

NETWORK HPN
paper**HIV/AIDS and emergencies: analysis and recommendations for practice**

by Ann Smith

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ABSTRACT

Responses to emergencies caused by conflict or natural disasters are typically confined to addressing basic needs such as food, shelter and fuel, water and sanitation and immediate health provision through disease treatment or prevention. Less well-recognised, however, is the relevance of HIV at the planning and initial stages of emergency response.

This paper argues that emergency practitioners need a better understanding of the links between emergencies and vulnerability to HIV. It illustrates how HIV-related considerations need to be taken into account

from the earliest point of response to an emergency and through every stage of involvement. The paper stresses that HIV-related considerations need to go beyond a narrowly medical or even general health-care focus, and calls for a concerted multi-sectoral approach to ensure that the diverse and complex issues raised by HIV in emergency situations are addressed. The paper identifies key considerations that need to be taken into account, and invites humanitarian agencies to review their policies and practices, and implement any changes needed in the light of the issues identified.

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Executive summary

Two decades after the first case was reported, the human immunodeficiency virus (HIV) has become one of the most alarming and devastating pandemics the world has ever seen. According to the UN Programme on HIV/AIDS (UNAIDS), by the end of 2001 an estimated 60 million people worldwide had contracted HIV, some 20m of whom had died (UNAIDS, 2001). In 2001 alone, some five million people were believed to have been infected with HIV, and there were an estimated three million AIDS deaths. As many as 90% of those infected do not know that they have the virus. The personal, social and economic impact of HIV on individuals and communities of the developing world is drastic and well documented, and establishes beyond doubt that HIV is a major development issue. Much less well recognised is the fact that HIV is also an emergency issue, not only because of the devastating effects that the pandemic is having in many developing countries but also because, in emergencies caused by war or natural disasters, HIV has become another and very significant threat to life, and a cause for further discrimination among populations already disadvantaged by the emergency. It is in this sense that HIV as an issue in emergency response will be discussed in this paper.

The link between emergencies and HIV vulnerability is essentially two-fold. First, the vast majority of humanitarian crises, whether related to conflict or to natural disasters, take place in countries where rates of HIV infection are *already* high, which means that pre-existing risks of infection and discrimination are significant. Honduras, devastated by Hurricane Mitch in October 1998, already had one of the highest incidences of HIV in Latin America; India, whose southern state of Gujarat was hit by a severe earthquake in January 2001, has the highest number of HIV-affected people in the world – an estimated four million Indians have HIV or AIDS (UNAIDS, 2001).

Africa's manifold complex emergencies are occurring in states already afflicted with high rates of HIV prevalence. Even before the 1994 crisis, Rwanda was one of the world's worst-affected countries, with prevalence rates ranging from 4% in rural areas to 35% in the capital Kigali. Other high-prevalence countries – the Democratic Republic of Congo (DRC), Angola, Liberia, Uganda, Ethiopia and Sierra Leone – also suffer complex emergencies.

The second aspect of the link between HIV and emergencies lies in the fact that the destruction, disruption, dislocation and displacement that emergencies typically cause can exacerbate vulnerability by increasing the risk of infection among affected populations. Under the pressure of conflict or natural disaster, sexual behaviour might change in damaging ways, or capacities to screen blood or blood products might be destroyed; loss of livelihoods might cause women to turn to sex work, or rates of sexual abuse by armed groups might increase. HIV can be difficult enough to address in stable societies. The virus is surrounded by stigma and myth, and is linked to blood, sex and death, some of the greatest taboo subjects in all our cultures. This makes it difficult to provide care and support for people infected by or affected by HIV, and to look openly at strategies that will effectively reduce people's vulnerability to infection. Conditions prevailing in an emergency only make these difficulties more acute.

Despite the links between emergencies and HIV vulnerability, agencies' emergency operations have tended to focus on meeting basic needs, providing shelter and food and treating infectious diseases like measles, cholera and dysentery. There are a number of reasons for this. HIV is generally not seen as a priority, and there are more pressing immediate needs in emergencies. It is perhaps difficult to think of long-term issues when there is so much uncertainty

about the 'here and now'. HIV may be perceived as having to do with development, rather than a concern for agencies responding to emergencies. Or HIV is understood exclusively as a health issue, to be tackled through medical responses, rather than a symptom of the social, economic and political conditions generated by an emergency.

These assumptions, and the programming that results, do not adequately acknowledge the detrimental impact that emergencies can have on the incidence of, and response to, HIV/AIDS, particularly where an emergency occurs against a backdrop of already-high HIV prevalence. In failing to take HIV into account from the earliest stages of the planning and implementation of an emergency response, humanitarian practitioners may unwittingly be exacerbating levels of infection. In communities affected by an emergency, vulnerability to HIV and discrimination against people already infected will be heightened or reduced by the policies and practices of those wielding political, military,



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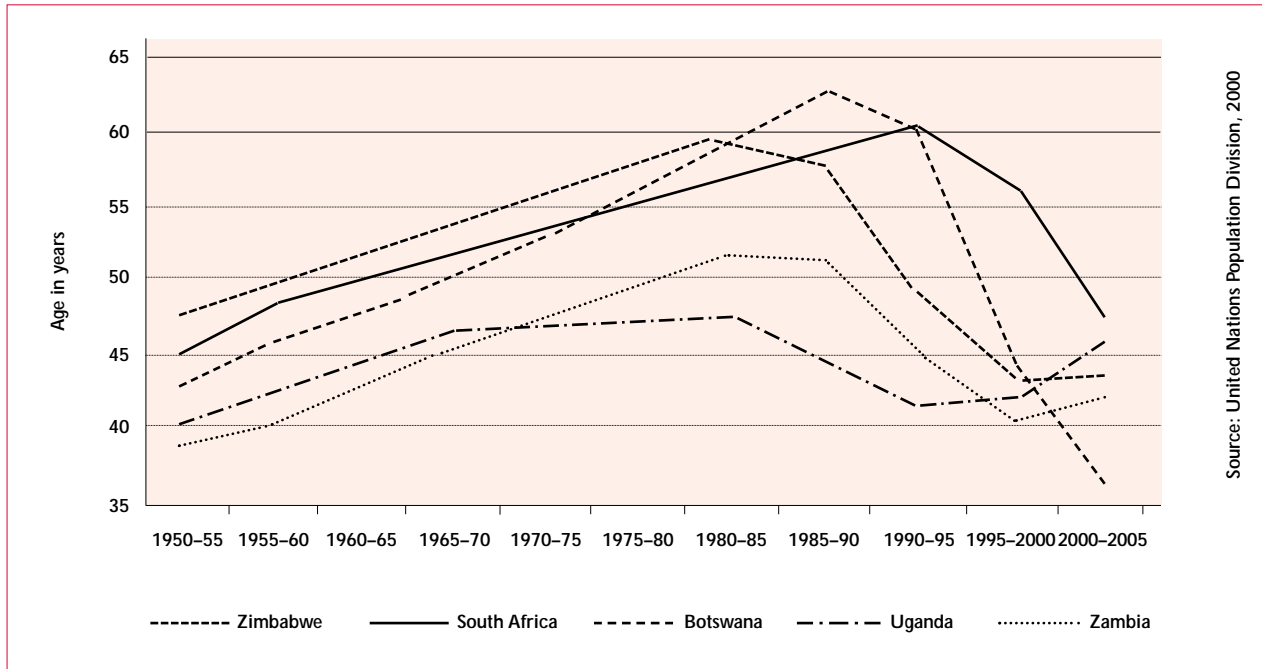
Some 60 million people have contracted HIV

organisational or financial power. Amongst those with organisational and financial power (and sometimes political power) are local and international groups working to restore social and political stability, and agencies bringing humanitarian assistance to disaster-affected populations.

Often, in discussions on HIV and emergencies, participants immediately look to see whether they have, or can establish, an HIV-specific programme along with their

other emergency response work. While some organisations might fruitfully identify specific HIV initiatives that can be integrated into their wider programmes, this report will have failed if this is its only, or even its main, outcome. Rather, this paper invites readers to take a perhaps more difficult path, which is to consider how the issues highlighted by HIV might inform, challenge and even reform existing general policies and practices within *all* organisations responding to emergencies, regardless of whether they ever implement a specific HIV-focused programme.

Figure 1: Changes in life expectancy in selected African countries with high HIV prevalence, 1950–2005



Box 1: Calculating prevalence rates

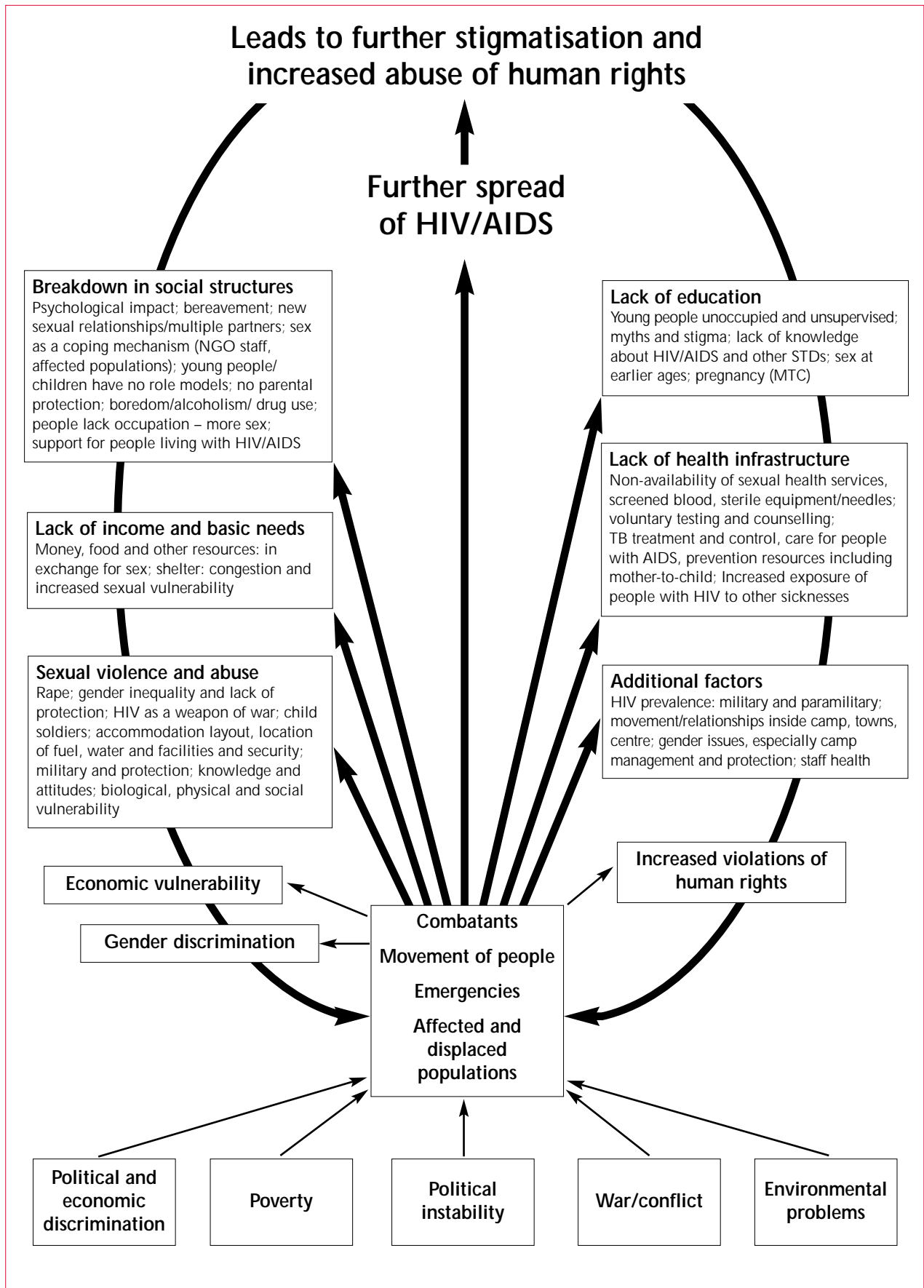
HIV prevalence rates are calculated and compared over time by defining the number of cases within a stable population. However, when a population is continually shifting because of conflict, it is difficult to identify whether changes in rates are due to changes in risk factors, or fluctuating denominators. Furthermore, sentinel surveys to estimate HIV prevalence are usually carried out in ante-natal clinics and centres for treating sexually-transmitted infections (STIs). In areas affected by conflict, these are most often not functioning. In Sierra Leone, for example, ante-natal prevalence data have not been available since 1992. Thus, UNAIDS reports of 3% HIV prevalence in the country must be regarded as inaccurate. In Angola, official statistics showing an HIV prevalence of just 3.4% are generally regarded as grossly underestimating real levels (UNOCHA, 2001).

