



# Refugees and the impact of war on HIV

On a recent afternoon in the eastern Rwandan town of Rwamagana, a support group met in a simple church. Its sloping tin roof creaked and groaned in the heat of the sun. Most of the voices inside were women's. They had come to share their experiences of living with HIV. After the meeting, a woman whose shock of black hair was streaked with grey, relayed the feelings of many. "The HIV infection we're facing now is a consequence of the genocide," she said.

For some Rwandans, the linkage between war and HIV is direct. An unknown number of survivors contracted the virus from the brutal, multiple rapes they endured during wartime. Others became vulnerable to infection after the war ripped apart their families and society and they migrated within or outside their country, sometimes trading sex as a means of survival and protection. For some, genocide and displacement may have had little to do with how they became infected. Still, regardless of how the women in the Rwamagana support group acquired HIV, many now struggle with similar problems in the war's long shadow. Those who lost their families to the genocide have no one to help them cope with their diagnosis. "When you're infected you need someone to take care of you," said one group member, "but because of the war, we don't have family."

This lack of support, combined with the psychological reverberations of trauma, including depression, leads some to give up altogether. "They don't want to live," said Beatrice Gasinga, a trauma counsellor and founder of Urunana, a national non-governmental organization (NGO). "They reach the point that they're supposed to take [anti-AIDS] drugs, but they just don't want to do it." When they do seek care, genocide survivors may encounter genocide perpetrators. Living in the same post-war communities, they attend the same health clinics, and participate in the same support groups, including this one. "Some of us killed," said one of the few men participating in the group. He recently stood trial in a local *gacaca* court for his role in the genocide, served time in prison, and acknowledged and apologized for his crimes.

Rwanda is only one of many countries where mass rape, conflict and forced displacement impact the HIV pandemic in multiple, complex ways. Since 1989, at least 122 armed conflicts have taken place worldwide, according to the comprehensive database of the Uppsala Conflict Data Program. As of late 2007, CrisisWatch, a programme of the International Crisis Group, was tracking 58 areas of current and recent conflict. Active areas of conflict included Afghanistan, Iraq, Pakistan, Somalia, Sri Lanka and Sudan. The Geneva Centre for the Democratic Control of Armed Forces documented conflict-related sexual violence in 52 countries over the past 20



Photo opposite page:  
Lologo transit camp,  
southern Sudan.  
Displaced people and  
refugees are sometimes  
accused of introducing  
HIV into host  
communities, although  
prevalence rates are  
often lower in refugee  
and IDP camps than in  
neighbouring areas.

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years in Africa, the Americas, Asia, Europe and the Middle East (Bastick, Grimm and Kunz, 2007).

Among countries with high rates of HIV, about half were also affected by major conflict between 2002 and 2005, including eight of the 15 countries with the largest number of people living with HIV (PLHIV), seven of the 15 countries with the largest number of children under 15 years living with HIV and AIDS, and six out of the 15 countries with the largest number of orphans under the age of 17 due to AIDS.

Many of the conflicts led to mass displacement among civilians. In 2006, the plight of some 32.9 million people fell within the protection and assistance activities of the Office of the United Nations High Commissioner for Refugees (UNHCR) (UNHCR, 2007). Roughly a third of them had fled across international borders seeking refuge or asylum from conflict and persecution. Nearly half were uprooted, but remained within their own countries of nationality. Because UNHCR's mandate covers only a subset of all refugees and internally displaced persons (IDPs), the true numbers of those affected by armed conflict and its aftermath are likely to be many millions higher. Internal displacement alone due to conflict and human rights violations affects roughly 24 million people, according to the Internal Displacement Monitoring Centre of the Norwegian Refugee Council. While acute emergencies involving tens of thousands of refugees are most likely to hit the evening news screens, in fact displacement often lasts for many years, even decades. A recent study suggested the average length of displacement was 17 years (UNHCR, 2004). Contrary to popular belief, the majority of all refugees live within host communities, not camps. That means that their exposure to HIV is intimately linked with that of the communities that surround them (UNAIDS and UNHCR, 2007).

## **What makes conflict-affected populations vulnerable?**

Conflict often disrupts educational systems and social programmes, robbing children and adults of opportunities for HIV education. "People in conflict settings are often isolated and don't have the level of awareness [about HIV] that you see in non-conflict-affected populations," said Susan Purdin, senior technical adviser for reproductive health at the International Rescue Committee (IRC). This lack of knowledge puts populations at risk when fleeing from areas of low to high HIV prevalence, or when experiencing the end of conflict, as physically isolated areas open again to commerce and contact with outsiders. It also endangers populations that interact with military forces, including peacekeepers, whose HIV and other sexually transmitted infection (STI) prevalence can be several times higher than that of the general population. For example, there is some evidence that armed conflict and the involvement of soldiers from multiple regions helped carry HIV from town to town in the early stages of the HIV epidemic in Guinea-Bissau, Sudan and Uganda (Spiegel et al., 2007).

Public and private health services, too, take a hit during wartime. Normal supply chains for drugs and medical equipment are disrupted. It becomes more challenging to ensure sterile equipment and a blood supply free from infectious agents such as HIV. Patients and healthcare professionals may be divided by front lines and unable to travel easily to designated facilities. The stress of war, poor nutrition, overcrowded and unsanitary conditions and difficulty accessing needed supplies and medications can exacerbate health conditions, including HIV and AIDS (Fink and Stinson, 2007).

