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REFUGEES AND HIV/AIDS

I. INTRODUCTION

1. This paper provides an overview of the impact of the HIV epidemic on refugee situations, and of the response so far by UNHCR and its partners (in terms of policies, guidelines and activities) to this grave affliction. It also outlines current challenges and opportunities and points to future directions, recalling that HIV/AIDS is not only a health issue, but has legal, socio-economic and security dimensions.

II. THE SITUATION

2. UNAIDS estimates that more than 36 million people world-wide live today with HIV/AIDS[1]. While no continent has been spared, the situation in Africa is particularly catastrophic. In this region, the total number of people living with HIV/AIDS is estimated to be 25.3 million. This means that 70 per cent of adults and 80 per cent of children living with HIV in the world, are to be found in Africa, which is home to 10 per cent of the world's population. Since the epidemic began, three-quarters of the over 20 million people world-wide who have died of AIDS have been Africans. The situation in other continents is also alarming. Asia accounts today for 20 per cent of all infections world-wide, and the AIDS epidemic in Eastern Europe is escalating.

3. It is widely recognized that conflicts, instability, food insecurity, as well as poverty and deprivation offer fertile ground for the spread of HIV and AIDS. This reality is most acute for the millions of refugees and internally displaced persons (IDPs), whose physical, financial and social insecurity erodes their habitual caring and coping mechanisms. In the United Republic of Tanzania, for example, it is estimated that HIV/AIDS is prevalent among 7 per cent of adults (15-49 years), representing some 14,000 infected adults among the current refugee population. In this age group, at least one third of these cases require frequent medical care. AIDS is already posing a huge burden on the health facilities in the camps and in the surrounding districts. The disease is also affecting a considerable number of children, adding to the magnitude of the HIV/AIDS problem. Within years, the mortality is expected to double in the refugee camps. The ravages of the HIV epidemic in the camps in terms of social and medical consequences and its death toll outweigh those of any other single disease.

4. A number of factors contribute to the gravity of the problem. Refugee situations are conducive to forced, high-risk sexual behaviour and sexual abuse, with women and girls finding themselves coerced into sex to gain access to basic needs such as food, shelter, and security. Women and children are also exposed to a heightened risk of violence, including rape, as already demonstrated during the exodus of Vietnamese "boat people" in the late 1970's and 1980's, when an estimated 39 per cent of women were raped or abducted, mostly by pirates. During Liberia's civil war, it is estimated that

[1] AIDS Epidemic update: December 2001

nearly half of the women and girls have been physically and sexually abused in the first five years of fighting. It has also been reported that nearly 80 per cent of women raped during the genocide in Rwanda who opted for voluntary counselling and testing were found to be HIV positive.

5. Other factors aggravate the risk of infection. An assessment conducted in late 1999 by Norwegian Peoples Aid, a non-governmental organization working in camps in the United Republic of Tanzania has suggested that young people start sexual activity as early as 10 years of age. This study also raised concern over other alarming practices: frequent use of multiple partners; unprotected sex among the young; and the exchange of sex for gifts from older males. It is believed that these practices are the result of widespread poverty and destitute living conditions in the camps.

6. Findings from various focus group discussions and studies on "Knowledge, Attitudes and Practices" conducted by various agencies in the United Republic of Tanzania have identified commercial sex, multiple partners, alcohol abuse, traditional malpractice and the poor social status of women in the community as the major causes of the transmission of HIV in the camps. Some 25 per cent of adults had a new sexual partner since arriving in the camps. Commercial sex is visible in the bars in the refugee camps. Commercial sex workers from the surrounding villages visit these bars in the camps during the day, while at night they mostly come from within the camps.

7. Yet another alarming fact is that HIV is under-recognized in populations affected by emergencies. This lack of recognition is due to the difficulty of diagnosing HIV/AIDS in the absence of testing facilities, the unfamiliarity of clinicians with the disease and the reluctance of those who do recognize it to risk stigmatizing their patients by reporting it.

8. Moreover, as non-nationals, refugees are not covered by national AIDS control programmes. Such programmes barely (if at all) cater for their own people.