economic migration. Men may migrate in search of work, leaving behind women-headed households that are unprotected and without income. In other instances, women and children migrate to nearby towns, seeking any means of providing for their needs. In conflict situations, people may be displaced across national borders as refugees into neighbouring countries, or they may be displaced internally within their own country. It is particularly difficult to monitor the conditions of people who are internally displaced, especially when this is for political reasons, making their vulnerability to HIV infection or discrimination against those living with the virus perhaps more acute. Typically, whether they are displaced some distance or remain close to their original dwelling place, people affected by emergencies have lost access to basic commodities like food, shelter, water, sanitation, services like health, education and social welfare and to any source of income. They may also lose the protection afforded by family and community and the safeguards of legislation against violence and discrimination.

new infections and of new viral strains being introduced in the home as well as the host setting. In areas of conflict, there may be an increased HIV prevalence because of an ‘imported’ military presence. It is a cruel irony that troops despatched to bring peace to an area may also be found to have caused considerable increases in HIV infection among local populations. Natural disasters often provoke an increase in

All of these factors increase people’s vulnerability to HIV, because they lead to increased poverty, dependency and powerlessness. In turn, these circumstances increase the likelihood of sexual coercion or bartering, physical and/or sexual violence and consensual unprotected and unsafe sex. Such circumstances also encourage a growth in the circulation and use of illicit drugs as a coping mechanism. The loss or absence of a functioning health service in

Figure 2: Factors of vulnerability to HIV



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Making the connections: HIV and emergencies

While HIV has affected almost every country of the world, nine out of ten people living with the virus are in the developing world. In some countries of Sub-Saharan Africa, up to 30% of the adult population is infected with HIV. The impact of HIV/AIDS is systematically eroding the benefits gained from four decades of development and health advances in the South. In Botswana, where 25–30% of the adult population is infected with HIV, life expectancy is predicted to fall to levels not seen since the 1960s. In Zimbabwe and Zambia, 25% more babies under 12 months of age are dying than would be the case without HIV. By 2010, Zimbabwe’s infant mortality rate is expected to rise by 138% because of HIV/AIDS, and the under-five mortality rate by 109%. By the end of 2000, AIDS was the number one cause of death in Sub-Saharan Africa, far outstripping even malaria.

Factors increasing people’s vulnerability to HIV

Emergencies – whether conflict-related or the result of a natural disaster – typically reinforce or make

more acute pre-existing factors of vulnerability within a population. The consequences of emergencies for people’s vulnerability to HIV are illustrated in the ‘problem tree’ depicted in Figure 2. (This long-established tool used in participatory learning (PLA) methodologies has been adapted by CAFOD to examine aspects of HIV vulnerability and prevention, and to explore the wider issues influencing behaviour choices.) These in turn become the causative factors making people more vulnerable to infection or re-infection with HIV.

In emergencies communities move, whether to neighbouring countries or provinces, or simply to the next village or a nearby site safe from the damage wrought by the disaster. Where war, conflict or protection is involved, combatants and military peacekeepers also move. When people are displaced, they may be relocated to or from areas of higher HIV prevalence and, perhaps, to or from areas of differing awareness about HIV. Their subsequent return to their home communities carries the further risk of

Table 1: HIV/AIDS by region, end-2001

Region	Adults & children living with HIV/AIDS	Adult prevalence rate	% of HIV-positive adults who are women
Sub-Saharan Africa	28.1m	8.4%	55%
North Africa & Middle East	440,000	0.2%	40%
South & South-East Asia	6.1m	0.6%	35%
East Asia & Pacific	1m	0.1%	20%
Latin America	1.4m	0.5%	30%
Caribbean	420,000	2.2%	50%
Eastern Europe & Central Asia	1m	0.5%	20%
Western Europe	560,000	0.3%	25%
North America	940,000	0.6%	20%
Australia & New Zealand	15,000	0.1%	10%

Source: *AIDS Epidemic Update: December 2001* (Geneva: UNAIDS, 2001)

conditions of increased injuries and sickness can also heighten the vulnerability of people exposed to blood as part of the rudimentary service set up following an emergency. These same conditions of poverty and powerlessness can increase the risk of reinfection and of discrimination against people known to be living with HIV; where resources are scarce, the health care, welfare and support services available before the emergency may be withdrawn. People with HIV may also be denied political entitlements offered to others affected by the emergency, such as visas and residence permits.

Neighbouring or host communities providing support to those affected by an emergency may find themselves having to offer relief from their own meagre resources. They too may lose sources of income or employment and find greater demands placed on any reserves they may have. Their already overburdened health, social and education services may become stretched beyond any capacity to cope. These communities may also be caught in the spiral of poverty, dependency and powerlessness caused by the emergency. Thus, they too may become more vulnerable to HIV.

The increased vulnerability to HIV infection or reinfection of aid workers involved in emergencies also needs to be recognised. In this context, issues related to exposure to HIV-infected blood or blood-contaminated instruments, while receiving or administering medical treatment, are most readily acknowledged. Much less acknowledged is the risk of infection through sexual activity. Aid workers, whether local or expatriate, will often be traumatised by the conditions they confront. Frequently, their only support comes from casual sexual liaisons and/or visits to local sex workers.

Thus, considerations of the HIV vulnerability of people affected by an emergency need to address the circumstances of affected-displaced groups, host communities and aid workers alike. Equally importantly, attention needs to focus on the underlying conditions that make people more susceptible to infection through sexual activity or from blood, and the circumstances in which discrimination against people who are already infected might occur. In conflict situations, the relationship between armed groups and HIV also needs to be considered.

HIV vulnerability through sexual activity

Emergencies can increase vulnerability to HIV by affecting patterns of sexual behaviour. This can happen in a number of ways, including:

- the increased use of sex as a commodity;
- increased sexual violence; and

Box 2: HIV transmission and care

HIV is transmitted mainly through sexual intercourse, though it can also be passed on through blood and blood products, via the shared equipment of injecting drug users, through the use of unsterilised blood-contaminated surgical or other skin-piercing equipment, and from mother to child in the womb, during childbirth and through breast feeding. There is as yet no cure for AIDS, and no effective vaccine affording protection against HIV. Anti-retroviral drugs that mitigate the impact of HIV are benefiting many people with AIDS in developed countries. But despite a landmark ruling in South Africa in April 2001 allowing the sale of cheap versions of patented drugs, these treatments are likely to remain beyond the reach of most people with HIV in the developing world. Even relatively cheap and easy-to-administer drugs to treat opportunistic infections related to HIV are beyond the reach of millions of people living with the virus.

- the breakdown of social or cultural structures and consequent loss of norms that regulate sexual activity in stable conditions.

For the vast majority of the affected population, emergencies commonly disrupt or destroy the usual means of income. The cyclone that struck the Indian state of Orissa in October 1999, for instance, left 800,000 live-stock animals dead and destroyed more than \$20m-worth of crops. In predominantly agricultural Gujarat, the earthquake of January 2001 left more than 20,000 cattle dead. In these circumstances, affected people rely either on aid, or on earning income by whatever means are available. This increases the likelihood of sexual bartering in exchange for food, clothing, shelter or money. Even when relief supplies are available, people can be required to queue for long periods to obtain basic commodities; this time may not always be available to women who have lost their husbands, and who are coping alone to secure their own and their children's survival. Economic dependence on their spouses can also place married women at a disadvantage as their lack of any personal economic resources makes it more difficult for them to refuse sex demanded in exchange for basic supplies, or to negotiate safer sex. A Liberian woman interviewed in a refugee camp in the early 1990s recounted how:

when food and clothing were being handed out women 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
(Kinnah, 1997).

The sex industry invariably flourishes in and around settlements of internally displaced people and refugees. According to a World Health Organisation (WHO) study of 1999, in eastern and central Sudan 27% of single mothers had become sex workers to earn a living (WHO, 1999). One area of huge

concern is the alarming and rapid rise in child prostitution associated with the arrival of peacekeeping troops (Machel, 2001). The UN Assistance Mission to Sierra Leone (UNAMSIL) is investigating reports that younger children are being brought in to service Kenyan and Nigerian peacekeepers who prefer young girls as they believe they are not yet infected with HIV (Renaud, 2001).

The UN Development Programme has estimated that nine out of ten new HIV infections resulted

Box 3: Forced migration and HIV/AIDS: the case of Burma

Burma has all the ingredients for an explosive HIV epidemic: 44m vulnerable people, poor or non-existent health care, large numbers of internally displaced people and refugees in a number of neighbouring countries, and a military dictatorship that refuses to acknowledge the magnitude of the country's HIV epidemic. Burma has the third-highest incidence of infection in South-East Asia, after Cambodia and Thailand. Rates among injecting drug users are among the highest in the world, reaching 74% in Rangoon, 84% in Mandalay and 91% in Myitkyina, on the border with China.