Doctors and nurses, seen as a major resource for warring factions, have been conscripted into service or directly threatened and killed for treating ‘enemy’ populations in places such as Bosnia, Chechnya and Iraq. Many, understandably, try to move themselves and their families away rather than remain and endure danger and deprivations. This can leave civilians without enough healthcare providers. And when populations flee en masse to safer territory, particularly in poor countries, authorities in their new communities may balk at making precious health services available and affordable to them. Even in countries where refugees are officially eligible for free healthcare services, such as in Armenia, Azerbaijan and Georgia, they have reported difficulty in obtaining these services; and refugees and asylum seekers in Turkey were found to have poor access to HIV prevention information and condoms (Homans, 2006a, b, c, d). Refugees and IDPs who feel stigmatized or who lack documentation, transportation and financial resources may not even seek healthcare services.

All of these factors mean that at the very time a conflict-affected population needs safe and comprehensive healthcare services the most, it often has difficulty accessing them. Medical workers who remain in practice are overburdened. “Health providers are doing so many other things,” said Purdin. HIV prevention, care and treatment too often fall by the wayside.

## **Vulnerable groups**

It is often said that conflict alters the fabric of society. Social norms break down and gender-based violence rises. When livelihoods are lost, both women and men may turn to sex work to survive and support their families. But the vulnerability of particular groups of women, men and children can also take subtler forms. During the Rwandan genocide, hundreds of thousands of mainly Tutsi survivors fled into neighbouring Tanzania. Most of them were women and children. “Men had been killed back in Rwanda,” said Carlos Cardenas of Mercy Corps’ health unit, who worked in a Tanzanian refugee camp at the time. Although men were few, pregnancy rates paradoxically soared. The reasons were complex and multi-factorial. Most men in the camp were protecting several women. “The only way [the women] had to pay back that protection was with sexual favours,” said Cardenas. Moreover, many genocide survivors said they felt the urgent need to repopulate their nation. At the time, aid workers focused their efforts on helping the women through their pregnancies to

healthy deliveries. They later wondered, though, whether the sexual dynamics that developed in the Tanzanian camps had contributed to the spread of HIV.

Women are frequently victims of physical and sexual assault in unstable circumstances. In addition, war-affected women, when ill, may be reluctant to leave their living quarters to seek medical care out of fear of being separated from children or putting them at risk during travel. Men are not typically considered a vulnerable group, although military-aged men are often at risk of being killed by hostile forces or forced into fighting. For cultural reasons, men may also be less willing than women to seek help for physical and especially psychological problems. Tragically children, too, are a vulnerable group in times of conflict and displacement. The United Nations Children's Fund (UNICEF) estimates that half of the people displaced by war are children. In a medical sense, children are more vulnerable than adults to the stresses and deprivations of trauma and displacement. Some, separated from their families, must fend for themselves in child-headed households or are recruited as soldiers. As refugees or IDPs, they may end up living on the streets in urban centres, engaging in sex work to survive. While children orphaned by AIDS are often raised by dedicated members of extended families and communities, some grow up without adequate support and guidance (Fink, 2007). They may be lured into criminal or anti-social activities. Based on the societal instability this may cause, authors such as Garrett (2005) have suggested that the HIV and AIDS pandemic could actually lead to violent conflict, though this remains unsubstantiated. This has not occurred in southern Africa, the region with the highest HIV prevalence in the world, despite early predictions that it might happen.

Again, the threat of HIV for children can come from unanticipated places. In West Africa, an explosive assessment published in 2002 by UNHCR and Save the Children UK alleged that humanitarian assistance providers – including United Nations (UN) peacekeepers, NGO workers and governmental representatives – were involved in sexual violence and exploitation of children (UNHCR and Save the Children UK, 2002). The findings led to an investigation by the UN. While most allegations could not be confirmed or substantiated, and sexual exploitation was found not to be widespread, the incident led to commitments by the UN and humanitarian agencies to implement protective actions and codes of conduct aimed at eliminating sexual exploitation and abuse of children and women (Machel, 1996; UN, 2002).

It is important for aid workers to receive education and training about HIV and AIDS and have access to counselling and condoms. In the past, aid workers have been subject to sexual violence, engaged in risky sexual behaviours, and been exposed to HIV in healthcare settings.

Armed personnel are also at risk of both acquiring and spreading HIV (see Box 5.1). In some countries, HIV prevalence rates among the military are two to five times

higher than among civilians (Kingma, 1996). The need to provide HIV and AIDS-related training to national uniformed services and personnel of UN agencies and other organizations involved in providing assistance in emergencies, including international peacekeepers, has been highlighted. The UN Security Council passed a resolution on HIV/AIDS and international peacekeeping operations in 2000 underscoring the importance of HIV and AIDS awareness and prevention initiatives among peacekeepers (UN, 2000).

## Box 5.1 HIV risks and peacekeeping troops

### AIDS and peacekeeping

In 2000, the UN Security Council passed Resolution 1308, in which for the first time AIDS was stated to be a global security risk due to its “deleterious effects on peacekeepers and peacekeeping”. Subsequently, UNAIDS and the Department of Peacekeeping Operations (DPKO) entered into a collaborative agreement under which both organizations agreed to inform the Security Council regularly on progress in implementing Resolution 1308 as well as to persuade member states to include a reference to HIV in the preamble of any new Security Council Resolution establishing or expanding mandates of peacekeeping missions.

In addition, DPKO has appointed a full-time AIDS Policy Adviser at their headquarters and established HIV focal points in all the peacekeeping missions. With a contribution from UNAIDS, DPKO also maintains a trust fund to sustain AIDS activities among peacekeepers. With the increasing focus on regional troop and mission management, UNAIDS has also supported African Union (AU) AIDS programmes for their peacekeepers as well as for several African national armed forces from where the AU peacekeepers are drawn.

