government has temporarily provided land for agricultural use by the refugees. Also of importance, the Government, in collaboration with the UN and other refugee-assisting organizations, has provided security services for law and order in the camps and the surrounding areas. As a result of the provision of all these services, many problems have been avoided, thus curbing the spread of HIV.

The strategies for controlling the spread of HIV among the refugees require the global response to the pandemic, as elsewhere. There is a need to adequately address issues of gender and equity as aspects underlying the risk factors for the spread of HIV. Governments, NGOs and other actors have an important role in this respect.

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### SESSION 3: THE GOVERNMENT RESPONSE

Responses to HIV/AIDS among refugees and migrant workers in Thailand and Burma  
Jackie Pollock, Empower, Asia

In the North of Thailand alone, there are 80 local People with AIDS (PWA) groups providing support and assistance to HIV positive people and their relatives. Funded initially from overseas donors, most groups now receive Thai Government backing<sup>2</sup>. The PWA network collaborates with the NGO AIDS Coalition and is regularly consulted on government policy decisions regarding HIV/AIDS. It educates about HIV prevention, discrimination, human rights, herbal remedies, and living with AIDS. Just across the border in Burma, despite an advancing HIV/AIDS epidemic, with high infection rates among injection drug users and a climbing rate of infection among the general population, there are no PWA groups, and anyone speaking of discrimination and human rights abuses is arrested. Dr Wiwat Rojanapithayakorn, Ministry of Public Health, Thailand, wrote in 1994 that "As the first nation in Asia to face an explosive AIDS epidemic, Thailand has learned many valuable lessons that could help other countries just beginning to feel the impact of AIDS. One measure he suggested they emulate was: "Strong involvement of NGOs. An NGO consortium and a national NGO subcommittee can be very useful in guiding NGOs' participation in the National AIDS Programme."<sup>3</sup> Burma does not allow indigenous non-governmental organisations to exist. The Salween River is all that separates Thailand and Burma physically, but there is a gulf of difference between their responses to AIDS.

In Burma the military regime, the State Law and Order Restoration Council (SLORC), has embarked on a superficial AIDS prevention campaign giving out messages on transmission and prevention of AIDS and that it kills. But it is said that it has little chance of convincing the population which has learnt from past experience not to trust the military regime and

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<sup>2</sup>In 1989, foreign donors funded 90% of the AIDS effort in Thailand. By 1994, the Thai government contribution had increased to US\$53.5m - far more than the \$8-10m provided by foreign and international donors.(AIDS Captions Vol. 1, No. 3).

<sup>3</sup>*Evolution of the response to AIDS in Thailand.* Wiwat Rojanapithayakorn, (AIDS Captions Vol. 1, No. 3).

considers their messages lies and propaganda. Indeed they blame the SLORC's Regional Development Programme for forcing ethnic nationalities to seek work outside their own communities and thus exposing young people to greater risk of HIV infection. In the case of the Wa and the Kachin, the majority of the young people end up working down the mines, in towns where there is a high incidence of HIV/AIDS through injecting drug use and unsafe sexual practices. Without the participation of local people, as Dr Wiwat advised, the campaign is doomed to fail. As a response to this situation the opposition groups, including 10 different ethnic groups and five other political parties, have made recommendations through the National Health and Education Committee regarding Burma and HIV/AIDS. The recommendations clearly outline their present fears regarding SLORC's response to the AIDS crisis. They are as follows:

#### General policy recommendations regarding Burma and HIV/AIDS

The root cause of the HIV/AIDS epidemic in Burma is the military dictatorship, SLORC. Due to its failure to achieve a political resolution, Burma is now facing a massive HIV/AIDS epidemic. Therefore, the following HIV/AIDS policy recommendations are made:

- That the people of Burma should have the right to fully and freely participate in the National HIV/AIDS Control Programme.
- Any international donor agency considering involvement with HIV/AIDS in Burma should initiate any such collaboration at a minimum in consultation with the elected leaders and ethnic leaders in and/or out of the country, and optimally in a full collaborative partnership.
- A commitment on the part of the donors and on the part of the SLORC to an open accounting of the use of funds and resources. Such an accounting should be made to a neutral international body, and would include clauses for the cessation of aid if resources were not reaching the target populations.
- An agreement by all parties involved in HIV prevention, care and research, to fully abide by the Geneva Accords on the rights of research subjects. Again, such agreements would include mechanisms of observation, and mandatory cessations of funds if rights violations were identified.
- The participation of people with AIDS and of people from groups at risk (sex workers, addicts and others) in the design and implementation of HIV programmes. These would include assurances of their protection, and again cessation of such projects if the rights of community members were violated.<sup>4</sup>

A task force will be responsible for education, training a mobile team, and developing a resource unit. The task force aims to target populations inside Burma, on the border, and migrant workers.

The populations of around 98,000 refugees along the Thai-Burmese border are housed in some 30 camps. The majority, 70,000, are Karen, and Karennis form the other largest group. A minimum of 20,000 Shan refugees are estimated to have crossed into Thailand from the Shan State since April 1996 as a result of the SLORC's forced relocation programme. In March 1996, SLORC began a massive campaign forcibly relocating civilian villages. At least 450 villages with approximately 80,000 people have been ordered to move. Unlike the Karen and Karenni borders, there are no refugee camps where these villagers can seek sanctuary. The Shans are not recognised as refugees either by the Thai government or by UNHCR. As a result, they are forced to disperse to avoid arrest as illegal immigrants, and have to seek work in order to survive. They are thus assimilated into the migrant worker population<sup>5</sup>.

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<sup>4</sup>National Health and Education Committee (co-ordinating body of Task Force on HIV/AIDS, Burma), AIDS Working Group, Burma.

<sup>5</sup>Reports by "Volunteers for Displaced Shans"; Karen Human Rights Group.

For refugees in camps on the border, the situation is ambiguous. Thai authorities have provided support, in some cases, allowing them to stay in the border camps for 10 years, and ensuring that the international community provides food, housing and medical care;. Nevertheless, their status remains such that they are unable to establish businesses, enter the workforce, to settle permanently in Thailand, or grow crops which might imply permanent residence. The refugees have not been included in Thailand's massive media campaigns about AIDS on the TV and radio, through government health clinics and through NGO community development programmes. Some refugees obtain contraceptives from Thai clinics and have access to testing through Thai clinics and hospitals; but the Thai authorities have not yet made provisions for counselling and health education in languages other than Thai. Currently HIV infection in the camps is considered to be extremely low—the ideal time to include HIV/AIDS prevention and care programmes in the general health education package. Refugees also need to receive information and education about prevention and about living with HIV/AIDS immediately in case they are repatriated. Thailand provides medical care on a humanitarian basis for refugees on the border, and health education has been left to the international NGOs. However, the government has only recently recognised the people coming from Burma who have no camps to go to; they have been classified not as refugees but as migrant workers.

The risk of contracting HIV and the risk of not receiving adequate care when sick is much higher for these migrant workers refugees than for refugees in the border camps. Thailand has around 700,000 to one million illegal immigrant workers according to a study by Professor Theeranat Kanjana-Aksorn of the Economics Faculty, Chulalongkorn University, Bangkok. Illegal workers have no access to social welfare, medical care or other benefits, nor the right to protection under the labour law. Thus illegal migrant workers become "invisible workers" whose presence can be ignored.<sup>6</sup>

The Thai government has recently passed legislation which allows migrant workers to register for a two-year work permit. Professor Theeranat says this limit of the working to a maximum of two years is to prevent them from receiving refugee status. Under these new laws, construction site workers, factory workers, farm-hands, fishermen and maids will be covered by Thai labour laws. In order to be accepted on the register, workers have to undergo a health check and can be refused permission depending on the results. Fortunately HIV/AIDS is not one of the diseases tested because Thailand responded to pressure and deleted AIDS from the list of "diseases requiring notification" in the Infectious Diseases Act in 1991.

In Chiang Mai, in the North of Thailand, the Thai authorities (Labour, Immigration and Public Health) are preparing to register 30,000 migrant workers, most expected to come from Burma. Previously, there had been no access to legal migration for people from Burma and everyone depended on third parties (agents, procurers, brokers). People thus started off work in debt and in vulnerable positions, without any control over their living and working conditions, with access only to limited information and restricted freedom of movement. Whether the new laws can put a stop to such practices remains to be seen, and there will still be workers who cannot apply for registration because they are already bonded in factories or brothels, or their work is not included for permits, (e.g. sex workers, sales assistants, waitresses). However, the new laws may help NGOs to access the migrant workers in need and to provide services and referrals legally.

Government services may recognise the need for translation services in the hospitals. The Thai National Plan for the Prevention and Control of AIDS (1992-96) says that testing of persons for HIV must only be carried out voluntarily and with informed consent, and it advocates pre- and post-test counselling. As some migrant workers will access the government services for HIV tests, it will have to be accepted that being told in a foreign language about a new disease cannot be said to constitute pre-test counselling. This will be another challenge for the Thai health services.

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<sup>6</sup>"Immigrant workers face dilemma", The Nation, Oct. 6, 1996.

For migrant workers or refugees in Thailand who become HIV infected, the already overstretched health system may provide treatment of particular conditions but will not be able to provide long-term care. There are few hospices in Thailand and while they have been allowed to take in individual illegal immigrants on humanitarian grounds, there are no services available or ready for large numbers of people requiring palliative care. The legal status of dying persons will be one issue which must be addressed. If migrant workers/refugees with HIV/AIDS return home or are repatriated, Burma offers no hope for giving advice and support, preventative treatments, general health care, or for looking after people with AIDS. For example, one young woman who went home sick with AIDS-related pneumonia, discovered that her village community in the Shan had been forcibly relocated. She had neither the resources nor the energy to find them and returned to Thailand to die in the care of an NGO.

At present, international NGOs on the border, local Thai NGOs, the ethnic nationalities and the opposition groups of Burma, are looking for effective ways to educate Burmese people within Burma, on the borders and in other countries about HIV/AIDS, its prevention and the care of people living with HIV/AIDS. Thailand has devoted many resources and given high priority to such education for Thais; the challenge will now be to reach and cross the borders. The gulf of the difference in response to the HIV/AIDS crisis must be bridged by pressure from international governments against the human rights abuses in Burma. As Dr Wiwat said an AIDS campaign without the people's participation can only fail.