There are around 150,000 Burmese refugees in neighbouring countries, of whom almost 100,000 are housed in about 30 camps along the Burmese–Thai border. Since Thailand is not a signatory to the Convention on Refugees, UNHCR has no permanent presence in any refugee camps, nor a role in their administration. Although women's groups within these camps are growing, problems of sexual violence persist, both in homes and at the hands of camp authorities. Medical services are provided by international NGOs, and HIV/AIDS education is included in most health education programmes. However, sex education poses challenges for communities trying to maintain their traditional culture in difficult circumstances. Issues of confidentiality are a huge concern in such closed communities. To obtain condoms at health clinics, young women have to sign their own names and those of their parents. Many camps are undecided as to whether blood for transfusions should be screened, and donors told if they are HIV-positive.

The situation is little better for illegal Burmese immigrants within Thailand. In many respects, they are in situations which make them even more vulnerable

to HIV infection and less likely to seek care for HIV-related health matters. Only a small percentage have been able to register for temporary work; the rest are without any documentation and risk immediate deportation back to Burma. Fear of deportation makes immigrants reluctant to go through the bureaucracy necessary to secure hospital care. Many young women work in brothels, where they have no control over decisions affecting their vulnerability to HIV. The threat of deportation makes it impossible for them to insist on condoms being used. With Thailand's economic setbacks since 1997, such problems have become even more acute. Women working in domestic service are vulnerable to sexual abuse by their employers. Burmese labourers on construction sites and in factories form sexual relations without information on or access to protection against HIV or other STIs. Drugs are easily available, but little information is provided for injecting drug users on how to reduce the risk of infection with HIV or other blood-borne pathogens.

Illegal workers have no access to social welfare, medical care or other benefits. For migrant workers or refugees in Thailand who develop HIV-related illnesses, the already over-stretched health system may provide treatment for particular conditions, but not long-term care. Migrant workers or refugees with HIV who are repatriated or return voluntarily to Burma face an even greater lack of care and support facilities, compounded by the policies of the regime. One young woman who returned home sick with AIDS-related pneumonia discovered that her village community in Shan state had been forcibly relocated. She had neither the resources nor the energy to locate the community, and returned to Thailand to die in the care of an NGO.

Source: Jackie Pollock, 'Forced Migration, The Military and HIV/AIDS in Burma', paper presented at the Silent Emergency Seminar, London, June 1999

from coerced sex (UN Foundation, 1999). Sexual violence and rape are commonplace in emergency situations, particularly where these are the result of conflicts and wars. Combatants have frequently and systematically used rape to terrorise a population and force it out of an area. Sexual violence has been used as a weapon of war in, among others, Mozambique, Rwanda, Liberia, Sierra Leone, Sri Lanka and Kosovo (Elliott, 1999). In Bosnia, 30,000–40,000 women were raped during the conflict in the mid-1990s (The Bridge, 1998). According to Damien Rwegera, adviser to the Joint UN Programme for HIV/AIDS in conflict zones in West and Central Africa: ‘There is widespread rape. People are no longer bound by social conventions. The soldiers rape, the men rape, especially as up to 95% of people in a refugee camp can be women and children’. Rwegera claims that rape by the military has become systematic in conflict-affected countries like DRC; despite the known risks of HIV, the authorities are doing little to control the epidemic. As Rwegera (2001) notes, ‘we can’t go on like this’.

The conditions prevailing in temporary shelters set up for people displaced or made homeless by an emergency, for example families sharing cramped living and sleeping quarters, increase the risk of sexual abuse of women and young girls. Additionally, displaced people are most often accommodated in so-called camps (though these may often resemble sprawling urban developments, or even mini-cities, more than a relief camp). The layout of camps can be a critical factor in making women and young girls (and increasingly young boys) vulnerable to sexual abuse. Women and children, who constitute around 75% of the esti-



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Cramped camp conditions can increase HIV vulnerability

mated 40m refugees and displaced people worldwide, are disproportionately vulnerable to HIV in these circumstances. A Liberian refugee recounted how the women’s shelters were set up on the fringe of the camp, making women more vulnerable to sexual violence from military personnel, police and male refugees (Kinnah, 1997). The installation of a thorn perimeter around a refugee camp in north-east Kenya in 1992 significantly reduced the number of women and young girls suffering sexual violence (Bissland, 1994). Research in Tanzanian refugee camps in 1995 showed an increased number of pregnancies among young women and girls living without the protection of parents. Additionally, the frustrations and idleness of refugee or displaced men and their drinking habits contributed to more violence and sexual abuse of women (Rädda Barnen, 1995).

Box 4: Sexual violence and conflict in Rwanda

During the Rwandan genocide in 1994, rape was used as a tool of ethnic cleansing; an estimated 15,000 women were pregnant as a result of rape or forced marriages by the end of 1995 (WHO, 1997). Young Hutu men in the camps in Tanzania boasted of their efforts to impregnate as many women and girls as possible, in order to help replenish the Hutu population (Benjamin, 1996a). Since 1994, 2,000 Rwandan women have voluntarily sought HIV testing; 80% were found to have the virus, probably contracted as a result of rape.

Source: Ester Mujawayo and Mary Kayitesi Blewitt, ‘Sexual Violence Against Women: Experiences from AVEGA’s work in Kigali’, paper presented at the Silent Emergency Seminar, London, June 1999

Disruption to communal or social standards governing sexual behaviour and the destruction of social and family networks can also have a profound impact on sexual behaviour, and thus on vulnerability to HIV. Many of the normally available coping mechanisms and social support networks, both for individuals and for communities, are weakened or destroyed in the wake of an emergency. Traditional family structures may disappear through loss or separation, and new sexual relationships may form. The loss of the cultural norms applying in a stable community may remove important mechanisms that protected individuals from physical violence and sexual exploitation. Among people affected by an emergency, there may also be a desire to replace lost loved ones, either by having new children or by developing relationships with new partners.

Orphaned and unaccompanied children are particularly vulnerable in emergencies. Most of the current debates surrounding the vulnerability of unaccompa-

nied minors concern how best to manage their basic needs, with little explicit reference to their increased vulnerability to HIV through sexual activity (see, for example, UNHCR, 1994; Williams, 1996). The loss of parents as a result of conflict or natural disaster can mean that such children are provided with some kind of foster care, or are taken into institutions which, hard-pressed to cover even their material needs, may not be able to offer the attention the children need to overcome the trauma of their experiences. Such children may also be more vulnerable to sexual abuse. In other instances, unaccompanied minors are left to fend for themselves, and large numbers of unaccompanied children can form a significant proportion of refugee or otherwise displaced groups. These children can be overlooked when basic commodities are being distributed, and can miss out on supplies of food, clothing or shelter. This in turn increases the likelihood that they will resort to trading sex for provi-

sions (thus, income-generating initiatives are an essential part of any attempt to address the sexual health needs of adolescents).

In the absence of formative social structures, positive role models and the constraining and guiding influence of the family and community, disaster-affected people, particularly adolescents, are more likely to engage in risk behaviour such as alcohol or drug abuse, and increased sexual activity. The Angolan Network of AIDS Service Organisations (ANASO) has noted that, even when young people had a high level of awareness of HIV, this did not translate into changes in behaviour to reduce their risk of infection. ANASO's executive secretary Antonio Coeiho Neto observes that a feeling of uncertainty as a result of conflict has led young people to ignore the threat of HIV: 'Young people here have only seen war, except for a few

Box 5: HIV/AIDS and natural disasters: the case of Honduras

Hurricane Mitch in October 1998 devastated Honduras, causing an estimated \$5 billion-worth of damage and affecting over half a million of the country's six million people. Throughout the country, Hondurans were left without housing, employment, cultivatable land and infrastructure. The disaster's impact on the country's large population of urban poor was particularly severe.

Even before Mitch, Honduras had one of Latin America's highest HIV infection rates, ranking third behind Guyana and Belize. Conservative estimates suggested that some 40,000 people, mainly in the 15–29-year age bracket, were infected. Women constituted a third of the infected population; between 1990 and 1997, AIDS-related mortality among women of child-bearing age rose from five per 100,000 to 25 per 100,000.

Mitch had a number of effects on the prevalence of HIV and on the treatment and support of people with HIV/AIDS. The health infrastructure was severely damaged, while health workers focused predominantly on tackling health problems directly linked with the disaster, such as malarial infections caused by the collapse of sanitation systems. NGOs suspended HIV prevention programmes in favour of providing food, shelter and short-term palliative care. Staff were called on to participate in national efforts to prevent epidemics such as cholera, dengue and malaria.

Mitch also had other effects related to pre-existing social and economic conditions. Even before the hurricane struck, Honduras was one of Central America's poorest countries. In its wake, child labour increased and the number of girls and young women involved in sex work grew. Children made homeless and forced onto the streets of the country's cities were (and still are) at increased risk of sexual exploitation and violence. Population movements within the country and across its borders increased as people looked further afield for work. Particularly vulnerable groups such as sex workers relocated to areas with high levels of sex tourism, such as San Pedro Sulas, La Ceiba, Comyagua and Tegucigalpa. For women and children, sexual violence has been exacerbated by the pressures of homelessness and relocation to new and unfamiliar areas.

In the long term, it is unlikely that these social vulnerabilities, and with them the risks of HIV infection, will decline. Reconstruction efforts have concentrated almost exclusively on the country's physical infrastructure, and areas of vulnerability, including HIV/AIDS, have not been adequately addressed. Despite attempts to provide education geared towards HIV prevention, sexual behaviour has not markedly changed, and will not do so while the country's civil society remains weak and structural, economic and social problems persist.

Source: Maria Esther Artiles, 'Socio-economic Issues of HIV and Emergencies in Honduras', paper presented at the Silent Emergency Seminar, London, June 1999

short spells. This has led to an attitude of “why should I care about anything?” Increased instability increases this kind of attitude’ (UNOCHA, 2001). According to a study by the New York-based Women’s Commission for Refugee Women and Children, published in January 2000, few sexual health programmes targeting adolescents are operational, despite the fact that health is the most developed sector of international response to adolescents affected by armed conflict. The study, *Untapped Potential: Adolescents Affected by Armed Conflict*, also noted that there is limited and conflicting information on what strategies are most appropriate to address the impact of conflict on the psychological and social wellbeing of adolescents, and that efforts to tackle sexual abuse of young people in conflict were scattered and generally ineffectual.

HIV vulnerability through blood: health systems, medical supplies and illicit drug use

Conflict and natural disasters can have a severe impact on health services, particularly in countries where the existing infrastructure is already weak. The disruption caused by emergencies can result in the partial or complete loss of even the most basic health services, at precisely the time when they are most needed to treat the often huge numbers of injured. According to the Ministry of Health in Sierra Leone, 62% of peripheral health units are not functioning (Renaud, 2001). In Burundi, the genocide eliminated Hutu doctors, and in Tajikistan there are not enough funds to keep health services going (Renaud, 2001).