Key components of peacekeeper AIDS programmes include awareness training, per-

sonal risk assessment, behaviour change counselling, provision of condoms, provision of post-exposure prophylaxis kits and voluntary counselling and testing. Missions typically develop peer education programmes, drawing on the UNAIDS peer education kit and AIDS awareness cards which have been translated into several national languages and distributed to over 1 million peacekeepers. While promoting condom use as a lifesaving measure, DPKO and UNAIDS have also ensured that prevention training clearly reinforces code and conduct.

Pre-deployment HIV training tools have been developed and national governments are encouraged to include AIDS in pre-deployment training sessions for their peacekeepers. In collaboration with UN partners in countries where the missions are operating, DPKO AIDS advisers also seek to mainstream HIV prevention into mission mandates and to undertake outreach activities within local communities – for example, training of the Haitian national police, collaboration with the Society for Women and AIDS in Africa in Sierra Leone or peer education among national armed forces in Eritrea. Overall, outreach education among uniformed services personnel and communities has reached many thousands of men and women directly or indirectly. International peacekeepers

have therefore been an important source of support to national AIDS programmes in some countries.

A more recent focus of work within the field of AIDS and peacekeeping is the integration of HIV into disarmament, demobilization and reintegration programmes (DDR). Evidence shows that the immediate post-conflict phase contains high risk of HIV transmission, but is also optimal for interventions (Clingendael Institute, 2005). There are a number of reasons for this: the armed groups participating in DDR often practise risky sexual behaviour. On reintegration they may continue to behave in the same way, especially if they have the money to purchase sex. On the positive side, combatants that undergo DDR programmes often have a certain standing in the communities in which they are being reintegrated and can act as role models. The UN Population Fund, UN Development Programme, DPKO and UNAIDS cooperate closely to use this window of opportunity, where it may be possible to use ex-combatants as a positive role model, while in parallel sensitizing them to their own vulnerability.

### **HIV risks and peacekeepers**

Peacekeeping troops come from over 100 countries; all are affected to varying degrees by the HIV epidemic. On average, every month the UN DPKO employs 90,000 international peacekeepers, including troops, military observers, police units and individual police officers. At the time of writing (January 2008) deployment is currently in 18 peacekeeping and three political missions with almost 80 per cent of troops coming from countries with HIV prevalence rates of less than 1 per cent. The rest of the troops come from higher-prevalence countries such as

Nigeria, Senegal and South Africa. International peacekeepers are supported by approximately 14,000 nationally recruited staff.

The standard for deployment, recruitment and retention of peacekeepers has been fitness to perform peacekeeping duties during the term of deployment. Pre-deployment medical examinations are mandatory for all troops and police units and are the responsibility of each troop-contributing country (TCC).

DPKO has adopted the policy that chronic medical conditions – including clinical AIDS – preclude fitness for mission duty. HIV tests on their own are not considered an indication of fitness for deployment (UN, 1999), but an estimated 90 per cent of TCCs have independently introduced pre-deployment HIV testing for peacekeepers. A number of peacekeepers from some countries have nevertheless fallen sick from AIDS, have been repatriated or died on mission, presumably because pre-deployment medical fitness examinations had not been carried out.

Interestingly, deployment seems to increase the risk of HIV infection among peacekeeping troops. Several reports of troops infected while on a peacekeeping mission have been published. An analysis of the Cambodia mission (1992–1993) states that while 21 peacekeepers died due to hostile action, 47 were diagnosed as HIV positive following deployment (AFP, 2001). By February 2007, the mission in Liberia had provided voluntary counselling and testing to almost 8,000 UN military personnel, with 1 per cent testing positive for HIV (Likimani, 2007). Increased infection rates have been reported among Nigerian peacekeepers returning from deployment in neighbouring countries as well as among Indonesian troops returning home in the 1990s.

The risk of peacekeepers contracting HIV during missions has been closely associated with the possibility of their spreading HIV to host communities. However, there is little hard evidence to substantiate such reports. The Cambodian government claimed that the rise of HIV in the country was due to the presence of UN peacekeepers in the early 1990s, and similar concerns regarding peacekeepers have been raised in Timor-Leste and Kosovo. Negotiating peacekeeping missions have in some cases been hampered by national authorities' insistence that only proven HIV-negative civilian and uniformed peacekeepers should be deployed.

The peacekeeping missions in Liberia and Haiti have been most comprehensively surveyed regarding their HIV knowledge, attitudes and practices. Another survey among 667 peacekeepers in Liberia revealed that approximately 25 per cent of those questioned had had sexual intercourse within the mission area, almost one-third had had two or more sexual partners and 21 per cent reported not using condoms despite their availability (Bazergan, 2006). These num-

bers are similar to those reported about the Eritrea/Ethiopia mission in 2002. A study in Haiti revealed only 6.5 per cent of more than 1,100 people surveyed reported having had sexual relationships while on mission. Some 95.1 per cent of those reporting sex with a casual partner had consistently used condoms (UN, 2007).