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### SESSION 3: THE GOVERNMENT RESPONSE

An assessment of HIV prevention interventions with refugees and asylum seekers, with particular reference to refugees from the African Continent:  
Krishna Maharaj and Ian Warwick, Health and Education Research Unit, Institute of Education, London

An outline was given of a recent study to assess HIV prevention interventions with refugees and asylum seekers in the UK, undertaken by the Health and Education Unit at the Institute of Education, London, and funded by the Department of Health.

#### Epidemiology of HIV among refugees

African communities are the second largest group in the UK affected by HIV after gay/bisexual men. Nine per cent of AIDS cases and 12 per cent of HIV infection are within the exposure category of "sexual intercourse between men and women - other partner abroad."

#### Background to the study

- Conventional HIV prevention strategies have often failed to involve refugees and asylum seekers.
- Recent epidemiological studies indicate a need for HIV interventions with refugee communities, with particular reference to refugees from Africa
- Assessing key informants' and community members' perceptions of what works in HIV prevention will help identify elements of good practice on which to base future interventions.

#### Findings

- The findings of the study can be considered under three headings:
- Key themes
- Specific needs
- Consultation and funding

#### 1. Key themes

#### The impact of HIV and AIDS

African communities are the second largest group in the UK affected by HIV. Of all the people with HIV infection who have lived in, or visited, countries in Africa, about 70 per cent have spent time in either Uganda, Zambia, Kenya, Zimbabwe or Zaire.

Perceptions of refugee groups should be taken into account when planning programmes: For example, when a member of one of the African communities knows that he or she is positive, they think that they will die...for those who do not know what their HIV status is, there is a kind of feeling around 'that I might be, so I won't plan for the future.

#### Contextualising HIV prevention

Many respondents in the study talked of contextual factors that would affect HIV prevention interventions. These included addressing general health needs, mental health needs and immigration and welfare needs.

"The HIV and AIDS issue cannot be dealt with in isolation from other social and economic factors. There must be a comprehensive programme to address all the issues of refugees. Without this, HIV prevention is meaningless." (The Refugee Men's Group)

#### Issues of transmission and safer sex:

When talking about HIV and AIDS, many participants made mention of the situation in their own countries of origin. Problems relating to safer sex and condom use were also raised.

'The conditions of civil war meant that medical standards were very basic. The war led to a massive displacement of people which can assist in HIV transmission. Prostitution was rampant. Large numbers of people were in crowded refugee camps where people would have intercourse without being able to use condoms. (Sierra Leonian group).

#### Racism, stigma and prejudice: denial and isolation

Key issues which ran through many discussions related to the racism directed towards communities, and stigma and prejudice within communities. These affected community members' responses to AIDS. In addition, as HIV prevention interventions necessarily involve addressing gender and sexuality, this was seen to pose a number of potential problems e.g. talking about condoms is not culturally acceptable for women in many communities.

'The link between AIDS and Africa has made some Africans defensive on this issue,' (Key informant interview).

'We are fighting with funders, on the one hand, to agree with us about the need for HIV prevention, and, on the other hand, with our own community who are at a denial stage.' (Somali group).

Stigma and discrimination within refugee communities, about particular sexual behaviours, may result in "hidden" sexual activity. This will have an effect on certain interventions, such as those aiming to involve men who have sex with men, and those addressing the needs of people living with HIV and AIDS.

## 2. Specific needs

- Working with women
- Working with men
- Working with young people
- Working with couples and families

#### Working with women

Key themes related to: difficulties in negotiating safer sex, contradictions associated with safer sex and pregnancy, male partners putting women at risk, and an over encouragement of women from Africa to be tested

Although some respondents felt that women were overly involved in HIV prevention and care, others felt that trainers needed to be more creative in the ways they encouraged women to take part in HIV prevention interventions

#### Working with men

Key themes which related to men and HIV prevention included: the difficulties in involving men and the perception held by respondents that men do not apply what they know about safer sex.

Major themes which related to refugee men who have sex with men included: addressing denial, gaining access to men who have sex with men, and recognising the distinctions between identity and behaviour.

#### Working with young people

During discussions about young people, respondents stressed the importance of cultural contextualisation of HIV prevention. Most respondents stated that effective HIV prevention should be integrated into events which were sporting or musical in nature, and within settings such as schools, youth clubs and commercial venues.

#### Working with couples and families

Respondents highlighted the value of involving couples and families in HIV prevention

‘There is a need to deal with the subject of safer sex within the married environment...Married men and couples should be treated as a unit. We need not only workshops for men and for women, but increasingly we need workshops for couples, so that we can bring men and women together to tackle this problem of AIDS.’ (Refugee men’s group)

#### 3. Consult and fund

Consultation with refugees and funding of HIV prevention interventions were perceived by many respondents to be closely linked. Use of refugee community organisations was believed to make consultation more effective and efficient than consultation with individuals.

#### Good Practices

The points below, drawn from interviews with key informants and refugee community members, summarise a number of key ways in which HIV prevention interventions might be focused.

- Involve refugee communities
- Focus interventions
- Aims for cultural relevance
- Address stigma and discrimination
- Address confidentiality
- Support community and organisational development

#### Involve refugee communities:

Refugees must be involved in the development of interventions to ensure that the values and beliefs of specific communities are reflected and have relevance to those communities. This relates to the overall design of interventions (see points below) and also to more specific aspects of an intervention such as the production of leaflets and publicity materials. Issues to address might include perceptions of sex, sexuality and HIV transmission (such as condom use, polygamy, perceptions of sexual behaviours including anal sex and ‘dry’ sex).

#### Focus interventions:

Interventions should be focused to the needs of particular communities, women, men (including men who have sex with men), young people, and people living with HIV and AIDS. Involving women, for example, should take into account settings where they may already meet (such as hairdressers, places of worship), and on social occasions they might enjoy (which might include activities such as cooking and sewing). In addition, child care facilities should be made available. Young refugees were perceived to respond particularly well to interventions linked with sports activities, music and when they involved famous personalities. For all communities, including HIV and AIDS issues in music, drama comedy and poetry events was seen to be appropriate.

#### Aim for cultural relevance

Both commonalities and differences between communities and individuals can form the basis of interventions. In some instances work with families and couples may be more appropriate than work with individuals. In a number of communities, for example, there is a common distrust of the promotion of condom use, This sometimes believed to be a "Western concept" which is underpinned by a desire to limit population growth in "other" countries. A useful strategy might be to build on the refugees' and asylum seekers' perceptions of HIV prevention interventions in their countries of origin.

#### Address stigma and discrimination:

Ensure that "targeting" people from African communities does not lead unintentionally to increased discrimination. In addition, recognise discrimination within communities. Such prejudice particularly affects people living with HIV, women, and men who have sex with men.

#### Address confidentiality:

Reassure refugees, where possible, that seeking help about their health will not affect their immigration status. Identify with them the limits to professional assurances of confidentiality. As discrimination exists within communities, respect the need for confidentiality at this level. Reassurance is of the role of the health promoter is crucial, given refugees' and asylum seekers' experience of some local authority and immigration officials.

#### Support community and organisational development:

Enable community organisations to develop their own interventions. To do this, some security of funding must be provided, and support given in relation to assessing needs, planning, implementing and evaluating interventions, and financial management.

#### Discussion points.

#### Role of Governments

The roles of Governments in relation to NGOs, donors and UN agencies

- NGOs have a role in calling for government action. This can be especially important in HIV, where action is required before there is a visible impact
- NGOs can also advocate for negotiations in conflict situations
- External donors have a role in influencing policy
- The UN agencies can provide guidelines, it is up to governments to adopt them: there may be a conflict if governments make the same provision for refugees as for the host population, while the UN guidelines for refugees and displaced people may be different
- UN agencies can also support NGO action and action on human rights

#### Involvement of refugees

- In the UK, refugee involvement has been encouraged through support for proposals from refugee organisations. Refugee communities are scattered and although best reached through refugee support groups, such groups for African refugees are still not well developed.
- Problems with legal status can increase insecurity and make it more difficult to involve refugees

- In all areas, refugee involvement is important for appropriate aid: but sometimes logistics make it difficult to provide the right aid for people away from their homes - for example, refugees whose staple diet is banana have been provided with maize, where problems with transport and storage made it difficult to provide the appropriate food.

#### Integration of refugees

- Refugees may be settled for long periods but still remain distinct from the host population and still known as refugees after up to 30 years, In Africa, people are recognised first by their nationality and then by their ethnic group.
- The local population can be affected in many ways by the existence of refugees including through security problems and environmental degradation. This will make integration less likely. This has happened in Ngara in Tanzania and the government was working on these problems to protect the local population.

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## SESSION 4: THE NGO RESPONSE

### HIV/AIDS, displaced/refugee populations and CARE

Joan Schubert, CARE, USA

CARE's history dates back to 1945, just after the end of World War II, when a group of Americans decided to send packages with food and chocolates to needy families and individuals in war-torn Europe. Since its beginning 50 years ago, the organization has grown to be one of the largest private NGOs in the world, employing close to 100,000 people, 94% of whom are national staff working in their own countries. In 1995, the organization provided a record US\$422 million in assistance to 48 million people in 66 countries. CARE's key sectors include emergency relief, food security, health and population, water, income generation, agriculture and natural resource management.

#### CARE HIV/AIDS Global Strategy: Some highlights

In the late 1980's, CARE country offices began addressing the AIDS pandemic. Approaches ranged from institution strengthening among government and non-governmental organizations (NGOs) to assisting communities to provide appropriate means of care and support for HIV-infected individuals. CARE's organizational commitment to this issue was formalized in 1995 with the drafting of the CARE Global HIV/AIDS Strategy. Apparently, the Strategy has resonated well with CARE Country Office staff around the globe. Today, HIV/AIDS is an important sub-sector for CARE's Health and Population Unit. Presently, there are 18 HIV/AIDS projects underway in Latin America, Asia, and Africa, and at least a half dozen more designed and waiting to receive funding.

CARE's response to the AIDS pandemic is divided into HIV/AIDS Prevention, and Community Support Programming. HIV/AIDS Prevention includes activities which can informally prevent individuals from entering into risk situations by providing economic opportunity, as well as basic information, education, and communication (IEC), condom promotion, and STD management services. In Community Support Programming, CARE provides households and communities coping with HIV infection with opportunities to help maintain economic and social stability. These include innovative opportunities in micro-enterprise and agriculture.