The loss or absence of a functioning health service in conditions of increased injuries and sickness can heighten the vulnerability to HIV of people exposed to blood as part of the rudimentary service set up following an emergency. Facilities for testing blood donations for the presence of HIV and for sterilising surgical equipment may be lost very quickly. Other health services existing prior to the emergency, such as tuberculosis treatment programmes or services to diagnose and treat sexually transmitted infections (STIs), are also likely to be disrupted. In Tanzania, Caritas ran two large refugee camps following the influx of refugees from neighbouring Rwanda. The short-staffed dispensary, which handled between 300 and 400 out-patients a day, suffered from shortages of drugs and equipment, including essential items to reduce the risk of HIV infection via blood and blood products. At the same time, there had been a five-fold increase in the number of patients needing blood transfusions (Panos Institute, 1994). If medical practitioners are over-burdened, poorly resourced or ill-prepared, there is a risk of accidents occurring in

clinical practice, for example during a mass immunisation campaign or through the overuse of injections. Inadequate measures for sterilising equipment or disposing of increased volumes of clinical waste pose additional risks.

People’s heightened vulnerability to HIV infection is not always taken into account in the medical supplies provided in response to an emergency. Making condoms available, for instance, is an important method of reducing HIV risks in emergency settings, yet their provision is often not considered essential from the earliest point of the response. When supplies are available, there may be increased resistance to their use among affected populations. This may be because of a desire by individuals to replace lost family members, whereby the urge to become pregnant outweighs considerations around STIs, including HIV. In other instances, fear, misperception (and simple dislike) may prevent or discourage the use of condoms (Benjamin, 1996b).

Populations displaced by an emergency may not receive adequate health care, even when facilities are available in their host setting. Where people are displaced to a neighbouring country, language barriers may discourage refugees from seeking advice or treatment, and may prevent them from understanding the information that is being given to them, or even what services are available. Refugees may also not have the same entitlements as people from the host community. Fear of losing their right to stay in their host country or their entitlements to other supplies and benefits may deter many refugees from seeking attention for HIV-related health concerns.

The use of illicit drugs can often increase immediately following an emergency, whether out of boredom and hopelessness or as a coping mechanism. The disruption and loss of order typical of emergencies make these drugs more readily available and easier to access. Social and economic breakdown in Tajikistan, for instance, has produced ideal circumstances for drug trafficking from Afghanistan. The World Bank estimates that 30% of Tajikistan’s national economy may be based on the drug trade. Drugs ‘leak’ in transit, and school children as young as 12 years of age have been injecting drugs (Renaud, 2001).

HIV/AIDS and armed groups

The first documented statistical link between military forces and an increase in the prevalence of HIV was reported in Uganda in 1991, where the geographical pattern of HIV incidence was found to correlate with the location of the Ugandan National Liberation

Army for the first six years of the civil war that followed the Amin era (Smallman-Raynor and Cliff, 1991). In most countries, HIV infection rates among the military are, in peacetime, generally two to five times greater than those for comparable civilian populations. In periods of conflict, these figures rise dramatically. According to UNAIDS data, HIV infection rates among Nigeria's military forces returning from peacekeeping duties in Sierra Leone and Liberia were 11%, compared with the national adult rate of 5%. In 2000, between 60% and 70% of military forces in South Africa reportedly had HIV, compared with 20% of the civilian adult population (Kirk, 2000). According to senior officers in the French army's health services, tours of duty overseas multiply the risk of HIV infection for French military personnel by a factor of five (UNAIDS, 1998). A study by the Ethiopian government of HIV prevalence among the military showed that 5.5% of those tested were HIV-positive. Although this was less than the national incidence of 10.6%, HIV-infected recruits were in fact rejected on initial screening. Given that the average length of stay in military service was just ten months, this suggests a rapid rate of infection among these conscripts (Renaud, 2001). The UN Mission in Ethiopia and Eritrea (UNMEE), working in conjunction with Ethiopian defence forces, has now set up a five-year plan to address HIV in the Ethiopian army.

Although it is clear that infection rates among many military and paramilitary groups are generally high, the relationship between combatants and HIV – both as vectors and as victims – is more complex. The circumstances of combat make many soldiers both more vulnerable to HIV infection, and more likely to spread HIV among local populations. Most military recruits in Africa, for instance, will receive little or no sexual health and HIV education as part of their often-rudimentary training; members of the continent's multitudinous rebel or other armed formations will receive even less. Troops are frequently very young (often between 15 and 24 years of age) and inexperienced, and ill-equipped to cope with the stress of modern combat. Unsupported and frightened, often brutalised by their day-to-day experience of violence, they may consider sex (whether consensual or forced) to be their only source of comfort. Sex may become a means of dealing with loneliness and stress, as well as reinforcing their sense of power. Child soldiers – an increasingly common feature of internal conflicts – are especially vulnerable to HIV, either through sexual violence by older officers or through peer pressure that encourages risk-taking behaviour. Injured troops may be treated in at best rudimentary facilities, and risk infection from contaminated blood or instruments.

Box 6: The military and the sex industry: UNTAC and HIV/AIDS in Cambodia

The UNTAC peacekeeping mission in Cambodia took place between 1991 and 1995. It involved some 20,000 soldiers from the US, Western Europe, Bulgaria, Uruguay, India, Pakistan, Bangladesh, Thailand, Indonesia and South Korea, as well as from several African countries. The mission was the first of its kind and was one of the most ambitious UN operations ever launched. Needless to say, with the massive influx of funds that came with it, the commercial sex industry flourished, and HIV rates increased (Beyrer, 1998). The prevalence of HIV among blood donors in Phnom Penh during the five years of the mission increased dramatically, indicating a corresponding rise in prevalence among the general population.

Local authorities in Phnom Penh were quick to attribute this rise in HIV prevalence and the growth in the sex industry to UNTAC. Although there is no concrete evidence to support this claim, local NGOs reported that, on average, prostitutes doubled their nightly number of customers, from five to ten. Studies of returning UNTAC soldiers in Uruguay and the US show that those who carried the disease were mostly infected with a particular sub-type E of HIV, found only in South-East Asia and Central Africa. It was estimated that 15% of the Indian soldiers that served with UNTAC came home infected (Beyrer, 1998).

As transmission agents, military forces and other armed groups are also a cause for significant concern. As noted above, sexual violence, with its attendant HIV risk, has been used as a deliberate tactic to intimidate or otherwise influence local populations. Military or paramilitary forces may also engage in sexual violence in refugee camps or other sites of displacement. Soldiers posted away from home will usually have more disposable income than the local population, making them valued customers in the sex industry and fuelling prostitution around camps. Ironically, these soldiers often leave spouses or partners at home in poverty, for whom sex work is their only means of survival (Talugende, 1998). Attention has begun to focus on HIV and peacekeepers and military personnel, and resources for HIV prevention have been channelled towards these groups. UNAIDS and the UN Department of Peacekeeping Operations (DPKO) have conducted

missions to Ethiopia, Eritrea, East Timor and Sierra Leone. The DPKO is also exploring the possibility of providing training in troops' home countries, rather than in the countries of deployment, because of language problems when peacekeepers from several countries are sent to one area.

Next steps

The factors that increase the vulnerability to HIV of populations affected by emergencies are complex. Clearly, many risk factors exist independently of the conditions generated by an emergency: prostitution, drug use or cultural issues that make it difficult for women to demand protected sex are not limited to complex political emergencies or natural disasters.

Nonetheless, as the examples in this chapter demonstrate, emergency conditions can easily exacerbate these risk factors: loss of livelihood sources can make affected women more likely to resort to sex work; the dislocations of community and family networks and the removal of social norms governing sexual relations in times of stability may see an increase in promiscuity or sexual violence. Given that natural disasters and complex political emergencies tend to occur in developing countries, where rates of HIV incidence are already high, this increased vulnerability must be a cause for concern. The following chapter assesses the steps agencies have taken to address HIV/AIDS in their emergency policies and guidelines.

Responding to HIV/AIDS in emergencies: policies and guidelines

Many agencies providing humanitarian assistance have not included considerations of HIV/AIDS in their written policies or strategies for emergencies. In agencies' thinking and policy development, HIV/AIDS has, at best, generally been understood as a sub-topic within broader subjects, notably medical practice, sexual health and sexual violence. Policies specifically addressing HIV/AIDS in emergencies exist, but tend to focus on technical and biomedical issues, or on minimising the risks of infection faced by humanitarian workers. A comprehensive review of all the relevant policies and guidelines related to HIV is beyond the scope of this paper. Instead, it focuses on key documents that are either directly concerned with HIV/AIDS in emergencies, or that address the issue as part of a wider policy set. Thus, the chapter assesses the guidelines and policies developed by UNAIDS, the principal UN structure responsible for tackling HIV/AIDS; policies on sexual health, particularly among refugee populations; and guidelines covering sexual violence and abuse. It also offers a brief review of some of the policies and guidelines agencies have developed to address HIV-related issues as they affect aid workers.

HIV/AIDS policy in the UN

HIV/AIDS in complex emergencies and natural disasters has become an increasingly visible subject within the UN. In January 2000, the Security Council discussed the pandemic, the first time a health issue had ever been treated in this way. The following June, Resolution 1308 called for a coordinated response to HIV in peacekeeping operations, while in December an Expert Strategy Meeting made specific recommendations for addressing HIV/AIDS during peacekeeping and humanitarian operations. In June 2001, the UN General Assembly held a Special Session on HIV/AIDS, which identified HIV and conflict as a key concern. The

Declaration of Commitment ratified by General Assembly members recognises that populations destabilised by armed conflict, humanitarian disasters and natural emergencies are at increased risk of exposure to HIV. The declaration called on UN agencies and NGOs to incorporate HIV prevention, care and awareness strategies into their programmes, urged governments to establish national strategies to address the spread of HIV among armed forces and civil defence forces, and recommended the inclusion of HIV awareness training in the preparatory training undergone by peacekeeping troops (UNGA, 2001).

UNAIDS

UNAIDS, the joint UN programme on HIV/AIDS, is the key UN body concerned with HIV/AIDS, bringing together the UN Children's Fund, the UN Development Programme, the UN Population Fund, the UN Drug Control Programme, UNESCO, WHO and the World Bank. UNAIDS sees itself as the main advocate for global action on HIV/AIDS.

The central UNAIDS document relating to HIV/AIDS in emergencies is the *Guidelines for HIV Interventions in Emergency Settings* (UNAIDS, 1996), produced in collaboration with the WHO and the UNHCR. The guidelines set out recommended interventions for what are defined as the five stages of an emergency: destabilising event; loss of essential services; restoration of essential services; relative stability; and relative normality.

Stage 1: Destabilising event. During the destabilising event, the guidelines recommend ensuring an HIV-free blood supply for transfusion, and making basic information on the HIV and STI situation available to relief workers and others going into the field. The guidelines suggest that few, if any, other HIV-related activities can be carried out at this stage. Efforts

should be focused on planning and assessment, and on mobilising funds and resources. Where an agency has specifically designated staff members responsible for HIV, these should be involved in developing or refining the organisation's protocols and guidelines (in local languages if possible/appropriate).

Stage 2: Loss of essential services. During the acute stage of the emergency, the guidelines recommend implementing the Essential Minimum Package (EMP). This consists of the following four components.