III. EXISTING UNHCR POLICY AND GUIDELINES

9. A number of policy documents, guidelines and manuals on HIV/AIDS are already available. The following (in chronological order) are of particular relevance to refugees and persons of concern to UNHCR:

- UNHCR Policy and Guidelines regarding Refugee Protection and Assistance and Acquired Immune Deficiency Syndrome (AIDS) (UNHCR/IOM/82/92, FOM/81/92);
- Sexual Violence against Refugees, Guidelines on Prevention and Response (produced by UNHCR in 1995, to be up-dated in 2001);
- WHO/UNAIDS/UNHCR Guidelines for HIV Interventions in Emergency Settings (1996);
- UNAIDS Refugee and AIDS Technical Update (1997);
- UNHCR's Policy regarding Refugees and Acquired Immune Deficiency Syndrome (AIDS), 1998 (UNHCR/IOM/78/98, FOM/84/98);
- HIV/AIDS Post Exposure Preventive Treatment Starter Kits for Staff (UNHCR/IOM/47/99, FOM/48/99);
- UNHCR Emergency Handbook (1999) (pages 113 and 166);

- Inter-Agency Field Manual on Reproductive Health in Refugee Situations (1999), with input by UNAIDS, UNFPA, UNICEF, UNHCR, WHO as well as the International Organization on Migration (IOM) and several non-governmental organizations.

10. Most of HIV/AIDS prevention and care interventions in refugee settings are now well codified and documented from the destabilizing event to the stable phase. In the acute phase of an emergency, the essential HIV/AIDS minimum package is based on four objectives: promoting universal precautions, ensuring safe blood supply, preventing and controlling sexually transmitted infections (STIs) and basic information on HIV/AIDS. As soon as the situation has stabilized, this action is complemented by more elaborate and targeted information, education and communication campaigns, access to Voluntary Counselling and Testing (VCT) services, treatment of HIV/AIDS-related conditions and home-based and community care of people living with AIDS.

11. Mandatory testing in refugee circumstances, with the single exception of testing blood for transfusion, is not justified. WHO and UNAIDS have determined that such testing should not be pursued as a matter of policy[2]. Already in 1990, UNHCR and IOM had issued a joint policy strictly opposing the use of mandatory HIV screening, and any restrictions based on a refugee's HIV status.

IV. CURRENT CHALLENGES AND OPPORTUNITIES

12. While recommended interventions and measures to reduce the transmission of HIV are well known, they are nonetheless notoriously difficult to implement as they touch on sensitive and private aspects of life, as well as cultural beliefs and behaviours.

13. HIV/AIDS is not a health issue alone. It also calls for a multi-sectoral approach (education, security, community services, site planning) that encompasses social and economic aspects, as well as human rights and legal issues.

14. Current research shows that adolescent girls and women are more at risk than men. This is due to their disadvantaged socio-economic status, increased exposure to violence, and the fact that sex is the "currency" with which they are expected to pay for life opportunities, such as passing a grade in school or crossing a border.

15. Community-level action, much of it initiated by persons infected or affected by HIV, plays a major role in the global response to AIDS. In many countries and circumstances, community response came before the official national response. Community involvement has proved to be an essential component of any successful response through awareness-building, prevention, impact alleviation, advocacy, and family or community care and support. All such actions are also much needed in refugee situations. Here UNHCR's Community Services officers and implementing partner staff have a crucial role to play.

16. In the context of assistance programmes in refugee-hosting areas, needs of the host communities to access HIV/AIDS prevention and care services have to be considered as an indispensable public health measure in order to contribute effectively to the control of the epidemic at local and regional levels. Close collaboration between UNHCR and national AIDS control programmes will therefore remain essential.

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[2] *Inter-Agency Field Manual on Reproductive Health in Refugee Situations*, 1999, page 56.

17. Some aspects of prevention and care of HIV/AIDS in refugee situations still need to be clarified. They include mother-to-child transmission (MTCT), introduction of voluntary counselling and testing, and access to anti-retrovirals (ARV). National policies of countries of asylum will guide actions to be taken, with due consideration of their technical and financial consequences. The average cost of testing one pregnant woman amounts to US $3.96 and the cost of preventing the mother-to-child transmission with ARV is US $5.96.