#### HIV/AIDS, refugee populations and CARE: A short history

In early 1991, CARE-Rwanda initiated a project with the Government of Rwanda to improve and expand existing maternal health and family planning services in Byumba Prefecture in north-eastern Rwanda. CARE had been working here since 1984 on several different projects, including agro-forestry, water supply and some AIDS education. When civil war broke out in the project area people began fleeing towards the south to seek asylum. CARE's response to the situation was to move with the people providing family planning, water and sanitation, reforestation work, and other basic services required by the displaced communities.

In March 1994, chaos broke out once again in Rwanda, this time on a national scale. Many of the people CARE was working with in the south were forced to flee to Tanzania. HIV/STD education and condom distribution activities were resumed in mid-1994, this time in partnership with PSI, AIDSCAP and JSI. Features of the programme include condom distribution and community outreach through networks of Health Information Technicians (HITs), AIDS Community Educators (ACEs) and occasionally Traditional Birth Attendants (TBAs). The project has the full support of USAID (technical and financial support), the Government of Tanzania, and UNHCR.

Since this time, other projects have started in the area which build and expand on the original reproductive health and HIV/AIDS information programme. Not far from Benaco is the Musahura Hill Camp. At this site CARE is engaged in implementing a comprehensive reproductive health programme largely at the request of refugee women in the camps. Services currently provided by the project include family planning and safe motherhood care and operate out of three clinics. Child survival is also an important part of the programme. HIV/AIDS continues to be addressed through networks of HITs, ACEs and TBAs who distribute condoms and carry out community outreach and education activities in Musahura Hill and other camps in the area.

The CARE Musahura Hill staff report that the project has been successful—the need for services is high and the facilities are apparently well used. At the end of this calendar year, however, following a directive from UNHCR and plans negotiated with the Government of Tanzania, CARE will turn its reproductive health services over to a different NGO for continuation. This represents a general policy shift toward moving responsibilities and funds for camp operations to non-Western and local NGOs. As a next step, CARE-Tanzania is investigating how and if some sort of regular technical assistance or partnership project can be developed with the NGOs designated to take over the clinics to facilitate a smooth transition phase between organizations, and the continued provision of quality reproductive health services at Musahura Hill.

The bigger institutional picture: The Reproductive Health for Refugees (RHR) Consortium

The RHR Consortium was established and funded in 1995 by the Andrew W. Mellon Foundation. The Consortium's purpose is to support the institutionalisation of reproductive health services in refugee settings worldwide, including HIV/AIDS/STD prevention. Core members include CARE, The International Rescue Committee, John Snow Research and Training Institute, Marie Stopes International, and The Women's Commission for Refugee Women and Children. Members bring a range of complementary strengths, skills and experience to the table, the collective goal being to advocate for increased attention and action among policy-makers, donors and service providers regarding reproductive health services for refugees, including the provision of services. Over the past year and a half, working relationships have been forged among numerous international and local NGOs, UN organizations, USAID, the US State Department, universities and various development organizations in Britain and Europe. What CARE has enjoyed as a member of this Consortium is the united front it provides for advocating and pushing on critical reproductive health issues, even within its own organisation.

Areas of reproductive health receiving priority attention by the Consortium are consistent with the priority concerns of the UN and others working on refugee health issues. Areas include:

- HIV/AIDS/STDs
- Safe Motherhood
- Family Planning
- Sexual and Gender Violence
- Emergency Obstetrics

The endorsement of these interventions for refugee settings by WHO, UNICEF, UNFPA and UNHCR has been invaluable for leveraging interest and legitimising the urgent call to action by development groups and relief agencies across the globe.

## Consortium Approaches

The Consortium is tackling its goal to support the institutionalisation of reproductive health services in refugee settings worldwide in a number of ways. They include:

- Advocate: Advocating for increased attention and action related to refugee women's reproductive health among policy-makers, donors and service providers.
- Educate: Expanding the body of knowledge currently available for the promotion of reproductive health in refugee settings.
- Support: Increasing the level of funding available for refugee reproductive health.
- Implement: Supporting the implementation of approaches to reproductive health services in Consortium field projects.
- Expand: Expanding the number of organizations involved in promoting and providing reproductive health services in refugee settings.

What are the next steps for CARE?

CARE is committed to doing more and better programming across the board in respect to HIV/AIDS and reproductive health not only with refugees, but also with displaced and migrant populations. Some of the ways the organisation plans to approach this over the next year include fostering and promoting active partnerships with local NGOs to provide services; designing and implementing follow-up projects with repatriated beneficiaries and finally establishing reproductive health as part of the standard training package for all CARE emergency staff in order to build awareness and institutionalise commitment to reproductive health issues, including HIV/AIDS in refugee settings everywhere.

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## SESSION 4: THE NGO RESPONSE

The African Medical and Research Foundation (AMREF)

Rashid Mkanje, AMREF Tanzania

The political unrest and civil war in Rwanda and Burundi have brought over 700,000 refugees to the Western and North Western Regions of Tanzania.

The situation has produced conditions which have the potential to enhance the transmission of sexually transmitted diseases (STDs) and HIV such as:

- disintegration of community and family life leading to a breakdown of stable relationships
- disruption of social norms governing sexuality
- dependency and poverty
- booming of commercial (sexual) activities and other social interactions between refugees and the indigenous population.

Women are particularly vulnerable to STDs and HIV because of:

- increased sexual violence governing relationships
- need for protection from men
- lack of power to negotiate for protected sex
- indulgence in commercial sexual activities for survival.

Children, especially orphans and adolescents are uncertain of their future in such a harsh and uncaring environment and tend to become sexually active at a younger age. Sex may also be means of survival.

HIV spreads fastest in conditions of poverty, powerlessness and social instability—conditions that are at their most extreme during emergencies.

HIV was a serious problem in Rwanda before the exodus, with infection rates ranging from 4% in rural areas to 35% in Kigali. In contrast to one of the host districts where a research

study showed a prevalence of 2% - 5%. In the overcrowded refugee camps of Tanzania, the risk of transmission of HIV seemed definitely heightened and this could result in a large HIV and STD epidemic in the region. Thus, there was an urgent need to design interventions to address this situation. With very few proven effective interventions against the transmission of HIV in communities, most programmes rely on the promotion of safer sexual behaviour and increased use of condoms as a means of protection. A recently completed trial in Mwanza Region in Tanzania has demonstrated that prompt and effective treatment of bacterial STDs could reduce the transmission of HIV by 40%. AMREF has been the main implementor of this research and intervention programme.

At the time of the Rwandan exodus, there had never been any large-scale experience of HIV intervention in refugee situations. UNHCR and other relief NGOs were naturally primarily concerned with basic human needs of shelter, food, water, security etc. The population lacked information about HIV, lacked access to protective devices for sexual intercourse (condoms) and many single women and children lacked protection from sexual violence. In addition, health personnel were poorly equipped with skills and means to treat STD conditions.

Finally, among international organisations specialised in refugee crises, there was no decided policy regarding HIV/STDs in a refugee situation. Specific drugs and protocols were not available; privacy at the clinics (which were tents) was not possible, condoms were not available and information regarding HIV/STDs was not part of any programme.

AMREF, with our long-standing experience in this field and our presence in the Region, proposed that an HIV/STD Intervention Programme be launched under the auspices of UNHCR, the governing body in the refugee camps. We started the programme in August 1994 during the early phase of the establishment of the largest camps which were in Ngara district. We later extended it to Karagwe district during 1995.

#### Objectives

The overall goal of the programme was to provide services aimed at reducing the incidence of STDs and HIV among refugees and Tanzanian communities.

- to raise awareness on the prevention of STD and HIV
- to promote safer sex practices among the sexually-active population
- to strengthen and support health units in the camps and neighbouring Tanzanian communities to provide effective STD control services
- to establish an infrastructure for the management and prevention of STDs and HIV/AIDS
- to integrate syphilis screening at ante-natal clinics
- to provide the UNHCR medical co-ordination with tools for rational decisions concerning STD service delivery and STD drug policy
- to establish a monitoring and evaluation system of the programme.

#### Needs assessment surveys

In the absence of reliable data on STDs prior to the intervention, we conducted a survey using the rapid assessment methodology to identify the extent of STD-related problems; and, in collaboration with CARE International, a knowledge, attitude practice and behaviour (KAPB) study was carried out to assess the knowledge and sexual behaviour pattern of the refugee population.

#### Implementation

##### Information, Education Communication (IEC)

Health promotion and prevention activities focusing on HIV/AIDS/STDs at clinics and in the camps were conducted through mass education campaigns.

At each refugee community, the following activities were undertaken:

- sensitisation of community leaders
- general HIV/STD public awareness campaigns
- mass education campaigns on STD treatment-seeking behaviour

- health education and sex behaviour modification through "peer education".

Eight large mobile exhibition boards were used bearing messages in the local Rwandan language with cartoons around the theme of HIV/AIDS/STD. Promotion of condom use, demonstrations and distribution was also undertaken during these campaigns. Learning materials, developed or adopted in the local language (Kinyarwanda), were distributed during the campaigns and by peer educators (i.e. members of the community whom we had trained to specifically interact with peer groups: youth, business people etc.).

A total of 120 mass education campaigns were conducted in Ngara district camps reaching 230,000 sexually-active people. We distributed 400,000 STD/HIV/AIDS leaflets in their local language, Swahili and English

#### Sexually Transmitted Diseases Services

Since October 1994, we gradually introduced STD services at all health units in the camps; at outpatient clinics, antenatal and family planning clinics .

We trained health workers from 13 different organisations which were providing medical care in the camps on the use of WHO recommended STD treatment flowcharts, on the establishment of a sexual partner referral system, condom promotion and on drug keeping and accountability. We organised these training courses every three months, followed by refresher training also organised on a quarterly basis. Clinics were equipped with essential supplies and effective STD drugs. Weekly supervision of the STD services and in-service training as well as data collection was done by an experienced STD Intervention Officer from AMREF and a refugee counterpart.

Over one year, more than 12,000 patients were treated for STDs among a population of 350,000 (half of them in the sexually-active age group) or a new infection rate of at least 7% per annum. By September 1996, a total of 10,107 cases had been treated. We also undertook to establish syphilis screening services at ANC in the camps. Nurses were trained in the use of the Rapid Plasma Reagin (RPR) test which does not necessitate sophisticated technology. Results were available within an hour allowing for prompt treatment of the infected women before leaving the clinic. This programme proved very popular among mothers as we had enrolled the active support of traditional birth attendants.

HIV testing is a controversial issue in such highly political conditions and was not allowed in the camps except for screening blood units for transfusion. This is also in accordance with the WHO position on HIV testing in the refugee situation.