- Adherence to universal medical precautions. These comprise hand-washing, using protective clothing including gloves, the safe handling of sharp instruments, the safe disposal of medical waste including sharps, and the decontamination of instruments and equipment.
- Measures to ensure safe blood transfusions, for example using blood substitutes wherever possible, transfusing only in life-threatening circumstances and when no alternative is available, and testing all donated blood for HIV (most likely using rapid tests, and alongside tests for blood type and rhesus compatibility).
- Provision of basic HIV/AIDS information.
- Provision of a free supply of condoms. Condoms should be considered an essential item in emergency relief supplies. Agencies should also consider the means of distribution, taking into account the need to ensure that the most vulnerable people have access to them.

The guidelines also recommend that, at this acute stage, there should be coordination on HIV-related interventions between all international, governmental and non-governmental agencies involved.

Stage 3: Restoration of essential services. As essential services are restored and basic needs are increasingly met, the guidelines suggest that agencies can begin to develop more sophisticated HIV/AIDS interventions. These include:

- Conduct a situation analysis, gathering further information on the infrastructure of the health

system, the equipment, supplies and skills needed for HIV interventions, existing information on HIV and STD prevalence prior to the emergency, awareness of HIV, patterns of risk behaviour and discrimination against people with HIV.

- Identify HIV programme coordinators and other staffing requirements, prepare a short-term HIV plan, and work with refugee and host community leaders, local and international organisations and host country authorities.
- Refine and develop further the basic HIV activities of stage 2, to include information, education and communication programmes, condom promotion and the support required to ensure a sustained supply of safe blood and blood products, control and treatment of STIs, care for people with AIDS-related illnesses and counselling and social support for people infected with, and affected by, HIV.



HIV/AIDS education is considered a basic right

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Stage 4: Relative stability. In stage 4, services to the affected population, whether in their home country or in refugee settlements elsewhere, are being restored or established. At this stage, the guidelines recommend that the activities already initiated continue, and that mechanisms are introduced to monitor these, with adjustments made as required.

Stage 5: Return to normality. At this stage, the destabilising event has been

resolved or is close to resolution, a degree of political, social and economic stability has been achieved and/or conditions have improved to the point where displaced people can consider going home.

The guidelines are detailed, and provide specific information on types and quantities of supplies, as well as sample health questionnaires and references to other useful literature. There is also a welcome section on aspects of human rights and ethics to do with HIV/AIDS and emergencies. This notes that, during an emergency, human rights may be violated in ways that either increase the risk of infection with HIV, or increase the impact of HIV or AIDS on infected people and their families. Examples of the former include lack of access to HIV prevention information and to the means of prevention. Thus, the provision of HIV/AIDS education and services is considered a basic right. People also have the right to be able to

refuse sexual relations if they threaten HIV infection. The document also calls for the human rights of people with HIV, or suspected of having HIV, to be respected. It condemns coercive or discriminatory measures (often taken in the name of public health), such as mandatory HIV testing, the publication of HIV status, the isolation or segregation of people with HIV, and the denial of asylum, health care, employment and assistance to HIV-infected people.

UNAIDS has also looked at HIV/AIDS in the context of refugee situations, and in relation to military and paramilitary forces. In 1997, for instance, it published *Refugees and AIDS: UNAIDS Technical Update*, which offers a technical summary of the issues, challenges and recommended responses set out in the guidelines described above. *AIDS and the Military: UNAIDS' Point of View*, published in 1998, is intended as a briefing resource for policy-makers, decision-makers and community leaders (UNAIDS, 1998). It describes the HIV risks related to military forces, and makes the following recommendations:

- *Addressing risk behaviour.* Recommendations include improved HIV prevention education, both for military medical and nursing staff and for troops; condom education and distribution; expanded STI treatment; and provision of HIV counselling and voluntary testing services.
- *Addressing underlying vulnerability factors.* Changes to posting practices have been recommended. These include measures to maintain family life, such as shortening tours of duty away from home or helping soldiers to bring their families with them if long-term postings are unavoidable, and security conditions allow. Changes to military culture are also called for, as are shifts in military attitudes to civilian populations.
- *Partnership with the civilian sector.* The traditional separation of military medical services from civilian input has been counter-productive in many countries, and the document calls for recognition of the constant interaction between military and civilian populations, and the importance of this interaction in HIV prevention and care.
- *Acceptance and care of HIV-positive military staff.* This recommendation calls for guarantees of confidentiality for HIV testing, enabling individuals to pursue their careers and carry out tasks they are still fit to perform, and providing care and support for soldiers and their families affected by HIV or AIDS.

One striking absence in these recommendations is that there is no reference to military accountability for sexual violence. Given the frequency of sexual

abuse and the use of sexual violence as a combat tactic, this is an important omission.

UNHCR

UNHCR updated its policy on HIV/AIDS and refugee populations in 1998. Key points are:

- HIV/AIDS must be addressed within the refugee environment at the earliest stage of an emergency situation, and throughout the stabilisation period.
- HIV prevention and care should be multi-sectoral, and should be integrated into all areas of refugee assistance, including education, protection and security, health/reproductive health and community services.
- UNHCR should coordinate with national AIDS programmes and establish open and collaborative communications with host-country authorities.
- Voluntary counselling and testing (VCT) can be considered if conditions allow complete compliance with all the guidelines governing VCT. However, UNHCR strictly opposes mandatory HIV testing of refugees because of consequent discrimination.
- The resettlement of refugees living with HIV is difficult, and must be given special attention to avoid placing these people at greater risk of discrimination, *refoulement* and institutionalisation.

UNHCR has also addressed the specific problems faced by refugee women and children. In 1991, for example, it published *Guidelines for the Protection of Refugee Women*. These provide guidance for practitioners, and address many of the factors that perpetuate the spread of HIV in emergency situations. The guidelines pay particular attention to gender-based sexual violence, access to health care, education and skills training, economic activities, access to food, water and fuel, and legal and protection procedures. They include a framework for assessment and planning. The adoption of such guidelines at the planning stages of an emergency response would address many of the vulnerabilities to HIV/AIDS faced by women and girls in camp situations. However, the impact on displaced populations outside a camp environment, and the appropriate response in these situations, is less clear and not addressed in any detail. UNHCR's *Sexual Violence against Refugees: Guidelines on Prevention and Response* was produced four years later. Building on the 1991 *Guidelines*, this document examines the phenomenon of sexual violence in refugee settings, outlines preventive measures, gives practical guidelines on responding to incidents, and covers legal aspects, including international law. The guidelines also highlight the importance of camp design in exacerbating or reducing levels of sexual violence and coercion. It

identifies four key elements that increase vulnerability:

- *Geographical location.* The risk of sexual attack increases if the camp is in an area of serious crime, is isolated from the local population, is difficult to patrol or is too easily entered from outside.
- *Overcrowding.* In overcrowded camps, unrelated families may have to share communal living and sleeping space. In some instances, this may force them to live in close contact with individuals traditionally considered enemies.
- *Poor design of services and facilities.* Lighting, the location of latrines and fuel and water supplies can all influence levels of vulnerability.
- *Lack of police protection and general lawlessness.* Police officers or military personnel are involved in acts of sexual abuse or exploitation, or are unable to maintain control and prevent such acts from taking place.

Inter-agency initiatives

There are also a number of inter-agency initiatives that address, albeit indirectly, problems of HIV/AIDS among refugee populations. The *Interagency Field Manual for Reproductive Health in Refugee Situations*, for instance, was developed by an inter-agency working group comprising UNHCR, WHO and UNAIDS, in consultation with governmental and non-governmental organisations and technical experts (UNHCR, 1999). It was first produced in 1995, and updated in 1999. The manual recommends the provision of a Minimum Initial Service Package (MISP) for reproductive health in refugee situations at the initial stages of an emergency situation. This incorporates most of the Essential Minimum Package of the guidelines for HIV interventions in emergency settings. In addition, it also addresses:

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

The document asserts that special programmes need to be developed to mitigate the physical, psychological and social consequences of sexual violence. Recommendations to address the problems experienced by victims of sexual violence include: the use of emergency post-coital contraception; the provision of voluntary counselling and HIV testing for pregnant women; and the use of same-sex medical staff to treat victims. The manual also recommends that the MISP should be followed by a more comprehensive intervention after the acute emergency period is over. In common with many policy documents concerning refugees and reproductive health, the manual makes scant mention of HIV-positive women and childbirth, and there is no consideration of the use of anti-retroviral drugs to prevent mother-to-child transmission.

Other initiatives within the UN

In addition to its contribution to inter-agency initiatives, WHO has produced a number of policy documents and guidelines on HIV/AIDS in emergency situations. In 2001, the agency published a guide for programme managers, entitled *Reproductive Health during Conflict and Displacement*. This document, designed as a complement to the Interagency Field Manual, considers the particular vulnerability of women and young people (boys as well as girls) to sexual violence. WHO is also developing a *Guide for the Clinical Management of Post Rape Survivors*, which outlines best practice for managing the health implications of rape. Another initiative is the possible implementation of Post Exposure Prophylaxis for women who are raped, which would provide short-course treatment with the drug AZT to prevent HIV infection. Kits are being piloted in countries not facing conflict, and have still to be tested in emergency settings (Renaud, 2001). The UN Population Fund (UNFPA) has also supported emergency reproductive health, with projects in more than 30 countries. These include efforts to prevent sexually-transmitted diseases; counselling for victims of sexual violence; the provision of emergency reproductive health kits, including condoms; and instructions for health workers on avoiding HIV infection (UNFPA).

Box 7: Action for the Rights of Children

Action for the Rights of Children (ARC) is a collaborative initiative between UNHCR and the International Save the Children Alliance. It aims to increase the capacity of UNHCR, government and NGO field staff to protect and care for children and adolescents during all stages of refugee situations, from emergency interventions to durable solutions. ARC is a compendium of training materials covering a range of issues of relevance to HIV vulnerability in emergency situations, including unaccompanied children; child soldiers; preventive health (including HIV/AIDS and STDs); and sexual exploitation and abuse.

HIV policies developed by NGOs

Generally, NGOs have approached HIV/AIDS as a health risk to staff, or purely as an operational/

Box 8: The Inter-Agency Standing Committee on Complex Emergencies in Africa

In February 2000, an Inter-Agency Standing Committee (IASC) sub-working group on complex emergencies in Africa met in Rome. The group included representatives from WHO, UNAIDS, UNHCR, UNICEF, FAO, ICRC, IFRC, IOM, OCHA, UNFPA and MSF. The meeting report, entitled *Controlling the Spread of HIV/AIDS in Complex Emergencies in Africa*, identified a number of specific steps (IASC, 2000). In common with others, the report highlighted the need for a multi-sectoral approach to HIV/AIDS in complex emergencies. It also argued that:

- governments hosting refugees must be assured that the international community will help to shoulder the extra burden;
- HIV interventions planned by local and international entities should be in line with national programmes;
- in the context of forced migration, every effort should be made to provide the same services for refugees/displaced persons and for the surrounding population;
- specific vulnerable groups, such as refugees, the internally displaced and sex workers, should be identified, and their needs assessed; and
- caution must be exercised to ensure that targeted interventions do not further stigmatise HIV-infected people.