There have also been a number of cases where sexual misconduct has been reported and/or alleged among international peacekeepers, and concerns have been raised about an underlying culture of improper sexual attitudes and behaviour in some units. There are very few hard facts, however, and most reports tend to be anecdotal. Apart from the disturbing possibility that deployment as such may have a negative influence on the health of an individual affected by an HIV-related disease, any breach of discipline may jeopardize missions. It is therefore imperative that the UN takes strong action to address issues of conduct and discipline, as well as HIV prevention and awareness and practice with all peacekeepers. The UN Secretary-General has mandated all missions to do so (UN, 2003). ■

## An issue of human rights

HIV raged throughout the world for many years before serious international efforts to address the pandemic in conflict and refugee situations emerged. HIV and AIDS were not initially considered appropriate to address in the immediate response to conflicts and other emergencies. Awareness was stirred in the mid-1990s. Graca Machel's study on children and armed conflict emphasized the potential threat that gender-based violence and exploitation posed in the spread of HIV (Machel, 1996). Humanitarian advocates also lobbied for addressing reproductive health concerns, including HIV, in emergencies. A Minimum Initial Service Package, or MISIP, was developed by aid agencies for use by aid workers in acute emergencies prior to the introduction of comprehensive services. Still in use today, its guidelines include the distribution and use of standardized kits for safe deliveries, post-rape management and contraception – including the free availability of condoms – and

efforts to ensure that medical equipment and blood for transfusion are free from infectious agents.

The development of the MISP coincided with a shift among mainstream humanitarians and development professionals to embrace a ‘rights-based’ approach to programming. “Refugees and the conflict-affected have a right to the same kind of services as anybody else; it’s just harder to get those services to them,” explained Purdin, who among others helped develop the MISP and the widely-adopted *Sphere Humanitarian Charter and Minimum Standards in Disaster Response*. The Sphere standards outline steps humanitarians can take to ensure that minimum human requirements for water, sanitation, food, nutrition, shelter and healthcare are met among disaster-affected populations (Sphere Project, 2004).

The Sphere handbook – first published in the late 1990s and revised in 2004 – is based on principles that have deep roots in international humanitarian law, refugee law and human rights laws and norms. These include the right to life with dignity enshrined in the Universal Declaration on Human Rights and in international human rights covenants, the distinction between combatants and non-combatants enshrined in the Geneva Conventions and other instruments of international humanitarian law, and the principle of non-refoulement (that nations must provide asylum to those who seek it and are seriously threatened at home) derived from the 1951 Convention on the Status of Refugees. Over 140 countries are party to the refugee convention, having committed to providing refugees with the same ‘public relief and assistance’, including medical care, available to nationals. Human rights law (fully applicable in peacetime and with certain limits during times of national emergency) also commits states to respect the right to health, the right to equality and non-discrimination, the right to privacy, the right to liberty and security of the person, the right to information, the right of participation, the right to work and the right to education, among others.

Acknowledging that refugees have rights implies that providing them with only whatever good-will and charity inspire is not enough. Governments must ensure that those affected by wars and disasters are protected and have access to the means of dignified survival. When governments fail, aid workers are ethically obliged to provide competent assistance.

Sphere incorporates the MISP as one of its standards and, since the 2004 revision of its manual, has included HIV and AIDS as a cross-cutting issue. It identifies people already living with HIV as a vulnerable population requiring particular awareness and attention in emergencies. In addition, the Sphere standard on chronic diseases should apply to HIV and AIDS in high-prevalence settings. It reads, in part, “for populations in which chronic diseases are responsible for a large proportion of mortality, people [should] have access to essential therapies to prevent death” (Sphere Project, 2004).

Additional guidelines specifically dealing with HIV-related rights in conflict, displacement and refugee settings have been produced by the Inter-Agency Standing Committee (IASC), a coordinating body for humanitarian response (IASC, 2003), in a framework for assessment and planning produced and used by UNHCR. UNHCR promotes the non-discriminatory access of IDPs, refugees and others to HIV and AIDS healthcare, information and education, protection against detention, restricted movement or return of IDPs or refugees to their countries of origin based on HIV status, respect for the confidentiality and privacy of health-related information and protection against sexual violence and exploitation (UNHCR, 2006).

According to UNHCR, multisectoral minimum essential HIV and AIDS interventions should be implemented early in a crisis, followed by comprehensive prevention, care and treatment programmes integrated with national programmes. By avoiding the creation of parallel or unequal services, integration reduces costs and also the inequalities that can contribute to tensions and conflict between refugee and host communities. Several regional programmes have been established to address HIV in conflict-affected populations. One is the World Bank-financed Great Lakes Initiative on AIDS (GLIA) in the Great Lakes region of Africa. It supports the refugees, displaced persons and returnees who migrate across the subregion, and promotes collaboration and capacity-strengthening among those who assist them (UNAIDS and UNHCR, 2007).

The GLIA includes key analytical features that should ideally be incorporated into all HIV programmes, including assessment, monitoring and evaluation. As HIV and AIDS interventions in settings of conflict and displacement expand, there is a need to conduct operational research aimed at improving the effectiveness of various programmes.

## Countering myths

While an understanding of the rights of conflict-affected populations has been critical to expanding HIV services to them, so, too, has the collection of evidence that overturned long-standing myths. Several years ago, the US State Department provided funding for the development of an HIV programme at UNHCR. Epidemiologist Paul Spiegel of the US Centers for Disease Control and Prevention (CDC) runs the programme. When he arrived, the agency had little information about how prevalent HIV was among the war-affected populations it served. “What I found was nowhere did we have any data to make proper decisions,” said Spiegel. “I started to arrange to do some sentinel surveillance work.” However Spiegel encountered resistance to his research plan. “People said, ‘You can’t do that. We know that the HIV prevalence is going to be high, and that’s going to increase stigma and discrimination.’” Spiegel persevered, and his research ultimately showed the initial beliefs to be a myth. “What’s clear is that conflict in most situations puts a brake on the epidemic.” For example,

Angola, Sierra Leone and southern Sudan – all areas that have experienced prolonged conflict – had lower HIV prevalence rates compared with surrounding countries (Spiegel, 2004). Refugee camps in Kenya, Rwanda and Tanzania had lower HIV prevalence rates than did surrounding host communities, whereas in Sudan, displaced and host communities had similar rates of infection (Spiegel, 2004).