#### Monitoring and impact evaluation

The progress of the programme has been assessed through epidemiological and microbiological studies. Two rapid STD assessment surveys have been conducted. The first survey conducted during the emergency phase of the crisis and described earlier revealed the magnitude of the STD problem. The second survey, conducted one and half years later, was aimed at measuring the impact, measuring STD rates in the camps, evaluation of the performance of health workers, assessing sexual behaviour and treatment-seeking behaviour. STD rates had remained constant in this population although STDs were less frequently affecting pregnant women; thanks to the screening programme. However, it was noted that 40% of men had visited commercial sex workers in local brothels, and only a minority of these men had ever used condoms. Increased efforts for condom availability and education through peer education was recommended.

The efficiency of drugs used to treat gonorrhoea was monitored. The survey confirmed the high prevalence of penicillin and tetracycline resistant strains of neisseria gonorrhoea as well as emerging resistance to cotrimoxazole, a drug frequently used to treat this pathogen. This study led to AMREF recommending a new drug policy to UNHCR.

#### Support to Tanzanian refugee impacted community

Characteristics of the programme were:

- Low-scale support due to limitation of funds
- Training: sponsored training of health workers in comprehensive STD case management
- IEC: Worked together with District Health Management Teams in STD/HIV control
- Supply of condoms and educational material
- Increase the capacity of health workers
- Tanzanian health system is inevitably involved in the refugee health delivery system (refugees getting better services than indigenous population)

#### AMREF new strategy

- To do a more comprehensive sexual and reproductive health project
- Received funding from UNFPA for sexual and reproductive health project in the refugee impacted districts.

#### Strategies:

- Participatory project planning and implementation with community and other partner groups
- Curriculum development and training of health workers
- Integration of sexual and reproductive health services, with particular focus on: prevention and management of STDs and promotion and provision of family planning services
- Information Education and Behaviour change (EBC) on sexual and reproductive health services
- Services to vulnerable groups and their sexual partners e.g. bar workers, adolescents, women, youth, businessmen, truck drivers and road construction workers
- Counselling and advocacy of rights and safety of women through MCH/FP services, community services sector and women's groups
- Establishment of a reliable system to monitor clinical, epidemiological and quality of services information concerning reproductive and sexual health services
- Impact evaluation
- Networking.

#### Conclusion

This programme shows that it is possible to take early action to reduce the transmission of STDs/HIV in very adverse circumstances. Control activities should be part of refugee assistance from the onset of the crisis. Participation of refugees is essential so that available manpower and community leadership can be utilised for planning and assessment of needs and dissemination of information. Co-ordination between implementing agencies and UNHCR is also required for a standardized approach.

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## SESSION 4: THE NGO RESPONSE

### Targeting the vulnerable: home-based care for HIV/AIDS in a refugee context in Tanzania

Susan Mwita, The Tanzania Red Cross Society

The Health Information Team (HIT) Programme was established in 1994 during the emergency phase in the first month of the Rwandese refugee influx to Ngara Region in Tanzania. The main objective was to treat minor ailments and to reduce deaths through active case-finding and referrals. The emergency phase is over and now our main task is preventive health through active health education targeting epidemics that are likely to occur in the camps.

Benaco, the largest camp in the whole Ngara refugee operation, is covered widely by Federation/TRCS preventive health activities, such as health education through the HIT programme, MCH/EPI and supplementary feeding. The population of refugees in the whole camp is 160,00, and the under 5 population is 33,000.

## AIDS/STD Prevention Programme for Rwandan refugees

The HIT team consists of 204 health workers, 15 of whom are actively involved in health education on prevention of HIV/AIDS. They conduct regular monthly training sessions to influential groups in the community, such as commune/sector leaders, market committees, women's groups and traditional birth attendants, church leaders and teachers who in turn impart the knowledge to the community, in collaboration with the HITs.

Regular health education is also given in out-patient and in-patient departments, mother and child health clinics, and schools, and to youth groups, such as boy scouts and girl guides. Flares/Brochures are designed by the HITs, and printed and distributed during health education and especially in big crowds, such as in football matches and other social gatherings.

Condom distribution is another important task of the HITs and these are obtained through CARE International which is also actively involved in HIV/AIDS prevention.

The HIT programme also has a popular drama group which attracts crowds in the camps. Through this group important messages on STD/HIV/AIDS have been effectively communicated.

### Care for the vulnerable

Since the beginning of 1995, attempts to provide care for chronically or terminally ill patients were begun but could not continue due to funding problems. It was not until June 1996, when four organisations, CARE/AMREF/DRA/IFRC:TRCS, reached a decision to establish a small team with minimum facilities to provide care for the chronically and terminally-ill people in the camp.

To date we have an estimated number of 150 persons who need such care, the majority being chronically ill and more than 34 persons that are terminally ill and can no longer be cared for in the hospital.

### Home-based care for the chronically and terminally-ill persons

The home-based care team consists of:

1. a doctor/medical assistant, responsible for medical care in the camp and follow-up, including inpatient care;
2. a nurse for nursing care and to ensure compliance with medical regimes at home and also for monitoring of vital signs;
3. counsellors (HITs to undertake):
  - counselling for the patient and family
  - health education to relatives, neighbours and family members who are responsible for the patient in the camp
  - home visits and tracing of new cases both in the hospitals as well as from the community
  - mobilising and training family members in caring for the sick;
4. social workers
  - provide the logistical link between the patient and the health care system;
  - record-keeping;
  - follow-up of admitted cases;
  - home visits.

This team has been together only a short time but has proved very effective and is well accepted in the refugee community.

### Problems encountered

Difficulty in mobilising family members to take care of the patients in the camp: Most of the refugees do not have relatives therefore the alternative remains dependency on the neighbours whose response is usually very poor.

As is well known the refugees are more concerned with their immediate survival needs, such as food and shelter, which leaves little time to care for each other. As a result, they always expect payment for whatever they are asked to do.

Due to shortage of funds, drugs for treatment of opportunistic diseases and medical equipment, such as BP machines, thermometers and materials for dressing, are in chronic short supply.

Means of transport to enable the team to do regular visits are also inadequate for same reason cited above.

Risk factors which contribute to vulnerability to HIV/AIDS in the camps

The risk factors which contribute to the spread of HIV/AIDS include:

- Non-availability of HIV/AIDS test (Western Blot). From January 1995 to July 1996, only 3,546 persons were tested at the German Hospital with the Elisa Test; of whom 355 were positive. The tests were carried out to establish diagnosis and for screening of blood donors. The Western Blot Test is not available because the reagents are very expensive, therefore the risk of giving contaminated blood exists. The Western Blot Test should be made available.
- Handling of patients in emergency situations, such as in maternity and surgical wards. Priority should be given to sterility of equipment and safe blood donation, especially for ruptured uterus, accidents and severe anemia.
- Low uptake of family planning campaigns - since the refugees strongly believe that they need to replace the lost population; ignorance is a risk factor. Better health education strategies on family planning should be established.
- Displacement, frustration, poverty, unemployment, breakdown of social structure and culture, and lack of parental guidance to the youth.

Discussion Points: the NGO response

Gender issues

- Gender issues were seen to be key to HIV prevention: these are not always adequately addressed by NGOs.
- CARE and other NGOs did include sexual and gender awareness in their training programmes for emergency workers in reproductive health. This needed to be a part of all training for emergency staff, and was neglected by many donor agencies.
- Gender needed to be a key issue from the start along with food distribution and water etc. Basic action needed to be considered to protect women and children e.g. location of latrines, lighting, provision of a police force etc. This would encourage better uptake among women of the more structured prevention programmes later.
- A holistic approach was most appropriate in an emergency situation, if the focus was on medical or technical issues then there was a danger that the gender dimension gets lost.

Provision of reproductive health services

If reproductive health services could be included at an early stage of a refugee exodus this might avoid losing time, and make it easier to incorporate into ongoing health care and maintenance programmes later. The community should be involved from the start of an emergency situation in developing mechanisms for dealing with important issues. For example, being responsible for the protection of water supplies, protection of women against violence, and involving women in the distribution of food. This would pay dividends in the second phase in established refugee camps so that reproductive health services would be better received in the community.

Due to the rapid turnover of many health staff in an emergency, little handover of HIV information occurred. NGOs should ensure that all health workers are trained in the prevention and treatment of STDs, including HIV/AIDS, as well as in gender awareness as mentioned above.

Income-generating activities

A problem for refugees was that because of their desperate situation they lacked motivation. It was important to give them a chance to work to restore their dignity and self-worth. One NGO had started some income-generating activities with refugees but was soon told to stop by the authorities. It was difficult to balance the demands of the host population with those of the refugees.

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## **SESSION 5: RELATIONS WITH HOST POPULATION**

NGO Action to reduce vulnerability to HIV/AIDS among refugees or displaced people and the host community in Uganda

Dennis Nduhura Mwebaze, Regional Programme Co-ordinator, East Africa Regional AIDS Programme (ACORD)

Since the early 1980s, Uganda has been under siege by HIV/AIDS amongst the general population. A problem that began as a small isolated issue among the fishermen and cross-border traders in the two tiny fishing grounds of Lukunyu and Kasensero, is today a major national problem presenting serious health and socio-economic challenges. Official statistics give the number of HIV-infected cases at about 2 million persons, and those who have developed full-blown AIDS are put at around 50,000 people (STD/ACP, 1995). These figures represent a fraction of the cases given the poor surveillance system in the country, and the fact that more than 90% of the population is rural based, where most deaths occur and never are reported (Asingwire, 1992). The underestimation notwithstanding, the above figures represent a grim scenario in the light of the country's population which is about 18 million, for it implicitly implies that 10% of the population is infected with HIV, the virus that causes AIDS. All the above is happening in the country, when the region is experiencing political upheavals that have culminated in population mobility both across borders and within borders. In most cases, Uganda fits in both categories:

- Uganda has been a host to refugees from neighbouring Rwanda and Southern Sudan.
- The internal strife that has raged in the northern region of the country has led to displacement of people in the country as a result of internal strife, especially in the Northern region.

It is the above overview that forms the basis of this paper.

Once a group of people from a different region or a country settles in an area which is already inhabited, social interactions and relationships are bound to evolve. In this era of HIV/AIDS, some of the relationships that emerge tend to be risk factors in the spread of HIV; first among the refugees or displaced persons themselves, and between the refugees and the host communities.

The interaction between the refugees and the local population results from circumstances, which mainly rotate around the "survival" factor/strategy. These have been discerned in some studies to include commercial, friendships, intermarriages and casual sexual relations and social gatherings (ACORD, 1996a, 1996b).