The report also outlined two 'standardised packages' addressing HIV/AIDS in countries with complex emergencies. The first would apply in the acute stage, and the second would cover pre- and post-crisis situations. The report identified a range of steps that needed to be taken in relation to these two 'packages':

- the need for all agencies involved to develop the capacity to identify needs and assess vulnerability *vis-à-vis* HIV/AIDS;
- the development of information and training packages on HIV prevention, and their distribution to UN and NGO staff, and local populations;
- the provision of condoms;
- the need for the early detection of STIs and possible AIDS cases. In the absence of confirmatory laboratory services, national syndromic management guidelines should be applied or developed;
- emergency response units and reproductive health services should incorporate the MISP;
- health delivery services (facilities, staff training, drugs and medical supplies and laboratory equipment) should be strengthened to ensure quality HIV care to displaced populations;
- work with adolescents and children should be undertaken to reinforce their self-esteem and emphasise their role in promoting positive values and healthy lifestyles in complex emergencies;
- medical protection should be provided for people, including humanitarian workers, who have been sexually assaulted (kits with contraceptives and anti-retrovirals might be considered an essential component of HIV prevention programmes). A clear policy to protect health workers from the risk of exposure to HIV should be implemented;
- local organisations in areas of high HIV prevalence should be strengthened to provide assistance/support for families and communities affected by HIV/AIDS;
- HIV-free blood supplies and test-kits for safe blood programmes are essential; and
- coordination, networking, community mobilisation and planning instruction in the field are crucial.

biomedical issue. Médecins Sans Frontières (MSF)'s AIDS policy defines a general framework for its interventions, applicable both to emergency situations and to longer-term projects. It outlines ten priority interventions, the first seven of which are medically-focused, and concerned with safe practices for transfusions and injections; sterilisation and the disposal of medical waste; the protection of health workers; the medical management of AIDS cases; and STI control. These are compulsory and must be implemented by all MSF missions from the start of an intervention. The policy also sees the promotion of safer sex and patient

counselling/social support as essential, to be developed progressively according to local needs, resources and capacities.

Other agencies have also attempted to address issues around HIV/AIDS in emergencies. In 1998, for instance, British health care NGO Merlin developed an HIV/AIDS Action Plan, incorporating existing guidelines for the prevention of nosocomial HIV transmission (that is, transmission within a medical facility), and for treatment after occupational exposure. The plan also calls for all expatriate and

Box 9: Sphere and HIV/AIDS

The Sphere Project's *Humanitarian Charter and Minimum Standards in Disaster Response* addresses HIV/AIDS as part of the recommendations for minimum standards in health services. Guidelines insist that the rights of people with HIV be respected and stress the need for action at the acute stage following a disaster; to ensure 'safe blood transfusions, access to condoms, availability of materials and equipment needed for universal precautions, and relevant information, education and communication'. Disappointingly, there is scant reference to the gender aspects of HIV/AIDS, nor is there any mention of the role that sexual violence plays in transmission.

local staff to be trained on the occupational hazards related to HIV, the vulnerability to HIV of populations in emergency situations, and issues related to gender and sexuality. Medical coordinators are to carry out situation analyses of HIV in-country to evaluate HIV distribution, assess governmental control programmes, determine the extent and nature of the involvement of other agencies, and evaluate the impact of Merlin's programmes.

A number of agencies have produced general HIV/AIDS policies for staff, setting out the organisation's position on employment, testing, insurance, confidentiality, care and support. Some NGOs have also incorporated HIV considerations into their disaster preparedness strategies or facilitated staff awareness initiatives in this regard. Following the UK NGO AIDS Consortium seminar in 1996, ActionAid, CAFOD and Save the Children UK set up awareness-raising initiatives for key staff. More recently, CAFOD has developed a leaflet setting out the issues highlighted by HIV and making recommendations for staff working in emergency situations (CAFOD, 2001). Intended for use in the first instance by CAFOD programme staff and its partner organisations, this leaflet has

been piloted by nine partner programmes worldwide.

In 1998, the UK NGO AIDS Consortium published revised and updated guidelines for aid workers overseas, and in March 2001, MSF documented the procedures to be followed in the case of an aid worker's accidental exposure to HIV, describing the prophylactic measures and psychological support an aid worker would need in the wake of such an incident (MSF, 2001). Also in 2001, InterHealth and People in Aid produced health and safety guidelines for aid workers on preventing HIV. The guidelines recognise the risk to aid workers from both blood-borne and sexual transmission routes, and the various recommendations take account of professional and/or personal circumstances that might increase an individual's vulnerability to HIV. Although focusing on the medical issues concerned, the guidelines also make an important – and rarely stated – acknowledgement that aid workers are often in hugely stressful and sometimes life-threatening situations, and that casual sex may be one of their only support/coping strategies.

The limits of existing approaches

Currently, policies are concerned mainly with HIV prevention, with comparatively little attention given to the needs of people living with HIV, or to related legal and human rights concerns. Prevention largely focuses on biomedical aspects. Such approaches are limited, and tend to emphasise the immediate aspects of vulnerability and transmission, such as contaminated blood, inadequate sterilisation facilities or deficient health education. This does not adequately tackle the underlying social and economic issues related to HIV in emergencies. How effective, for instance, will condom social marketing realistically be when disempowered women have no influence on the conditions of their sexual relations, or where adolescents are so brutalised by conflict that concerns about HIV are meaningless to them? How valuable are guidelines for minimising the risk of blood-borne HIV infection in a context where appropriate facilities do not exist? The following chapter echoes some of these questions by looking at the practical experiences of NGOs in dealing with HIV/AIDS in emergencies.

3

Responding to HIV/AIDS in emergencies: practical experiences

In common with the focus of their policies, UN and NGO responses to HIV/AIDS in emergencies have generally been confined to narrowly medical issues, such as providing safe blood for transfusions. Agencies have been slower to make the connection between HIV vulnerability and behavioural changes determined by emergency conditions, such as increased sexual activity or higher levels of exploitation and sexual violence. Little thought is given to the wider social and economic forces determining sexual behaviour, and hence influencing HIV vulnerability, in emergency situations. This chapter reviews the limited documented experience that exists on NGOs' on-the-ground responses to HIV in emergencies (that there is such a paucity of material is itself indicative of the fact that HIV has not been to the fore in the responses formulated by relief and development agencies). It draws on two main sources: the results of a survey of HIV/AIDS programmes carried out by Merlin in 1999; and the proceedings of a seminar organised by the UK NGO AIDS Consortium in the same year.

Programming realities: findings of a survey by Merlin, 1999

Merlin's research, published in February 1999, gathered information on 13 HIV/AIDS programmes for refugees or displaced people (Young, 1999). The survey covered:

- HIV/AIDS programmes for Rwandan refugees in 1994, carried out by the African Medical Research Foundation (AMREF), CARE (in conjunction with AIDS Control and Prevention (AIDSCAP)), John Snow Inc. and Population Services International.
- Programmes for refugees in Liberia, Nepal, Sudan and Uganda, undertaken by SCF (UK).
- CAFOD's support for local NGO partners with programmes for refugees in Liberia, Sierra Leone and Rwanda, and for internally displaced populations in Burma.
- Programmes undertaken in Tanzania in 1994 by ACORD's East Africa Regional AIDS programme and the Tanzanian Red Cross.

Table 2: Major types of intervention

Rank	Type of intervention	Number of programmes
1	Promoting safer sexual behaviour	13
2	Distributing condoms	8–10
3	Strengthening and supporting health units (STD services, equipment, training)	6
4	Home-based care for terminally ill people	3
5	Income-generating activities to support orphaned care-takers	1

Many of these programmes were initiated after the initial emergency period was over; those in the Rwandan crisis, for instance, started four months after the refugee crisis began. The HIV-related initiatives were integrated into the wider relief programmes supported by these NGOs. Table 2 summarises the main types of intervention that featured in the programmes cited by responding NGOs.

While the survey results lack detail on the specific contents of the interventions, the table indicates a telling pattern of response. All of the interventions were concerned with promoting safer sexual behaviour (although what this meant in practice is not documented), and a majority saw distributing condoms as an important intervention. Only three out of the 13 initiatives addressed the care needs of people with HIV-related illnesses, and just one provided support for orphans. According to the Tanzanian Red Cross Society (TRCS), for example, attempts to provide care for chronically or terminally ill people in Tanzania were begun in 1995, but faltered because of lack of funds; widespread home-based care began only in June 1996, with a joint initiative by AMREF, CARE, the IFRC and the TRCS (Mwita, 1997).

HIV prevention and care in an emergency: AMREF's programme in Tanzania

The AMREF programme for Rwandan refugees (Mayaud, 1999) is typical of the approach of NGOs to sexual health services. In April 1994, an estimated 350,000 Rwandan refugees established themselves in two large camps in Ngara district, in north-western Tanzania. Given the camps' living conditions, the nature of the crisis and the high prevalence of STDs and HIV in both the Rwandan and Tanzanian populations, STD/HIV measures were urgently needed. The AMREF programme was set up in collaboration with the London School of Hygiene and Tropical Medicine, Tanzania's National Institute of Medical Research (NIMR), UNHCR-Ngara, CARE, ICRC, MSF and the TRCS. A rapid STD/HIV situation analysis was undertaken, composed of five elements:

- a literature review of the epidemiological situation in Rwanda and north-west Tanzania, with particular reference to Ngara district;
- a review of facilities providing care in the camps;
- a review of the health information system and STD statistics in the camps;
- a rapid STD survey conducted among 100 visitors to ante-natal clinics, 40 men randomly selected from each of the camps' six outpatient clinics (a total of 240) and around 300 men selected through a multistage cluster sampling frame; and

- a rapid Knowledge Attitudes Beliefs and Practices (KABP) survey, conducted among both men and women.

The review of the epidemiological STD/HIV situation indicated a high potential for epidemic spread given the refugee population mix, with higher HIV rates among urban Rwandan populations (35%) compared to rural Rwandans (5%) and the host populations in Ngara (7%). STD rates were known to be high in both countries prior to the exodus. The health facility survey confirmed the absence of STD guidelines and basic training among health staff operating in camp clinics; the rapid STD and KABP confirmed the presence and widespread utilisation of alternative care providers, such as traditional healers and market vendors.

In the baseline STD and KABP surveys, both men and women reported frequent experience with STDs and high-risk sexual behaviour. Despite good knowledge of HIV risks and prevention measures, and self-assessment of risk, only 16% of men admitted to using condoms. Predictably, high levels of STDs were recorded: over 50% of women attending ante-natal clinics were infected with vaginal pathogens, and 3% with gonorrhoea; the prevalence of urethritis was about 10% in men, of whom 3% had *N gonorrhoeae* or *C trachomatis* infections; the prevalence of active syphilis was 4% among women, and 6% among men.