More recent analyses, albeit hampered by a shortage of good-quality data, found no evidence to suggest that conflict has increased HIV in affected populations in Burundi, the Democratic Republic of the Congo, Rwanda, Sierra Leone, Somalia, southern Sudan and Uganda – in some situations, prevalence rates actually decreased (Spiegel et al., 2007). The conclusions were in some cases surprising – for example, it had been widely believed that the mass rape that took place during the genocide in Rwanda led to large, population-based increases in HIV prevalence, but the review by Spiegel and colleagues did not find evidence to support this. The same study also considered 12 sets of refugee camps: three-quarters had a lower prevalence of HIV infection, two camps had a similar prevalence and one a higher prevalence than the host communities that surrounded them (Spiegel et al., 2007).

The research highlighted an important point. While conflict can increase HIV risk for all the reasons discussed above, the isolation and decreased mobility associated with conflict-affected areas can actually hinder the spread of HIV. “Since refugees come from those areas, they often have lower HIV prevalence” than the non-refugee populations that surround them, said Spiegel (see Box 5.2). Furthermore, refugees in camps may enjoy better access to HIV prevention programmes and messages that can help them avoid risk behaviours. These findings, published in peer-reviewed medical journals including *The Lancet*, have bolstered efforts to reduce stigma and misconceptions about refugees. They provide evidence that can and should be used to convince policymakers to end official discrimination against refugees.

Mothers bring their infants to the Mundri primary health clinic, southern Sudan, to be vaccinated. Under international law, refugees have the right to receive the same ‘public relief and assistance’ as nationals, including medical care.

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## Box 5.2 Angolan refugees leaving Zambia: taking home 'the weapon of prevention'

During the decades of civil war in neighbouring Angola, Zambia was home to thousands of Angolan refugees. Zambia's HIV prevalence rate is significantly higher than Angola: 17 per cent compared with 4 per cent (UNAIDS, 2007).

Angola's war-induced isolation has helped slow HIV infection rates and the challenge now is to keep the country's relatively low prevalence in check.

The situation poses an acute problem: will peace and the reopening of the country, including the return of many refugees from neighbouring countries, mean a jump in HIV prevalence levels?

The problem is aggravated by the very limited knowledge about HIV, its transmission and prevention among the Angolan population.

In Zambia the International Organization for Migration (IOM), in partnership with UNHCR, has developed and implemented a wide range of programmes targeting Angolan refugees as well as the surrounding Zambian communities in Mayukwayukwa camp, in the western part of Zambia.

The programme's activities aim to increase the general awareness levels on HIV and AIDS, increase the vocational and life skills of refugees and implement HIV prevention activities in the areas in Angola to which refugees are returning.

Equipped with these skills, refugees will be better able to support and protect themselves once they have returned to the communities they were forced to abandon in Angola.

Also, most importantly, the refugees are encouraged to pass on their knowledge to their home communities in Angola.

The younger refugees – both boys and girls – are encouraged to participate in a foot-

ball league, where safe sex and HIV and AIDS are discussed before and after matches.

Farming skills are peppered with lessons in nutrition and general health, while literacy training and health workshops help build awareness of HIV and other diseases. Condoms are readily available and freely distributed.

"We believe the messages about HIV will flow into the community here, and back into Angola when they repatriate. If myths about the disease can pass from person to person, why not the truth?" said HIV coordinator Chola Musonda.

When Lucas Savier, 43 years old and a married father of two, fled Angola for Zambia in 2000, he knew nothing about HIV, except that it was a disease that could kill. An eager student at health classes in Mayukwayukwa camp, he now teaches others.

"Prevention is very important, you should not be doing unprotected sex," Savier said. "You should not use the same razor blades as other people, but HIV can't be caught from drinking from the same glass or from hugging somebody. It's crazy what some people think."

"The refugees have dealt with the problem by acknowledging it," said an IOM representative. "When they go back to Angola, prevention will be the weapon they take with them." ■

## Treating patients affected by conflict

A different myth took longer to dispel: that it was impossible to treat refugees, IDPs or those living in conflict-affected areas with life-extending anti-retroviral treatment (ART). Refugees and IDPs were thought to be too mobile for treatment, and when it came to individuals who remained in troubled areas, “there was concern that there would be ongoing conflict that would make it difficult for people to follow up on their treatment,” said Leslie Shanks, head of the public health department of Médecins sans Frontières (MSF) in Amsterdam, the Netherlands. MSF doctors and nurses in the field were seeing patients sicken and die from AIDS, and they put pressure on the organization to do something. “The doctors and nurses knew that in the West, treatment was available, and they pushed very hard to make that available to the patients where we were,” Shanks said. “We didn’t want to ignore the medical needs of people in front of us because of potential barriers and risks in the future. We decided to come up with a way to deliver HIV care to people in these situations rather than accept the naysayers who said it was impossible.”

The methods that MSF developed include providing patients with the information and resources – including supplies of ART – they needed to cope with conflict-related disruptions in health services, or even the need to flee across borders to escape outbreaks of violence. Once educated about dangerous practices such as sharing medications and splitting doses in half to keep supplies from running out (stopping ART completely is safer), patients are provided with several weeks’ stock of medications to keep at home in case of emergency. Emergency stocks are also kept securely in local clinics and, in certain contexts, spread out throughout urban areas in the homes of key MSF staff members. Patients are informed of the various sites where medicines are available when free movement is dangerous or restricted. They are also given copies of their treatment cards, containing information about their disease and medications, which they can present to other practitioners if necessary.