In most places where refugees or displaced persons have settled in Uganda such as Oruchinga in Mbarara, East Moyo and West Nile, some tendencies of "urbanization" have occurred. This quickly transforms remote places into a semblance of urban centres where commercial transactions between the refugees and the local population evolve. In these "urban centres" the major economic activities include petty trading and alcohol selling, which act as a spring-board for accelerated HIV transmission. As a consequence, young men and women in the local communities find this life exciting and entertaining. For instance, in East Moyo, Adjumani township which is believed to have a high sero-prevalence rate is located almost at the centre of the refugees' settlements. It brings together the refugee population and locals. Given the high level of interaction between the refugees and dwellers of the township, the refugees as well as the local population are potentially exposed to the risks of HIV infection.

In a situation where there is high interaction characterized by excessive taking of alcohol and all sorts of merriment, the chances of new friendships emerging become quite possible. Sexual adventuring where people find it prestigious to have sexual relations with those of different ethnicity is not uncommon among the refugees and the host communities.

Specifically the relationship between the host communities and the refugees is reinforced and sustained by socio-economic factors, which at the same time facilitate the transmission of HIV infection in the two populations:

Abject poverty and other hostile socio-economic conditions seem to serve as a fertile ground for HIV transmission.

Women/girls in the camps exchange sex with fellow refugees, and men from the local communities for material goods or money. Refugee women are reported to exchange sex with men from the local communities for foodstuffs which they cannot access in a camp situation. On the other hand, women from the local communities also fall prey to male refugees, as the latter provide free items such as cooking oil, maize flour etc. which they normally get as relief (Asingwire, 1996).

Unemployment in the camps where refugees are not engaged in any meaningful social or economic activity opens the way to excessive drinking and sexual relations. These often substitute for recreational activities which are indeed lacking in the camps.

Sexual abuse and assaults within the camps, and settlement patterns which do not offer sufficient privacy.

The position of local and international NGOs

To date, most NGOs operating among the refugees and displaced persons are preoccupied with the immediate survival of refugees but not HIV/AIDS issues. They are concerned with basic relief items, including foodstuffs and primary health care. For instance, despite the existence of over 25 NGOs in East Moyo (most of them helping refugees), the AIDS problem is not occupying a central position in any of their programmes, except for ACORD, Moyo.

In addition, the refugee population in East Moyo is so big that the little that is done to address HIV/AIDS cannot cover all the refugee settlements. In Rhino camp, Arua, the German Development Service (DED) is the only implementing NGO in the camp on behalf of UNHCR. This organization, like many others, has no HIV/AIDS-related programmes for the refugees. IPSE, another NGO operating in Rhino camp, basically offers counselling services to the refugees, particularly those with mental and other psychosocial problems.

In Oruchinga, Mbarara district, Red Cross is an implementing partner of UNHCR, but HIV/AIDS intervention is not part of its core activities. ACORD, Mbarara, has AIDS programmes in the area which to a lesser extent benefited the refugees. Despite the inadequacy of NGOs in addressing the HIV/AIDS problem among the refugees, they still remain important entry points for HIV/AIDS intervention programmes alongside other relief activities in the refugee camps.

Way forward

Since the 1980s, Uganda has hosted refugees from the neighbouring countries which have been experiencing civil strife. The same period has been characterised by increased levels of HIV sero-prevalence in the region. Not only are sero-prevalence rates high, but the socio-economic effects created by the epidemic are now being felt in most societies.

What is clearly apparent is that the AIDS epidemic entails enormous and unique challenges for the AIDS Control Programmes (ACP) in the country, especially among the relatively unstable communities, such as the refugees and (IDPs). For, in the absence of a vaccine or a cure, AIDS education aiming at behavioural change remains a practical strategy through which the transmission could be minimized. Refugees' and internally displaced people's access to HIV/AIDS prevention and control services should be treated on the same levels (by UNHCR and implementing partners) as basic needs, since it is a right. Such interventions may include AIDS education using various channels, condom promotion and distribution HIV testing and counselling, STD prevention and control, among others.

It is also true that HIV/AIDS flourishes in situations of abject poverty which is characteristic of refugees and other displaced persons. Thus, any strategy to address HIV/AIDS issues

requires a focus on enabling the refugees and displaced persons to get some means of economic livelihood.

In conclusion, refugees interact freely with the host community. In such interactions, both stand a risk of HIV infection. NGO interventions should target both communities if HIV prevention strategies are to be effective.

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## SESSION 5: RELATIONS WITH HOST POPULATION

ACORD'S Programme in refugee affected area of Karawe, Kagera Region, Tanzania  
Donald Kasongi, Programme Co-ordinator, ACORD, Karagwe, Tanzania

ACORD's Programme in Karagwe District of Tanzania started in early 1996 with a major aim of supporting local communities to cope with the impact of refugees following the 1994 massive influx from Rwanda. The Programme is in an area with a refugee population of 125,000 while the local population is about 362,000. Refugees in this area forage on 30% of the district land area. ACORD's intervention followed an identification study carried out in the areas in 1994, the results of which prioritised the urgent need for implementing an HIV/AIDS control component under this Integrated Programme. This was further confirmed by a KAPB study which revealed that the host communities had little knowledge about the existence of the pandemic in the area.

ACORD's current support covers Nyabiyonza Division with a population of 56,000 people living in villages surrounding the refugee camps. Although it is generally considered that prolonged stay of refugees in an area makes the host communities hostile to the newcomers, the situation in Karagwe is concluded to be one of "tolerance". Areas of contact between the two communities include the access to and sharing of resources, mainly water, firewood, food and land. There are, however, growing conflicts on land allocated by the government, for which individuals from the local communities claim ownership. Trading centres have also developed in the camps as a result of the interactions. Refugees provide cheap labour for the banana and coffee farms and get foodstuffs in exchange. Refugee labour is mostly provided by women and children, while most refugee men are involved in trading. Women and children have to walk 10-19 kilometres daily to obtain firewood and to work in the farms for food not provided by UNHCR such as banana, cassava and potatoes. Women and girls are more vulnerable to sexual abuse. They rarely have a choice other than offering sex for food, security and money. Reported cases of rape are on the increase, while more adolescent girls from both communities are becoming sex workers. The interactions between the two communities in this area, through sympathy and familiarisation, have grown to the extent of intermarriages, without one side doubting of the other for possible threats like HIV/AIDS transmission.

In addressing the socio-economic and cultural needs of the local community for continued co-existence with the refugees, ACORD's Programme is undertaking the following:

Identification and training of local structures and vulnerable groups in HIV/AIDS control. These include village leaders, religious leaders, traditional birth attendants and traditional healers.

Identification (with the local communities) and training of women and youth peer educators. Supporting care-takers of orphans through income generating activities.

Providing legal education on widow/widower inheritance.  
Distribution of condoms and ensuring accessibility to both refugees and locals.  
Staging film and video shows on HIV/AIDS education.  
Collaborating and networking with UNHCR, UNHCR's implementing partners, and government institutions involved in HIV/AIDS and STD programmes.

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## **SESSION 6: THE MILITARY AND GUARDIANS**

Vulnerability of displaced refugees to HIV/AIDS: the Liberian experience

Anita Beyan, Save the Children, UK, Liberia

Liberia has been plunged into war for nearly seven years now, and more than 50% of the population are presently living in displaced shelters and refugee camps in neighbouring countries. Statistics suggest that about 700,000 people are internally displaced and nearly 800,000 are in neighbouring countries. Shelters for the displaced are usually located in the areas secured by the West African Peace-Keeping Force (ECOMOG) comprising about 10,000 troops, or in the control areas of one of the six warring factions in the country. According to reports, the combined strength of the warring factions is about 60,000.

In a situation of complete breakdown in the socio-economic structure and security of the country, people tend to rely on the available guardians, which in this case are the military or militia, to meet their needs. In March 1995, a study was conducted to investigate reports that children were being used as prostitutes in military camps and to find out what factors had contributed to this practice. At the time, the area with the largest concentration of ECOMOG troops, Buchanan, Grand Bassa County, was selected for the study. A summary of the findings are given below.

- Children were being used as prostitutes by both the military, which includes troops of ECOMOG, and the fighters in their control areas.
- There were reports that fighters in control areas had committed acts of rape, where children were the victims. (One victim of a sexual assault was interviewed during the study).
- Children were forced to engage in this unwholesome practice as a means of livelihood. Many of the children got involved through the influence of friends, and a few were pressurised by their mothers.
- Girls lacked knowledge on the use of condoms, as a result refused to use them when offered by the partners.
- Some of the girls had not reached the age of consent but were engaged in sexual acts with these men.
- Collapse in cultural and family structures of the society, lack of parental love and guidance had contributed to children practising prostitution. A few of them, particularly the younger girls, were in a permanent relationship which indicated that they lived with these men for support and protection.

### Interventions

Following the study, several interventions were implemented. These included: a series of intensive awareness sessions on HIV/AIDS and other sexually transmitted diseases aimed at local communities, especially girls, and military personnel in the Buchanan area; hiring and training personnel in a local NGO, Buchanan Community-Based Child Care (BUCCOBAC) that shares information in the local dialect; video showing; training of laboratory technicians in HIV testing procedures; and training of health workers and community health workers. The proper use and importance of condoms was stressed during each activity.

### Present situation

In August 1996, an assessment visit was made to Buchanan during which discussions were held with the Ghanaian medical authorities and representatives of Abused Women and Girls Project (AWAG), and BUCCOBAC. A major constraint to the evaluation of the intervention strategies was the constant rotation of the troops. The East African contingents were recalled

home in June 1995. However, the discussions revealed that child prostitution was not as widely and openly practised as in the previous year. Although teenage girls could be seen loitering around bars at night, attempts to talk with them proved futile.

Medical reports from the ECOMOG health facility indicated a high incidence of sexually transmitted diseases but at a steady level with no increase. The use of condoms among the soldiers was poor as is evident in the number of STDs and unwanted pregnancies. It is regrettable that figures could not be made readily available. However, clinics in Lower Montserrado, Margibi, and Bong Counties are reporting increases in STD cases. Nearly 10-13% of cases treated in these areas are presenting signs and symptoms of STDs, including three syphilis cases. It is important to note that these counties have large numbers of militia and internally displaced people.