The STD/HIV programme was launched four months after the start of the Rwandan crisis. It consisted of the following components:

- health education materials, such as posters and leaflets, were produced in Kinyarwanda, and 14 refugee health behaviour promoters (HBPs) conducted regular mass STD/HIV education campaigns. Community education and support programmes for AIDS patients consisted of home-based care and counselling provided by a network of approximately 100 AIDS community educators (ACEs) recruited from the refugee population;
- bar and brothel workers were trained as peer educators;
- condoms were supplied through various outlets: at clinics, during campaigns and by peer educators;
- health workers were trained in syndromic diagnosis of STIs (that is, diagnosis based solely on clinical symptoms, with no access to laboratory analysis);
- STD case management at all outpatient clinics and the provision of STD drugs; and
- screening for syphilis at antenatal clinics and training of traditional birth attendants.

Following the intervention, the number of self-reported STD cases at clinics increased from 20 to about 250 per week, and over 11,000 STD cases were treated in the first 12 months of the programme. The programme conducted 120 education campaigns in 18 months, reaching about 230,000 sexually active people. Condom demand increased substantially, and about 1.5m were distributed in 12 months, around half of them through peer educators. The impact of the programme was assessed through a repeat of the rapid STD and KABP surveys 18 months after it began, as well as through a review of other programmatic process indicators.

Lessons learnt?

A number of valuable lessons emerge from AMREF's experience, some of which are supported by other interventions identified in the survey. The first is that these programmes can have an impact on STI levels among targeted populations. In AMREF's case, prevalence remained at a constant level, indicating that, in the context of the emergency, there had been a mitigating effect because rates would have been expected to rise in the absence of the intervention. Yet where other aspects of HIV vulnerability are concerned, the intervention had more doubtful results. In particular, sexual behaviour did not substantially change, and there were indications that levels of prostitution and sexual violence against women and young people had increased.

Among the conclusions drawn from this experience was that specifically designed interventions must be set up rapidly if they are to benefit their potential target group. Training of peer educators, the provision

of condoms and STD treatments all began relatively late in the operation. Another constraint of the programme would seem to be that, while it recognised the increased levels of sexual violence in the camps, it did not include any strategy for addressing this, a major factor increasing women's and children's vulnerability to HIV. The programme took a narrower approach of providing information about HIV and other sexually transmitted infections and establishing much-needed sexual health services, but one of the underlying factors preventing behaviour choices seems to have remained unchallenged. The programme reports make no mention of collaboration with other agencies that might have been better placed to address this issue.

Although in the AMREF programme, condom use increased significantly, the experience of other interventions shows that condom availability does not necessarily translate into acceptance and use; the CARE programme, for instance, found no significant increase in condom use, possibly as a result of rumours that condoms contained HIV, the tendency of religious leaders to equate condoms with promiscuity and the desire to replace children lost in the Rwandan conflict. On the other hand, during the CARE programme there was a reported decrease in the number of sexual partners people were taking, access to health services for adolescents increased, and support groups were set up for people with AIDS and for 'unmarried mothers' – the term used to refer to women made pregnant as a result of being raped during the conflict. The programme also reported substantially improved understanding of HIV transmission modes, and less social isolation. CARE's

Box 10: Changing sexual behaviour

Many programmes concerned with the health implications of sexual behaviour rely heavily on information, education and communication (IEC) campaigns to change behaviour patterns so as to minimise the risks of HIV infection. Such initiatives typically include talks, posters, videos, drama presentations, leaflets and media broadcasts, all designed to provide factual information about HIV and AIDS and wider sexual health. Such an approach has weaknesses, as well as strengths. Where they are well-planned, well-executed and culturally appropriate, IEC campaigns are effective in raising awareness about HIV, and ensuring an accurate understanding of the nature, means and likely course of infection. In improving an individual's and a community's understanding, IEC also helps to dispel fears and reduce the

stigmatisation suffered by people affected by HIV. However, IEC is only a first step – albeit a valuable one – in HIV prevention and support initiatives, and it needs to be integrated into a wider strategic response. In itself, IEC cannot be regarded as the solution, or a complete programmatic response. Essentially, these initiatives are purely awareness-raising tools – means of providing *information about* possible behaviour changes. This information does not automatically lead to *actual* change. This will only become a realistic option when the initiative also addresses the social, economic and political factors making people affected by emergencies more vulnerable to HIV. More seriously, there is a danger – perhaps particularly in emergency situations – that agencies might consider that they have comprehensively addressed HIV by providing IEC programmes.

experience also demonstrated the importance of camp design in influencing levels of sexual violence; in the camps in its programme, for instance, latrines were set out in large blocks, were communal and were located some distance from living quarters, facilitating sexual assaults on women and young girls. Similarly, women and children compelled to search for firewood outside camp boundaries were targeted.

Talking through the issues: the Silent Emergency Seminar, 1999

The second key source of NGO experience explored in this paper is taken from the Silent Emergency seminar, held in London in June 1999. The seminar, organised by the UK NGO AIDS Consortium Working Group on Emergencies and HIV/AIDS, brought together emergency policy-makers and practitioners and HIV/AIDS specialists from around the world, along with staff of UK-based NGOs responsible for their agencies' responses to emergencies. The aims of the seminar were:

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

Although the findings cannot represent a comprehensive survey of NGO responses, they are indicative of NGO experiences to date. The table overleaf demonstrates that NGOs gave very little consideration to HIV during the early stages of an emergency. HIV did not tend to feature in organisations' policies for disaster preparedness, nor in the preliminary phase of planning and implementing a response. In the period of immediate response, the greatest single HIV-related concern for NGOs seemed to be the safety of blood, skin-piercing instruments and clinical waste, followed by STD treatment and sexual health. More specific recognition of HIV as a concern in emergency situations featured mainly as part of agencies' long-term responses, and the health and wider support needs of people affected were also acknowledged only at this stage. In general, the responses described seemed to focus on a more medically-oriented, pragmatic approach to immediate risk reduction rather than wider considerations related to the environmental circumstances that increase people's vulnerability to HIV.

The obstacles and constraints identified by participants in the seminar were essentially four-fold: first, HIV was not considered a priority and emergency programming was not seen as an appropriate or effective mechanism for HIV response in the earliest phases of a crisis; second, organisational or institutional structures and attitudes made any effective response difficult; third, aid workers responding to emergencies feel themselves ill-prepared, inexperienced and unskilled in addressing HIV-related issues; and fourth, local conditions and sensitivities deterred agency staff from getting involved in this area.

Prioritisation issues

HIV was not considered a priority in situations where basic needs – food, water, shelter, security and elementary health care – were being addressed. This was the case even in countries like Uganda, where there had been a long and active response to HIV among the stable population. The immediate survival needs of people affected by emergencies were considered more pressing. Where the personal security of victims of violence or of agency staff was a concern, this was seen as an issue of wider protection, without any acknowledgement of HIV vulnerability. Another reason given for NGOs' tardiness in addressing HIV-related matters was a reluctance to tackle what was perceived as a long-term issue through the kinds of short-term intervention typical of humanitarian responses to emergencies. Some participants, for instance, expressed reservations about initiating responses that, given the unstable situations prevailing in emergencies, may not be sustainable, and were wary of having to retract programmes.

Skills and resources

Participants also expressed concerns that the particular skills required by emergency programming were not suited to addressing HIV-related issues. Furthermore, there is little information available on effective HIV interventions in emergency settings. Participants observed that knowing how best to tackle the sensitive and complex issues associated with HIV/AIDS is not straightforward, confidentiality may be difficult to ensure, and failure to preserve it may have damaging repercussions for people seeking recognition as refugees. Some commented that they felt powerless to do anything about sexual violence. When such violence was symptomatic of larger power struggles, NGOs had no means of redressing this situation. Where resources and staff capacity were limited, these were channelled into responding to immediate, more obviously pressing needs, where workers could apply well-established skills with ease.

Table 3: HIV-related activities by response stage

This table details the types of HIV-related activities and initiatives mentioned by seminar participants, grouped by response stage.

Response stage	Number of mentions in small group reports
<i>Disaster preparedness stage</i>	
HIV as part of the training for emergency programme staff	2
Policy modified to include considerations of blood transfusions and clean needles and surgical equipment	1
Training/awareness-raising for military and peacekeepers	1
<i>Needs-assessment stage</i>	
STD rapid assessment	1
Knowledge, Attitudes, Practice (KAP) survey of new arrivals in a camp to assess health needs	1
HIV acknowledged as a priority for refugee communities involved in designing programmatic response	1
The potential impact of HIV on young people affected by conflict was considered	1
Review of supplies needed to implement UNAIDS EMP	1
Local HIV prevalence assessed	1
<i>Immediate response stage</i>	
Training health care workers	1
In-service brief to peacekeepers	1
Distribution of condoms	2
Safety of blood, needles, other medical practices	7
UNAIDS EMP implemented	1
Acknowledgement of the presence of brothels in UN compounds and the HIV risks to women and to troops	1
Acknowledgement of problems of sexual violence and lobbying armed factions to prevent human rights abuses	1
Awareness-raising among women and community leaders, on gender issues, sexual violence concerns	1
Support and counselling for victims of sexual violence	3
Location of water points to minimise sexual violence	1
Recognised the link between latrine sites and sexual violence	1
Inclusion of women in design of facilities/toilets	1
Treatment of STDs	4
<i>Long-term response</i>	
Counselling and training for workers	2
Counselling for child soldiers	1
Funding, support and skills training for vulnerable people, including those known to have HIV	1
Health education (via clinic staff, peer education, media, posters and pamphlets)	3
Campaign to improve health services and to respect human rights	1
Diverted increased resources to HIV/AIDS activities when stability was restored	1
Acknowledgement that staff are away from their families for too long	1
Review of staff health policies	1
Condoms provided in long-term camps	1
HIV prevention and care programmes (including TB) established	1
Sexual violence/gender programmes set up (no details given)	1

Organisational issues

The seminar also revealed that organisations often consider that HIV and the issues arising from it do not fall within their remit. In some instances, organisations maintained an excessively narrow understanding of their role; income-generating initiatives, for instance, were not considered an issue that a medical organisation needed to address. There is little awareness among senior managers and policy-makers of the inter-connectedness of HIV and the conditions prevailing in emergencies; consequently, HIV is not seen as a priority by management. Thus, even when individual workers recognised the need to respond to issues raised by HIV, they could not pursue their concerns because of a lack of institutional understanding or support. Other participants noted that poor coordination between agencies and a lack of clear definition of their respective roles and responsibilities, along with the diverse backgrounds and experiences of agencies, made it difficult to address issues posed by HIV. One participant also commented that national/local NGOs were overwhelmed by international agencies. Against this, another commented that the deterioration of national infrastructure left international agencies without any credible local counterparts, and so it became too difficult to implement programmes. A lack of evidence of effective HIV interventions was also cited as a deterrent, as was the lack of commitment among policy-makers.