In 2004, these types of preparations were put to the test. One of MSF’s first HIV programmes in an unstable, conflict-affected area – Bukavu, Democratic Republic of the Congo – shut down temporarily when the city fell under attack. “The patients really understood how important it was for them not to interrupt their drug supply,” Shanks said. They made use of their emergency stocks. “During that time, they were able to keep going on their treatment.” Many Congolese crossed the border to Rwanda, becoming refugees. Those on ART sought and obtained treatment at another MSF clinic there.

Now, MSF provides a wide range of HIV prevention, care and treatment services in various humanitarian settings. Programmes include the treatment of STIs, condom provision, prevention of mother-to-child transmission and assistance to support groups run by PLHIV.

MSF's success in Bukavu helped silence the 'naysayers'. Opposition to treating refugees and other conflict-affected individuals further dissolved in the face of the larger activist movement to expand treatment access in low-income countries. The June 2001 UN General Assembly Special Session (UNGASS) on HIV included conflict-affected populations in its Declaration of Commitment on HIV/AIDS, stating (perhaps a bit too definitively) that "conflicts and disasters contribute to the spread of HIV/AIDS" (UN, 2001). The declaration called on governments and international assistance agencies to include HIV and AIDS awareness, prevention, care and treatment within emergency response strategies.

Despite these commitments and declarations, Spiegel and others have published research showing that many developing countries with AIDS programmes have been excluding refugees from their HIV/AIDS National Strategic Plans and funding applications (UNHCR, 2007). This poses an obvious threat to national prevention and care efforts, because refugees and host populations interact daily. In response, UNHCR has produced a series of policy documents on providing ART for refugees, and the agency advocates for governments to include refugees in their treatment plans. Thanks to the research of Spiegel and colleagues showing that refugees most often have lower HIV prevalence than host populations, the advocacy has become somewhat easier. "The data we received helped us to say they're not going to overwhelm you, it's not about millions of HIV-positive people," he said.

Integrating HIV and AIDS interventions with refugees and surrounding host populations can improve services for both communities. UNHCR has helped countries such as the Democratic Republic of the Congo to integrate refugees into national HIV and AIDS funding proposals. In addition, UNHCR sometimes pays governments on a fee-for-service basis to offer medical care to refugees, which can be more cost-effective than creating separate, camp-based health systems. Such arrangements have been put into place, for example, in South Africa and Zambia. Refugees are now accessing HIV services in those countries as well as in Kenya, Rwanda, Thailand and Uganda, among many others. For the past several years, the President's Emergency Plan for AIDS Relief (PEPFAR) has also made US funds available for the treatment of refugees.

## Challenging conditions

As humanitarian agencies increase the provision of ART and other HIV-related services, they confront challenges in each phase of the cycle of conflict – from violence to displacement to asylum to return. "Each of them has their own risks and solutions, all context-specific," said Spiegel. "It makes it extremely challenging to meet all the needs of refugees and those surrounding them."

Typical challenges of dealing with HIV in low-income countries are often magnified by conflict. As described above, shortages of medical workers and barriers to access are

common, and whatever medical infrastructure is present must deal with many competing health problems. Isolation and insecurity complicate the delivery of necessary supplies and equipment. For individual patients, competing survival needs and experiences of violence, personal trauma and the deaths of key support figures can decrease willingness to seek services and care or to sustain needed treatment. Aid workers, too, are often targeted by militants in wartime, in violation of international humanitarian law, and it can be difficult to recruit qualified staff to work in insecure and austere conditions (see Box 5.3).

### Box 5.3 Providing ART for refugees and returnees

Challenges to providing services for people with HIV and AIDS remain even when conflict is over and rebuilding is taking place. The International Rescue Committee's successful ART programme in Kakuma refugee camp is a case in point. Kakuma camp was set up in the northern Kenyan desert in 1992 when a large number of refugees fled war in neighbouring southern Sudan. The camp grew to become one of the largest in the world as conflict sent residents of numerous other African countries to Kenya for asylum.

The IRC has provided health services in Kakuma refugee camp in Kenya since 1992. It now runs an HIV programme that includes a full range of prevention services and clinical and psychosocial care. IRC's camp clinic treats more than 100 people with ART, working with local organizations to provide these services to both refugees and the adjacent host community (Purdin et al., forthcoming).

Many of those treated in the camp clinic are refugees from south Sudan. The end of hostilities opened up the possibility for them to return home. However, a recent evaluation by IRC found that extremely limited HIV and AIDS-related services are available for returnee, IDP and host populations in south Sudan. Perhaps because of the area's many years of isolation, there remains persistent stigma around HIV, denial that the infection

exists in the community and misconceptions about the best way to deal with the threat of infection. While HIV prevention education, condom availability and voluntary counselling and testing (VCT) services (IRC runs the VCT programme in the state hospital) are now robust, there is little in the way of support or treatment for those who test positive. Facing stigma, they are often lost to follow-up. Pregnant mothers with HIV have no access to Nevarapine to reduce transmission of the virus to their babies – supplies of the drug have run out and have not been replenished.

IRC aims at improving access to care for people living with HIV and AIDS in the region, but it faces many obstacles, from degraded roads and communications systems that make it extremely challenging to establish robust drug supply chain logistics, to poor local drug management and storage. The NGO has also been so far unable to find a donor willing to fund ART and a staff nurse to provide services to those who test positive at VCT centres.