Another factor which increases the vulnerability of the internally displaced people to HIV/AIDS is the lack of equipment at health posts to carry out tests for screening blood for the virus. Blood transfusions are being carried out without testing. According to reports from a local hospital in Bong County, an average of 250 blood transfusions are being carried out monthly without screening. Of this number, 150 (60%) involve children and only parents or close relatives are allowed to donate. However, it seems the practice is unsafe for the child. The blood donors, usually young men make up the fighting forces.

Recent developments in the country have shown that internally displaced people living in inaccessible areas are in deplorable health conditions. The Cape Mount and Bomi counties provide clear evidence.. Fifty per cent of the internally displaced people, were terribly malnourished, a particular impact being on children, women and the elderly. The people had been out of food for nearly six months. Only the fighters and their girlfriends appeared in good health. In such conditions, people become highly vulnerable to HIV infection and other diseases. The death rate from tuberculosis is also on the increase.

#### Recommendation

Although HIV/AIDS is not considered an emergency issue, it is during the emergency that all factors which contribute to the spread are manifested. Like other areas of health, efforts should be made to design strategies and activities to prevent the spread of the disease. This can be achieved by putting into place an integrated health delivery system. It is recommended that this should provide condoms, standardized STD treatment, clinic supplies, including gloves and delivery kits, and HIV/AIDS tests for screening.

It is also recommended that programmes are designed for children and young adults in displaced shelters that will be of some economic benefit to them. These may include small income-generation projects and skills training, including agriculture, handicrafts and sewing, as well as recreational activities.

Not enough is being done by ECOWAS and the United Nations in training troops intended for international duties on the rights of the child, and HIV/AIDS and sexually transmitted diseases prevention. It is recommended that such vital education be made a part of the package for all troops serving in this capacity, instead of solely relying on the receiving country, whose economy is already shattered, to carry it out, as is currently the case. This could help curtail the sexual exploitation of children who are innocently engaging in these practices only for survival.

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## SESSION 6: THE MILITARY AND GUARDIANS

The military and guardians

Major R Ruranga, Joint Clinical Research Committee, Uganda

I have been involved in the sending of people into displacement, I am HIV positive and work for the military and I have participated in the repatriation of refugees. Thirty years of upheavals in Uganda gives us credence to know what it means to send people into displacement and exile. The military is always at the forefront supporting politicians in creating problems.

#### History

There are over 12 million refugees in the world, and more are made every day. Internal displacement is worse. Liberia, Rwanda, Burundi, Zaire, Sudan, Uganda and many other countries in West Africa, Arab countries, Russia and Europe continue to be the refugee-breeding centres. HIV/AIDS thrives in these situations. 10,000 people are being infected every day, worldwide and 30-40 million people will be infected by the end of this century

Extent of the problem as it relates to displaced people and refugees

In these situations there is an:

- Increase in poverty
- Increase in the lack of medication
- Increase in unprotected sex
- Increase in number of unwanted pregnancies
- Increase in the number of infected children born

Pre-disposing factors to HIV vulnerability among displaced people and refugees

- Destitution and desperation:
- Being pushed out of home with naked hands
- Losing everything acquired in a life time
- Not knowing what will happen next
- Living in danger all the time

Diversity:

The main groups in special circumstances:

- The vanquished
- The victors
- Military

The environment:

- Too many people of different ages, upbringing and sex are heaped together
- There is fear and confusion
- People become idle
- There is shortage of the most basic needs such as food
- there is no provision of education or condoms and worse of all - no hope
- There is sex

The vanquished go with their defeated. The victorious welcome their heroes Both parties are unfortunately in a situation that creates conducive conditions for self appeasement

Challenges include:

- Readiness to receive these groups knowing they move with HIV
- UNHCR needs to carry out a study to help understand better the holistic approach to be taken.
- The immediate concern of a displaced person is survival now. HIV/AIDS does not appeal at this time.
- The consequence of HIV/AIDS is a disaster.

Prevention of the spread of HIV in this situation depends on our preparedness to address the immediate concerns:

1. Understanding that HIV is moving with the groups
2. Providing the basic needs in the area of:

- Protection of women
- Protection of children and adolescents
- Rapid and appropriate warnings all the time
- Food security
- Relevant films
- Identification of peers
- Reassurance

This approach may help the vulnerable women

3. The Military should be immediately separated from the civilian community, as their nature of work is conducive to HIV infection in many ways:

- They are young people
- They live away from their families for a long time
- The use of condoms or any other method of HIV prevention does not appeal to them as a bullet threatens their immediate survival.
- Many of them will have lost hope in life because of the criminal acts they have committed during the time they are being used by politicians.

#### Conclusion

The high prevalence of HIV is a snare in Africa and the world and the conditions of displaced people and refugees deserve serious study.

The causes of war should clearly be co-related in order to put the military in the right perspective as refugees.

The international community should put in place an appropriate framework for the administration of justice.

Unnecessary wars are encouraged because of the support UNHCR and other agencies accord to the war mongers.

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## **SESSION 7: REPORTS FROM SMALL GROUP DISCUSSIONS...**

### **Reports from small group discussions**

Group 1: Displaced people and refugees with HIV/AIDS

*Facilitator: Ann Smith CAFOD*

*Rapporteur: Catherine O'Keefe*

The group had found it difficult to focus on people with HIV/AIDS in view of the many other issues that had come up, and because those affected: don't want to know their HIV status, know but ignore, or don't know

Action: if possible, involve people who are open about HIV status in programmes

#### *Commerce*

- There is a relation between commerce, money and survival in the refugee camp setting. People use their bodies for sex in order to obtain basic commodities e.g. water, food. Therefore HIV status is ignored
- Sex work leads to increased STDs and health deterioration

- Increasing sexual activity occurs in camps, reasons for this include: purchasing power, boredom, reproduction/procreation to replace loss, sense of death and dying, alcohol.

Action:

- address boredom etc. factors
- income generation
- positive approach to sex education
- actively involve refugees
- peer work
- refugee networks

*Violence*

- Increased violence in camp situations - sexual violence also increases
- Problems of abuse of power and imbalance of power

Action:

- Can NGOs influence power structures in camps, especially from negative effects towards women
- Educate the military and peace-keepers
- Different models for "organising refugees"
  - do we need refugee camps? - if so, issues to consider include size (should they be large or small), location, length of time people stay in them,
  - give a voice to refugees regarding their own needs

*Human rights*

People with HIV/AIDS in the refugee situation are faced with:

- social isolation
- scapegoat/prejudice
- when ill, if no social support, easy prey to robbery, violence and false cures
- asylum depends on HIV status
- access to health care may be denied to people living with HIV/AIDS (limited resources)
- lack of community support system, counseling etc.
- how to ensure confidentiality for people with AIDS
- pregnant women are denied informed choice

*Health*

lack of adequate care and support

overburdened health system

increased poverty for people with HIV

lack of antenatal care and STD treatment

voluntary HIV testing needs careful thought::

- need appropriate awareness, training, back-up support
- offer the same services as (1) host country; (2) home country

For further attention

- target camp and country authorities re sexual violence
- NGOs help in empowering refugees, especially women, to look at issues (i.e. 80 per cent of refugees are women and children)
- HIV epidemic is an emergency itself, how to deal with it is a long-term issue
- involve host community, see them as a resource
- distinguish between refugees and IDPs, as the situation can be different for HIV people in this different contexts
- involve refugees in planning
- addressing wider issues = reducing vulnerability to HIV and discrimination against people affected by HIV
- must remember the marginalised among refugees e.g. the elderly, injecting drug users, men who have sex with men.

Group 2: Women who are displaced or refugees

Facilitator: Gillian Wells, Helpage International

Rapporteur: Lindel Sachs, Marie Stopes

#### *How commerce affects vulnerability*

- distribution of basic needs e.g. food
- working with women/empowerment for better negotiating skills
- power structures in the community in relation to the traditional income-generating activities available for women
- educating girls to provide more options for income generation
- NGOs to assist with marketing of goods
- having to travel long distances to get food etc. makes them more vulnerable

#### *Vulnerability to HIV in terms of gender*

- Empower women by providing barrier methods that will help in prevention of HIV/STDs. Other contraceptive methods such as microbicides and spermicides should be investigated.
- Provision of healthcare to women should take account of their daily chores and time at their disposal. The healthcare should be easily accessible to the women e.g. mobile clinics.
- Collaborate with traditional healers in the provision of advice and care to men, who usually prefer to use traditional healers for their healthcare needs.
- Targeting the services in a manner to reach women, consider time, access, privacy and confidentiality.

#### *Violence and HIV*

- Women have no security in terms of legal redress from their oppressors, host country.
- Rape as a specific means of HIV transmission
- Women need safe access to water, food, firewood etc.
- Men as a factor in the transmission of HIV: alcohol consumption, domestic violence
- FGM; young girls being raped to "cure" men of HIV: exposure of young girls in commercial situations e.g. as bar maids

#### *Effects of bereavement and displacement*

- Some widowhood rites: wife inheritance and other harmful traditional practices.
- Social status as a widow i.e. without a male "protector" makes her vulnerable to sexual harassment.
- Actively seeking sexual relationships to validate themselves for social status
- Psycho-social counseling should be appropriate and culturally sensitive.
- Practical support to help the women go on with their lives.

#### *Human rights related to HIV*

##### Commerce:

- Immediately and in the short-term refugees rights to commercial activities are restricted.
- Sero-positivity status limits a person's access to economic activities. Refugees are more vulnerable in such a situation.

##### Gender:

- NGOs to make women aware of their rights in refugee camps.
- The role of NGOs and the justice system, security of women.
- NGOs to report human rights violations
- NGOs as camp managers, as advocates for improving conditions.
- NGOs should lobby UN agencies and governments, including Western governments

#### Violence and bereavement?

- Safer and confidential access to basic needs. NGOs need to incorporate this into all their programmes for refugees.
- involve the women/service users in the development of programmes, especially in empowerment of women and other psychosocial activities.
- Services need to be tailored to client group's needs (men or women)
- NGOs have a role to play in advocacy and monitoring of human rights/protection issues and also to increase awareness of other organisations working in the camps.
- NGO programmes and staff need to be culturally and situation sensitive
- NGOs to provide practical support to enable the women to go on with their lives after bereavement or displacement.
- Investigate the potential of religious and traditional leaders as a resource for outreach work
- Identify the appropriate systems for the community through women
- Make use of trained personnel in the camps/community.
- Women controlled methods and STD prevention
- Ensure confidential access to reproductive health care

#### *Future NGO activities*

NGO activities were considered at two levels, the institutional level and programme delivery level.