18. UNHCR is only too aware that the implementation of policies and guidelines continue to be difficult. A review of its programmes for 2000 and 2001 showed that comprehensive projects on HIV and AIDS prevention and care were reported in only a few countries. A review of the Consolidated Appeal Process (CAP) documentation has illustrated similar shortcomings. According to UNHCR's Regional Health Co-ordinator, their main causes comprise: a lack of awareness and perception of the seriousness of the epidemic; a lack of technical capacity and know-how, limited access (if any) to financial resources. Currently, UNHCR is benefiting from funds under the United Nations Foundation (Ted Turner) amounting to US $ 2 million and covering 15 projects in 14 countries over 3 years. This is excellent seed money that serves to initiate some pilot HIV/AIDS projects and document lessons learnt.

19. UNHCR also continues to be gravely concerned about protection issues and the potential discrimination against HIV-positive refugees in terms of asylum and resettlement. Advocacy measures to combat this danger include addressing the stereotyped perception that “refugees bring AIDS”.

V. FUTURE DIRECTIONS

20. HIVAIDS is not only a health issue. It represents a threat to human security and an impediment to development. It is in this context that it is now on the agenda both of the Security Council and of the General Assembly. Recommendations have also been made by the Inter-Agency Standing Committee (IASC). In June 2001, The United Nations General Assembly will convene a special session to review and address the problem of HIV/AIDS in all its aspects. This is aimed to secure a global commitment and to enhance co-ordination and intensification of national, regional and international efforts to combat HIV/AIDS in a comprehensive manner.

21. Central to any chance of success in achieving a reduction of the transmission of HIV and AIDS, will be the strengthening of existing partnerships and developing new ones. For UNHCR, the main areas of collaboration will include:

- Strengthening existing partnership with UNAIDS and its co-sponsors (UNDP, UNESCO, UNFPA, UNICEF, UNDCP, World Bank, WHO) at central, regional and country level through:

  - a review of the current Framework of Co-operation with UNAIDS;

  - support to the development of partnerships and regional action plans between UNHCR Regional Directorates and UNAIDS Inter-Country Teams together with other partners operating in complex emergencies in various regions (IOM, German Agency for Technical Cooperation(GTZ), International Federation of Red Cross and Red Crescent Societies (IFRC), Médecins sans Frontières (MSF));

  - strengthening UNHCR's participation in United Nations Theme Groups on HIV/AIDS at country level in order to ensure that refugee and migrants are part of the agenda.

- Continued participation in relevant inter-agency mechanisms, including the inter-agency working groups on reproductive health in refugee situations, and on education in situation of emergency and crisis.

- Development or reinforcement of partnerships at regional, and country level with operational partners with expertise in HIV/AIDS, such as the African International Council of Aids Services Organizations (AFRICASO), the World Association of Girl Guides and Scouts (WAGGS) and the International Council of Women Living with HIV/AIDS (ICW).

22. Within UNHCR, it is planned to establish an internal Task Force bringing together representatives of various Departments/Divisions and Bureaux, to develop a comprehensive, medium-term strategy to mainstream the integration of HIV/AIDS prevention and care-related issues into UNHCR operations and to monitor progress. The Task Force will mainly focus on promoting the development of regional plans, introducing or reinforcing reporting mechanisms, disseminating best practice and user-friendly material, and promoting training activities and applied research. Such actin must also be accompanied by a strong institutional commitment from the highest level down to field level, with the goal of raising awareness and strengthening interventions to combat HIV/AIDS in refugee populations and in refugee-affected areas.

VI. CONCLUSION

23. The magnitude of the HIV/AIDs challenge is daunting. UNHCR owes it to the people of concern to the Office to give priority to HIV/AIDS prevention and care, so that the trauma of exile and displacement is not compounded by this terrible disease. The response, to be effective, can only come through partnership at all levels and through the full and active support of all concerned, including that of members of the Executive Committee.