So what is IRC's advice to its ART patients from south Sudan in Kakuma refugee camp? Stay put, for now. "The best plan is to allow people who are on anti-retrovirals to stay in their country of asylum where they have access [to the drugs], until access improves at home and they can return," said Purdin.

While improving HIV and AIDS services in south Sudan is difficult, it is also critical for the humanitarian community. Years of conflict and isolation may be responsible for keeping

HIV prevalence relatively low there, but the epidemic could grow rapidly now that opportunities for movement and, therefore, exposure to the virus have expanded. ■

Funding is also a limiting factor. During wartime, governments may divert healthcare funds to serve the military. Many NGOs rely on donor agencies for funding, and monies are typically granted in short, six-monthly or year-long cycles during acute crises. This makes it difficult to develop the kinds of community-based programmes needed to change HIV risk behaviours and reduce stigma (particularly in situations where major cultural and language differences between humanitarian staff and beneficiaries must be bridged). For many NGOs, the choice to launch a particular programme is also influenced by whether the donor “has the money or wants us to do it,” said Mercy Corps’ Cardenas. “We’re so donor-driven.”

Refugees are more difficult to reach when they live in urban settings than in refugee camps. “Many urban refugees aren’t registered with us or with governments, so they don’t have the means to access care,” said Spiegel. Refugees may not realize they have a right to access healthcare; they may be fearful of doing so and they are often wrongly denied services. Language and cultural differences can also present difficulties obtaining healthcare in countries of asylum. There is a need to do more “advocating with governments to ensure [that refugees and asylum seekers are] part of existing systems and not being left alone, so vulnerable, dying of AIDS before they come see us,” said Spiegel.

## **A vision of the future**

Several years ago, a Burundian family with several members on ART fled to Tanzania, becoming refugees. They appeared at a medical NGO in need of medicines. At the time, the Tanzanian government had no policy for providing ART to refugees. The family’s treatment was continued ad hoc while UNHCR officials worked with the government, offering support if the country would allow refugees to access ART in government facilities.

Some experts believe that the humanitarian community is poorly prepared to deal with conflicts or emergencies that occur in areas of high HIV prevalence and treatment access. Emergencies that send hundreds or thousands of ART patients, rather than just a single family, fleeing from where they currently obtain medicines and services are “going to happen more and more as anti-retroviral therapy becomes more widespread,” said Spiegel. The violence that erupted after Kenya’s contested presidential elections in December 2007 put these fears to the test (see Box 5.4). MSF and Kenya Red Cross Society workers canvassed IDP camps to locate patients on ART,

and a free help hotline was established. However, some clinic patients were lost to follow-up, IDPs who forcibly or willingly relocated to rural areas with host populations were difficult to reach, and camp residents with AIDS reported difficulty accessing ancillary services including adequate nutrition.

Clearly, more work needs to be done to prepare for and respond to the HIV pandemic in emergencies. “There has been good progress on HIV, however there are still many gaps in terms of ensuring people have access to the whole treatment packages,” said MSF’s Shanks. That includes treatment and prophylaxis for opportunistic infections.

### **Box 5.4 Providing ART and healthcare for HIV-positive people during the Kenyan emergency**

On 27 December 2007, disputed presidential elections unleashed an explosion of frustration and violence in Kenya. The violence quickly degenerated into bedlam and bloodshed between ethnic groups, and up to 1,000 people are estimated to have been killed, and 300,000 displaced. Many Kenyans, including employees of organizations responding to AIDS, had travelled to their rural homes for holidays and/or to participate in the elections and were therefore caught up in the violence. The main areas affected by the unrest were the slum areas of Nairobi, Eldoret and Burnt Forest in Rift Valley Province, and Kisumu in Nyanza Province. Coast Province, including the main town of Mombasa, and Western Province have also been affected by violence, looting, burning of homes and reported incidences of rape. The situation is also having a regional impact with an estimated 5,400 people displaced into Uganda.

The national prevalence of HIV was estimated to have dropped to 5.1 per cent (4.6–5.8) in 2006 from a high of 10 per cent in the late 1990s. The government of Kenya estimates that 55,000–100,000 Kenyans were newly infected with HIV in 2006, which indicates a significant drop from previous estimates. The government further estimated that

35,000 deaths were prevented due to successes reported by ART programmes (UCO, 2008). The displacement caused by the post-election violence threatened to erode these gains. The disruption to ART for thousands of patients was particularly worrying as it puts patients at risk of developing resistance to the drugs. Displacement also interrupts steady access to nutritious foods, which also affects the patient’s ability to respond well to ART.

At the time of the violence, the Ministry of Health estimated that 15,000 displaced Kenyans were HIV positive out of whom 6,750 were in need of ART and 2,550 were beneficiaries of ART programmes while in their communities.

#### **The response**

The Ministry of Health (MoH) has moved quickly to provide guidelines to health workers for the clinical management of disruptions to ART. Guidance has also been provided to patients who are on ART programmes to report to the nearest government health centre for further management.

Across the country, NGOs developed new ways to trace HIV patients. MSF set up a toll-free national hotline, launched on 21 January. “The hotline will run for six weeks and will

be advertised in the national English and Kiswahili newspapers,” said MSF’s Anouk Delafortrie, who is coordinating the project. “We are asking patients to call for advice about the closest centre if they have had to relocate, and letting them know what their options are if they are no longer near an MSF health facility” (PLUSNEWS, 2008).

“When the unrest broke out after the election, many of our patients were displaced, so we have set up this mobile clinic in Jamhuri Park [in Nairobi, where 2,400 IDPs are living] to try and trace them and alert them to our presence – since we have been here, about 50 of our own patients have come to refill their ARV [anti-retroviral] prescriptions,” said Mohamed Hamid, coordinator of the mobile clinic. “We are not turning away patients from other health providers – if they have their medical records with them then we are providing them with drugs” (PLUSNEWS, 2008).