#### Institutional level

- NGOs look at policy and programmes relating to women and HIV.
- need to get more women into positions of power e.g. in Government and NGOs etc. so they can make the decisions about women in refugee settings
- lobbying governments to adhere to obligations of the conventions
- Western NGOs need to lobby donor governments
- lobby with other NGOs to ensure better coordination ensure consistency, same outcomes and avoid duplication
- lobbying pharmaceutical companies and other agencies involved in techniques and procedures to assist development in female controlled methods of STD prevention
- advocacy on human rights and protection activities as they relate to women in refugee settings

#### Programme delivery level

- need gender awareness training for NGO staff to ensure programmes that focus on women do not affect them negatively.
- NGO staff should be aware of AIDS and also that important skills exist among refugees to avoid transmission of HIV and to find solutions that are culturally acceptable
- role of NGOs as human rights monitors to look for human rights violations as they relate to women
- role of NGOs training in culturally-sensitive practices and programmes that are culturally sensitive
- programme development needs to be examined in different refugee settings worldwide. as programme delivery varies between countries
- flexible approach to cope with competing demands of programmes
- need for refugee programming to look not just at emergency relief but also development aspects of programme delivery
- programmes to empower women to know how HIV affects their lives
- NGOs must be aware that when refugee women are involved in programmes, don't overburden them in view of the work they already undertake in their traditional role
- educate and train women for the future so they can obtain work outside prostitution
- programmes should involve men who are the main players in AIDS.

Group 3: Men who are displaced or refugees

*Facilitator: Judy El Bushra, ACORD*

*Rapporteur: Susan Amoaten, ODI*

It was noted that little research has been conducted on men with HIV who are displaced or refugees.

#### *Vulnerability*

- being a refugee was equally traumatic for men as for women
- all men are vulnerable to conflict but in different ways as refugees, IDP, prisoner of war, military, people who don't flee their country and youth
- people's knowledge of HIV may be negatively affected by conflict and their flight lead to change in perceptions and priorities i.e. the "live for the moment" mentality.
- men's status is a critical issue in understanding their vulnerability - change loss or maintenance of

#### *Commerce*

- men are more likely to get involved in trade and have access to sexual opportunities

#### *Gender*

- status of men affects their vulnerability
- losing their position as head of household
- status through sexual activity
- power relations among men

#### *Violence*

- concentrated on the military and their vulnerability to conflict, and military as refugees
- coercion of young boys into fighting, use of drugs and alcohol, rape or themselves being sexually abused - systematic desensitization of boys as they become part of the fighting force
- peer pressure - violent life affects value systems

#### *Bereavement and displacement*

- under recognition of the effects on men of loss of family
- replenishing children
- norms of breakdown - life for now again an issue of status

#### *Future issues*

- Need to understand how people became refugees
  - where are the men (80 per cent worldwide are women and children)
  - to what extent are social structures transferred to the new situation?
  - how do men's roles change in the light of this?
- not enough knowledge of the importance of identity and history in determining their behaviour patterns
- what is the extent of the refugee settlement outside camps - do we concentrate too much on the more visible refugee populations and ignore those refugees living outside camps?

Group 4: Displaced and refugee children

*Facilitator: Lola Nathanail, Save the Children*

*Rapporteur: Gay Palmer, Consultant, Infant Feeding*

Children were defined as aged between 0 and 13 years.

- Orphanhood                      child-headed household
  - unaccompanied minors e.g. street children
  - stigmatisation of children whose parents have died of AIDS
  - street life which leads to sex work
- Sick parents                      child cares for them

- economic burden on the child to give money for the family
  - stigmatisation
- Economics                      basic needs not met
  - burden of earning for the household
  - used as cheap labour, often exploited
- Violence                        seen as second Class citizens and may suffer violence
  - harassed by security forces in camp and sexually abused
  - seen as a safer option for sex
- Accountability                under-reporting of abuse of children
  - accepted as child's fate if abused
  - weak structures to deal with these problems
  - lack of awareness of children's rights
- Emotional needs-trauma of witnessing death from HIV and violent death
  - lost trust so difficult to establish relationships
  - poor structures to deal with problems
  - reduced contact with mother due to pressures on her e.g. food queues etc.
- Information                    Media has a helpful role to draw attention to problems
  - problems ill-defined
  - low awareness of Convention on the Rights of the Child among NGOs, parents, and in community
  - general education for children suffers in refugee situation
  - loss of contact with family may mean loss of identity
  - some confusion among health workers about breastfeeding and HIV
- Social needs stigma towards children from host country
  - play sessions important but may not be available if parents under pressure
  - support for mothers or carers

*What can be done by NGOs?*

- NGOs should pressure government in meeting its responsibilities towards children e.g. CRC
- Need clarity about who is responsible for IDPs and refugees
- NGOs should be responsible to define the problem - collect qualitative and quantitative data - to present to governments
- NGOs should support the community in programme design
- NGOs should support carers and parents
- NGOs should focus on process not just output (to help the community to help itself).
- gender sensitive programming - NGOs could facilitate gender awareness
- woman's role in protection -
- Rights of the child should be summarised as the 3 P's -
  - protection of children
  - prevention of suffering of children
  - participation by children in decisions

Group 5: Young people who are displaced or refugees

*Facilitator: Lyn Elliott, Save the Children Fund*

*Rapporteur: Ruth Hope, University of Keele*

Young people were defined as aged 10 to 25 years.. They were sub-divided into three groups: 10-13 years, 14-19 years, and 20-25 years, while recognising some possible overlap between young people and children and young people and adults.

#### *Vulnerability to HIV as young people*

Young people are vulnerable because:

- economically dependent
- impressionable - peer led
  - susceptible to wealth, especially girls used by older men for safer sex
  - susceptible to misleading by elders
- all young people struggle with their identity
- incomplete education
  - formal
  - informal
- lack of knowledge re sex and sexuality
- sense of invulnerability e.g. sex, drug taking
- risk-taking behaviour
- biological/physiological immaturity
- access to health care limited
- "trouble makers" due to boredom/lack of occupation
- family breakdown
- not involved in decisions on their own lives

#### *Vulnerability to HIV as young refugees*

- increase in family breakdown
- lack of decision-making/sense of hopelessness
- involved in armed conflict/soldiers, mainly boys
- trauma gun-toting boys
- dehumanising with a false sense of power
- psychological scars
- increase in economic need and responsibilities
- lack of guidance, knowledge, awareness from parents, and role models in society
- parents absent deprived of socialisation process
- parents main concern is their own immediate survival (not socialisation of offspring)
- undeveloped social skills including, assertiveness, negotiation skills, sense of being and worth
- living arrangements disrupted in communities where child may live outside home
- lack of privacy and confidentiality in camp health services which do not attend to young peoples needs
- no specific young peoples services
- legal rights breakdown
- role of church and religious beliefs may increase or decrease vulnerability

#### *Gender issues*

- Important in relation to vulnerability to HIV as young girls and boys are seen by society in relation to different norms and roles
- sexual exploitation, men become less vulnerable with age, but girls remain vulnerable
- parenting- girls are more likely to have child care responsibilities
- education may be more available in camps, but girls are more likely to be withdrawn if this conflicts with other needs
- leadership - men make the decisions
- need for male and female occupations and roles
- greater sense of loss and role change for men in camps (frustration could lead to violence) as girls still maintain some "home-making " functions
- more pressure to find a partner and to procreate (security)
- more abortions in young people in camps

### *Human rights*

With the exception of rights of the child there is a very limited understanding of issues related to human rights. Social, political and civil rights concepts are not well developed or understood.

### *What can NGOs do?*

- Proactive not reactive
- Relief workers must be aware and skilled in
- HIV/AIDS issues
- Gender issues
- Esteem and roles
- integrated planning rather than HIV in vertical programmes
- young peoples programmes must firstly:
  - develop life skills
  - develop self-esteem/sense of worth
  - assertiveness
- Use child-to-child and shared learning approaches to involve young people in plans and decision-making. Pilot "stepping Stones" project for developing life skills.
- develop peer roles for older groups with responsibilities for young people to tackle such issues as boredom etc.

### *Models*

3 models for intervention

- paternalistic - inappropriate, no sustainability
- parallel - wasteful, need coordination among agencies and linking activities
- partnership

co-operation among agencies and linking activities

beware lack of sustainability as will lead to demoralisation later

avoid setting up services that are better than those available to host community

consider young peoples centres to provide the following services:

- social
- health
- sport
- skill development

Rotate staff for skill development training i.e. skill development services may be appropriate in some places especially if staff from other parts of the camp could be brought in to learn about young peoples needs so they had a role in staff training and development so young peoples needs met in more integrated fashion.

### Discussion

#### *Childbearing and attitude change*

Research using focus group discussions in Ngara camp in Tanzania showed that women may want to have children initially in an emergency situation, but later when they were more settled, women did not want more children under such conditions. Attitudes were likely change over time. One participant pointed out that it was the men who wanted children for political reasons even if women did not, and that greater attention should be focused on women's needs.

#### *Issues around discussion of HIV and refugees*

The UK study presented by Krishna Maharaj and Ian Wright had shown that UK refugee groups did not want information to show the high prevalence of HIV/AIDS among refugees

because of the danger of further alienation. It was suggested that raising the HIV issue too high on the agenda would increase alienation. On the other hand not raising the issue would put the refugees at greater risk of HIV. It was noted that in one Asian country, fear of raising the issue of HIV among refugees, had meant that there were no programmes for refugees and displaced persons on HIV prevention. People who were living with HIV/AIDS, including refugees, were the best placed to fight for their rights and to improve their conditions.

*Unequal access to health care*

The experience of one participant working in Europe was that migrants were not interested in HIV/AIDS, they were more interested in unequal access to health care in general. Migrant groups needed to support action in support of this need.

*Identity*

On the question of identity, it should be realised that refugees may not want to assume the identity of the host country and may perceive any moves towards integration as a loss of their own identity. This subject was badly handled by governments, NGOs and refugees.

*Sex distribution in refugee camps*

The Refugee Studies Programme at Oxford had looked at the sex distribution of adults and children in camps and found that it reflected that of the normal population.

## **SESSION 8: SUMMING UP AND RECOMMENDATIONS**

What have we learned and where do we go from here?

Chair: Lyn Elliott, Save the Children Fund

Lyn Elliott acknowledged that it had been a significant task to organise the seminar. There had been difficulties accessing people who worked with refugees and displaced people and HIV/AIDS. If there was a weighting of participants from one region rather than another, it was through no lack of trying to make the seminar as comprehensive as possible.

She pointed out that it had been one of the first meetings on NGO action on refugees and displaced people and their vulnerability to HIV/AIDS, and hoped it would be the first of many. She also hoped that next time there would be a wider global representation of participants. She expressed her gratitude to those who were represented at the seminar for their contributions, a lot had been learned, and it was a good forum to carry many of the areas identified for action forward.

Summing up by Sue Lucas, UK NGO AIDS Consortium and Calle Almedal, Norwegian Red Cross Society

In their summing up, Sue Lucas and Calle Almedal outlined the major issues that were raised during the seminar for refugees and displaced people with HIV/AIDS, as follows:

- Human Rights
- Adolescents
- Gender
- Community Action/Community Development
- Role of Military
- Access to Information/Education
- Identity

Cross-cutting issues

A number of issues were identified that could be considered with each of the above.

- balance between host community and refugees
- phases of an emergency and later refugee settlement, survival issues, change over time
- refugees in different situations - camps, locations
- balance between the emergency of HIV and the immediate needs of refugees
- clarification of definitions

#### Human rights

- need to define concept and basis of human rights
- issues of discrimination against people with HIV (or thought to have HIV) as well as against refugees
- role of UN in protecting human rights
- role of governments in protecting human rights
- People with AIDS - rights to health care and protection
- issues of asylum-seeking and HIV status
- role of testing/context of testing

#### Community action

- enable voice of refugees to be heard to inform policy and action
- community development approach
- participation of refugees
- identification of previous skills of refugees and displaced people before displacement occurred
- understanding of social structures refugees bring with them and how these change
- involvement of young people
- use of existing refugee skills

#### NGO action

- train NGO staff to use refugee skills and community development techniques
- Groups representing refugees and displaced people should advocate for equal access to health care, including HIV/AIDS care, as appropriate??

#### Gender

- violence against women, girls and younger boys
- imbalance of men/women
- refugees misconception?  
implications of imbalance?  
reasons?
- too little emphasis on men
- lack of women in influential positions to bring women's health issues into focus
- lack of understanding of social/psychological pressures on men which may facilitate HIV transmission
- need to replace children - pressure to procreate? stage?
- adolescent issues: exploitation, education and parenting
- men's trauma is equal to that of women
- pressures from former military life
- effects of loss of status

#### Power relations

- sexual activities become more important increasing the risk of HIV  
need for partnerships (sex) for security

#### NGO action

- Training NGO staff in emergency and gender issues  
research on masculinity and violence/ male sexuality

#### Adolescents

- need to develop life skills of young people
- government role in responsibilities for young people and children and their protection
- problems of orphan-hood
- problems of education in general and education about HIV in an unsettled situation

#### NGO action

- develop skills
- training staff
- better coordination of NGOs
- centres for young people
- ? sustainability

#### Military

- improve training of military
- military as refugees:
  - role of UN/rights of military as refugees
  - role of sanctuary or failure to protect them
- education in prevention of HIV/AIDS
- coercion of young boys
- sexual abuse
- desensitisation of boys in military effects behaviour

#### NGO action

#### NGO role in work with the military

#### IEC

- access of information for women, especially sex workers
- knowledge of HIV and behaviour is changed by the fact of displacement
- education of children about HIV
- role of media - use of media

#### NGO action

NGOs working with refugees could include information on HIV/AIDS during festivals. etc??.

#### Identity

- identity/security and how people respond to the importance of HIV - new area?
  - relevance of identity to security and protection
  - identity of young people and children
  - male identity
- long-term identity of communities and discrimination and particular needs relating to HIV

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#### BACKGROUND DOCUMENT:

#### HIV/AIDS and refugees in developing countries: a background discussion document

This paper is based on information received or sought out during work on this seminar at the Consortium. It is not the result of an exhaustive literature survey, and it is probable that important papers have passed me by. I hope that nevertheless it will be of interest to participants in the seminar and will give some background information to those who are not familiar with the issues.

There was little discussion of the effect of HIV on refugees and the impact of emergencies on the spread of HIV until the Rwandan crisis in 1994. Reasons for this included fear of increasing discrimination against refugees, and the tendency to denial which has been a characteristic of the response to the HIV pandemic.

Since the UN Conference on Population and Development in Cairo (1994) and the Fourth World Conference on Women in Beijing (1995) there has been emphasis on reproductive health and rights and the discussion on HIV and AIDS has mostly been as part of this. While this is to be welcomed, in that reproductive health and HIV are linked, there are areas which are neglected if the debate is restricted to reproductive health. Such areas include care for those who are HIV positive, work with men who have sex with men, older women and children. On the other hand, emphasis on reproductive health has led to a much greater recognition of the vulnerability of women and the risks of sexual violence and abuse. Such emphasis is immediately relevant to the spread of HIV, and here the overlap with reproductive health is a welcome link. However, it is still worth pointing out that although there is now a growing awareness of HIV/AIDS and the issues it raises for refugees, there is not yet much change in practical approaches at field level.

Vulnerabilities will differ in phases of an emergency and response to an emergency, from the chaos of initial flight, to the establishment of temporary accommodation and the meeting of immediate needs, to more permanent settlements.

The following points have been drawn from a number of articles about refugees and reproductive health and HIV and the vulnerability of women in emergencies.

In general, vulnerability is increased because of:

- destruction of families and deterioration of social structures
- loss of homes and incomes
- overburdened health services and lack of access to sexual health care services
- exposure to different populations with different levels of HIV infection while on the move
- commercial sex industry within camps
- language difficulties

For women, vulnerability is increased because:

- men are unemployed in camps, thus increasing levels of boredom, depression and alcohol use and increasing the likelihood of sexual abuse of women
- there are high proportions of women and children in refugee camps and women without men are particularly vulnerable. In many societies women are second class citizens and under the protection of husbands and families. Separated, they are unprotected but still second class citizens, vulnerable both as women and as refugees
- women who have been raped have very low status and may lose the protection of their families because of the rape. They are therefore easy targets, as they have no support or sympathy
- without other opportunities to make a living, women may find prostitution the only means of survival open to them
- the structure of camps increases the vulnerability of women if there are communal latrines, no lighting and no protection for women who must collect water and firewood outside the camps
- women who have been raped or abused have no recourse to justice - the guards, military personnel and administrators who are supposed to protect them are likely to be their abusers, and there may be no legal framework in the country of refuge which they can use
- rapes may not be reported for fear of retribution
- It is known that military personnel, including UN peacekeeping forces, are especially vulnerable to HIV infection and that there are high levels of infection among them. Since there is likely to be sexual interaction between them and refugee women, this adds to the vulnerability of women in camps.

Young people and adolescents are at risk because:

- there are no secondary schools or opportunities for education
- with little to do, uncertainty about the future and little security, young people become sexually active at a younger age
- there are cultural barriers to discussing sex
- teenagers may be separated from families and living alone without guidance or support
- there are no income opportunities for the girls

- adolescents tend to distrust the health facilities and not understand how to use them

#### Approaches and priorities

Activities must take into account the following:

- lack of trust of services and authority after social upheaval
- lack of information about services and who they are appropriate for
- assessment of the risks and levels of HIV in a refugee population is very difficult, and runs the risk of increasing stigma, discrimination and insecurity. Assessment has to be made through the levels of HIV in the home country and the host population
- for HIV and other STDs, services should be available to both the refugee population and the surrounding host population

Some priorities are:

- protection of women
  - better camp design
  - increased security in camps
  - increased sensitivity of staff and refugee groups:
- development of a legal framework for protection of women
- provision of condoms from the start (though condom promotion did not result in much increase in levels of use in Tanzania)
- access to treatment for other STDs
- safe blood
- use of universal precautions for health staff

Successful approaches which will reduce vulnerability to HIV must include

- involvement of the refugee populations in all decisions
- empowerment of refugees through community development to enable them to solve problems
- inclusion of women in all levels of decision making and increased female staff
- sensitivities to the priorities of the refugees themselves - eg for Rwandans fertility is vitally important, so an approach to encourage STD service take up could be through the information that this will protect fertility

The points which follow were not covered in published papers and need more attention.

#### People with HIV

As most of the published material is about women or reproductive health, there is little about the problems of people with HIV. However Benjamin (1996) writing about Rwandan refugees in Tanzania, notes that after the first year there were increasing numbers of people becoming sick with AIDS. In this case, volunteers were organised to help. It was important that all sick people were treated in the same way, and that this was not just a service for those with HIV because of the levels of discrimination against people with HIV.

A problem which is not often mentioned is that of resettling refugees finally. Many countries which could be final destinations (e.g. the US) do not accept those who are HIV positive and insist on compulsory testing. This means that the possibility of permanent splitting of families may have to be faced if there is a possibility of HIV infection in any one member.

#### Children and HIV

This again is barely mentioned. From my own knowledge, linking children's vulnerability and refugee situations, the following points need to be considered:

- for an emergency in a country with an established HIV epidemic, there will already be high numbers of orphans. What happens to these children in mass population movements?
- Where there is a high level of infection in the refugee population, more children will be orphaned as parents die of AIDS within camps. Provision must be made for these children, who will be highly vulnerable for all the reasons above and because they may also be stigmatised.

- Children affected by HIV may already have suffered trauma already, to which is added the trauma of becoming refugees
- HIV infected children will need special care
- there are unresolved issues around advice over infant feeding and wet-nursing where infants are separated from their mothers in an emergency
- where women are at greater risk of infection, which is clearly the case for refugee women, their unborn children are also at greater risk of infection
- vulnerable children are likely to be at risk of physical and sexual abuse: since this is likely to involve bleeding, the chances of transmission where HIV is present are high. It is not known how vulnerable boy children are in comparison with girl children.

#### Older women

It is known that older women are at risk of HIV infection, and that the efficiency of sexual transmission to women is greater after the menopause. The literature, other than UNHCR Guidelines on Protection of Refugee Women, does not mention older women at all, and the papers on reproductive health specifically refer to women under 45. There is no information about whether older women are also at risk of rape - since pregnancy would not be an outcome, such rape if it exists would be even less visible than rape of younger women. Older women may also have an extra burden of care of children and the sick.

#### Men who have sex with men

Currently, information is slowly becoming available about men who have sex with men in developing countries, especially in Africa where up to now there has been a blanket of denial. It is not known whether male rape takes place in refugee settings.

Sue Lucas, UK NGO AIDS Consortium, 1996

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