The MoH and several other health NGOs have also set up satellite centres at Jamhuri Park and in IDP camps in the Rift Valley to trace their patients, with particular emphasis placed on tracing those on ARVs and tuberculosis (TB) medication.

Other agencies, like the Kenya Red Cross Society and CARE International, have been involved in ensuring the basic needs of these and other displaced people are met, distributing food and non-food items, including mosquito nets, and supplying water and sanitation facilities in camps. Medicines alone are not

enough to maintain the health status of those with chronic illnesses.

The quick response of the MoH and NGOs to ensure continuity of access to ART, and attend to the basics that maintain health, serves as an example for future emergencies.

### Looking forward

The response of the Kenyan government and NGOs to the unexpected violence was commendable, and highlighted the importance of preparedness. UNAIDS, the Kenya Red Cross Society, the World Health Organization and others underlined the importance of rapid assessment and establishment of the magnitude of the problem in terms of interruptions to treatment, including:

- Developing a contingency plan for managing treatment continuity/interruption among those on ART
- Ensuring availability of testing and post-exposure prophylaxis (PEP) kits in all the areas, along with the necessary psychosocial support
- Developing a comprehensive HIV information kit (including condoms and guidance on managing ART interruption) to accompany all response efforts, especially among the displaced
- Ensuring appropriate relief food baskets and special protection from the weather elements for the chronically ill
- Treatment of opportunistic infections (especially TB) and STIs. ■

Keeping HIV from falling off the agenda of humanitarian responders is always a challenge when so many other urgent priorities exist. “The really acute post-conflict settings are not getting the amount of attention they need to address HIV and a lot of other things like health system development and re-development,” said Purdin of the IRC. “In the poorest settings with the most devastation from conflict, the problems are very deep and the support for programming isn’t sufficient.”

There have also been some steps backwards. As part of UN reform, the structure of humanitarian response has changed, and aid workers from various sectors, including health, now coordinate within a ‘cluster’ system. Advocates have had to work hard to keep access to HIV services in the forefront of the response to complex humanitarian emergencies. “It’s really frustrating to have to keep fighting the battles,” said Purdin.

## Opportunities

While the challenges and risks related to HIV in conflict and displacement settings are great, so, too, are the opportunities to improve healthcare and protect populations. Conflicts can draw humanitarian agencies into remote, low-income settings, where healthcare services were poor even before the conflict. Thus, the presence of the agencies and their financial, technical and logistical resources during or after a conflict presents an opportunity to provide certain populations with HIV prevention, care and treatment services that had previously been absent or too costly for most people, particularly the marginalized, to afford.

The provision of HIV-related services can be easier in refugee camps. The population within them is well defined and easy to access. In fact, research has suggested that refugees returning to their homes post-conflict, because of their exposure to HIV prevention programmes, are sometimes more knowledgeable about HIV and engage in fewer risky behaviours than those who had not been displaced (Spiegel and Nankoe, 2004).

## Conclusion and recommendations

In conclusion, the relationships between HIV, conflict and displacement are complex and contextualized. Research suggests that populations isolated by conflicts in recent decades often have lower than expected rates of HIV infection, probably due to fewer opportunities to come into contact with the virus. On the other hand, all steps in the cycle of conflict, displacement and return can increase vulnerability to HIV. The weakening of societal cohesion and social norms open the way for sexual violence and exploitation. Trauma and loss of livelihoods may lead some to engage in higher-risk sexual activities including sex work. The degradation of educational, health and social services also hinders protection. War-affected populations may also assume more risk of contracting HIV when interacting with higher prevalence populations such as some armed forces or host communities in countries of asylum.

Therefore:

- It is important to prioritize basic HIV prevention and related interventions from the earliest days of a crisis and build towards a comprehensive, integrated package

of prevention, treatment, care and support services for refugees, IDPs and host populations. When planning and providing services, attention should be paid to the views of PLHIV and the special needs of youth and survivors of gender-based violence.

- Ultimately, comprehensive HIV interventions for refugees and conflict-affected populations are similar to those in other settings, with particular attention paid to vulnerability reduction (including food security), the provision of culturally and linguistically appropriate services and support for demobilized soldiers and survivors of sexual and gender-based violence. Prevention activities should centre on changing risk behaviours, facilitating access to condoms, advocating against gender-based violence (and making healthcare services available for its survivors), ensuring the safety of medical equipment, medical supplies and blood for transfusion, and making sure post-exposure HIV prophylaxis, HIV counselling and testing, prevention of mother-to-child transmission and STI management services are available.
- HIV care, treatment and support should ideally be similarly comprehensive and continuous, encompassing not only ART, but also prophylaxis and treatment for opportunistic infections, psychosocial, nutritional and economic support (including to orphans and vulnerable children) and palliative care.
- Achieving sustainable success requires that agencies also engage in capacity-building activities, such as recruiting and educating healthcare professionals, when possible from the affected community, and strengthening physical infrastructure, supply chains and laboratory services.

All of this can be a tall order in the context of an emergency or post-emergency situation. Still, with recent advances in knowledge, the widespread recognition of the right of refugees to a full range of HIV services and the expansion of funding sources, the opportunities for addressing HIV among the war-affected and displaced have never been better. The remaining challenge is to turn these opportunities into effective actions, overcoming the many logistical, operational and attitudinal obstacles involved in addressing HIV among those devastated by conflict and displacement.

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