Local cultural and social issues

The stigma, taboos and political sensitivities that attach to HIV and related issues regarding sexuality and gender were also named as deterring factors, as were the personal fears of agency staff with regard to HIV. In some instances, the attitudes of local authorities (personal or institutional) were named as constraints. One participant spoke of the difficulty of

reaching women refugees and providing them with information on HIV because the materials offered were rejected by local community leaders; in another instance, church groups opposed a proposed HIV-related initiative. Conversely, aid workers themselves were said to lack awareness and sensitivity to local cultures, and the requisite linguistic skills. Another participant spoke of the opposition of the host government to a syndromic approach to treating STDs because this was not part of the national policy. Difficulties were also identified around ensuring the confidentiality of people found to be HIV-infected.

Mitigating factors

Improving the response to HIV/AIDS in emergencies is fraught with difficulties, and agencies face very real problems in the field. Obtaining data on the incidence of HIV/AIDS in an emergency may be difficult, as is understanding the context in which HIV infection is occurring when societies are undergoing crisis. The problem is effectively 'invisible'; the long symptom-free period associated with HIV may mean that the effects of increased vulnerability to the virus may only become apparent long after the immediate crisis has passed. Similarly, the impact of reduced care and support services for people with HIV or AIDS may be lost from sight in a situation where the wider standards of health and wellbeing are compromised. Consequently, HIV has tended to be seen as a longer-term problem, and teams responding to the immediate emergency often believe that HIV or AIDS do not apply to their work. Yet, while these very real practical and programming constraints cannot be ignored, it is important to acknowledge that the level of integration of HIV considerations into aid organisations' existing emergency responses is not only inadequate, but risks further endangering the very people humanitarian agencies are working to help.

Conclusion

Evidence thus far suggests that most agency initiatives around HIV have been concerned with HIV prevention. Relatively little attention has been given to the care and support needs of the people and families affected by the virus. In the prevention initiatives reported, there is little evidence of agencies developing programmes to tackle the underlying factors making displaced and neighbouring or host populations, as well as aid workers themselves, vulnerable to HIV. Approaches have, on the whole, focused solely on the immediate reduction of the risks of infection through medical practices or sexual activities, concentrating on, for instance, applying universal precautions and screening blood donations in medical practice; treating STIs and providing condoms to populations deemed at risk. At the strategic level, senior policy-makers and managers in agencies and governmental response groups lack awareness of the impact of emergencies on HIV vulnerability. Consequently, there is no commitment to addressing this at the level of strategic planning, and aid workers find themselves with inadequate support, skills and resources to respond to the problems they encounter in the field.

Recommendations for humanitarian agencies

Against this background, this chapter sets out a series of recommendations related to HIV/AIDS in emergencies. The recommendations pertain to six key areas: policy-making and review; risk assessment; decisions and practices that influence people's vulnerability to sexual exploitation; decisions and practices that influence the balance of power – including gender-based power relations; the provision of health care; and the need for a multi-sectoral and integrated response. These recommendations carry far-reaching implications for agencies; these are outlined in the final part of the chapter.

Policy-making and review

Agencies providing humanitarian response in an emergency situation need to revise existing policies and strategies so that they adequately take account of the issues raised by HIV. Disaster preparedness policies need to recognise HIV as a priority that requires consideration from the initial moment that the decision is taken to respond to a specific emergency. Patterns of behaviour and survival mechanisms among people affected by an emergency become established very quickly, and are more difficult to address later on. Agencies need to define, at the level of general policy, what practical strategies they should adopt at every stage of their engagement.

Part of disaster preparedness may include efforts to establish the actual incidence of HIV infection in a geographic region affected by an emergency. Occasionally, agencies think that this requires them to set up HIV testing before they can proceed further. However, existing UNAIDS epidemiological data is fairly comprehensive, and is a reliable indicator of general levels and patterns of prevalence within a country or, at the very least, in a region of a continent. This is sufficient to indicate the potential impact of HIV on people affected by the emergency, and the impact of the emergency on people infected with, or vulnerable to, HIV.

The fact that HIV considerations feature in an organisation's policy is not an automatic guarantee that measures are being taken on the ground. Even though UNHCR, for instance, has incorporated HIV into its policy, many of its personnel in emergency settings do not put the resulting guidelines into practice. These called for UNHCR to ensure that all its staff are made aware of its HIV/AIDS policy. In the execution of its coordinating role in emergency situations, UNHCR should also ensure that

HIV/AIDS is on the agenda of responding organisations, from the earliest planning stages onwards, and that NGOs take responsibility for putting the required measures into practice. Donors also have an important role to play in monitoring what is being done on the ground.

Risk assessment

Agencies' initial risk assessment should include an assessment of the vulnerability to HIV of affected populations and aid workers. Particular attention should be given to the composition of the displaced and surrounding 'host' populations to establish whether, for instance, they are mostly women and children, single women, unaccompanied children or armed men. Whether people remain in or near their homes, are displaced internally or become refugees may influence the shape of an intervention. As part of their wider risk assessment, agencies should also determine:

- the prevalence of STDs and HIV in the host and home country, area or region, if this has not already been established as part of disaster preparedness work;
- which factors might heighten people's HIV vulnerability, and which should be targeted with specific interventions;
- cultural beliefs, attitudes and practices concerning sexuality and sexual health, STIs and HIV/AIDS. These should be gathered from the affected populations first hand, through focus groups and interviews;
- what HIV policies exist as part of any national HIV/AIDS programme that a country affected by the emergency or hosting refugees might have, in order to ensure that services provided are in keeping with those already available to the neighbouring or host population;
- whether illicit drugs are being used, and if so how and by whom;
- what forms of sexual and gender-based violence or exploitation are occurring, in what circumstances and perpetrated by whom;
- whether women, children and young people have opportunities to develop skills and educational opportunities;
- whether the particular views and needs of women and children are being heard in information-gathering exercises, and accommodated in decision-making processes; and
- ways of earning income are available to targeted populations that do not involve exchanging sex for money and resources.

Decisions/practices influencing vulnerability to sexual violence or exploitation

Preventing or at least minimising sexual violence and exploitation among people affected by an emergency is key to any programming aimed at addressing HIV/AIDS. One obvious step where displacement has occurred is to take the risk of sexual violence into account when planning accommodation and temporary shelter. Large camps, for instance, are most often the preferred model when organisations are faced with the need to provide shelter, food and health care quickly to large numbers of displaced people. However, the camp model may often be chosen out of administrative convenience, or from a desire by aid organisations or host governments to contain refugees or internally displaced people within defined boundaries, regardless of whether or not these are the most appropriate responses for the specific situation.

Situating a water supply, toilets/latrines or washing facilities at the outer edge of a temporary accommodation site, or in an otherwise remote area, may make young girls, boys or women more vulnerable to sexual attack. Small, four-family units located near people's homes are better than large communal latrines built some distance from living quarters. Where women, young girls or boys have to gather firewood, mechanisms of protection should be put in place, such as supervision by officials or community leaders (with appropriate safeguards), or wood-gathering only in organised groups. Site boundaries themselves should offer protection by making it more difficult for would-be attackers to access the camp or other temporary accommodation, for instance by erecting barriers of brambles or similar deterrents, planting thorn bushes if this accommodation is to continue in the longer term, or installing high or barbed wire perimeter fences.

Wherever possible, families should be accommodated in smaller single-family units rather than in communal shelters. The combination of cramped conditions and resulting enforced intimacy along with a lack of privacy and supervision can increase the likelihood of sexual abuse. Agencies should also try to ensure that families are not split up and that unaccompanied women, young girls or boys are not separated out and accommodated on their own in host settings. Where accommodation is provided in local villages or in the homes of a host population, host communities should be given adequate compensation for any financial outlay, and should also be

given whatever support is available to displaced people to deal with the trauma and distress that may be unburdened onto them.

Decisions/practices influencing power relations

Every effort should be made to ensure that displaced people retain some power, autonomy and sense of self-esteem. Attempts should be made, over time, to have displaced people as active players in, rather than passive recipients of, relief efforts. Often, the people affected by an emergency are best placed to inform decisions on what type of response should happen how, when and where. Depending on the skills of the particular people affected, and the circumstances prevailing at different stages of an emergency, displaced people themselves will be most adept at providing health, education and other support services to their communities. They understand their own culture, language and customs and, where circumstances permit, this should be incorporated into the wider relief initiative.

Where possible, agencies should actively involve people affected by an emergency in decisions regarding accommodation and the location of facilities, in running day-to-day events, in controlling the distribution of resources and provision of services and in developing longer-term plans. They should draw on specific areas of expertise among displaced populations, for example in health care, education, counselling or construction. Measures to encourage autonomy could include enabling families or groups to cook their own food rather than standing in line at communal feeding points, and in on-going emergencies facilitating income-generating activities. Agencies also need to take into account potential imbalances of power within displaced populations, based, perhaps, on ethnicity or political affiliation, and to implement safeguards to minimise these.

Unaccompanied, unsupervised children and adolescents, often arriving in large numbers at relief centres, are particularly powerless and thus especially vulnerable to sexual exploitation. As soon as possible, aid workers should strive to establish a structured existence for children and young people, drawing on the skills and insights of adults from the affected group. They should also provide a culturally appropriate framework of rules or behaviour norms for unaccompanied children and young people, as well as attending to their particular health needs (including their sexual health needs). This should include psychological support for traumatised children within the primary health response.

The mode of operating of local and international groups providing assistance to emergency-affected communities can also have a significant influence on the balance of power. International groups shipping in their own personnel and supplies can undermine local structures and economies, or can entrench vulnerability by channelling resources and supplies through discriminatory structures. Where possible, international NGOs should work through local groups, appoint local personnel to advise and lead the response, and source their supplies locally. International NGOs should work in a coordinated and complementary fashion, not only at ground level but also at the highest levels of management. NGOs need also to work, wherever possible, in consultation with local and national governments affected by the emergency.

Men are usually the key players in influencing decisions about the forms of shelter provided, and in shaping programme management. They often fail to take women's views and concerns into account. In many instances, male decision-makers (be they from the local military or government, or local or international NGOs) fail to recognise that they even need to specifically seek out women's views. A common mistake is to believe that the community leaders (themselves usually male) will speak on women's behalf, and represent their needs and opinions fully and accurately. Men with decision-making powers, and those who control accommodation design, food, resources and future opportunities, for example employment, refugee entitlements and visa concessions, often barter these for sex. Rape at the hands of the men who 'police' a relief operation is common, and redress rare.

While in many cases such power imbalances pre-exist the particular emergency, relief agencies do have an opportunity to influence structures that increase women's powerlessness and hence their HIV vulnerability. For example, agencies can ensure that displaced women are involved in decisions about accommodation design and layout, and that women have some measure of control over how resources are distributed, and over the running of the relief site. Agencies must not simply assume that community leaders speak for the interests of the whole community, and need to make sure that women are heard and that they can also represent their community's interests when decisions are made. Where possible, female interpreters should be available wherever translation is required, and particularly in discussions about legal, political or financial entitlements.

Armed groups play a key role in influencing gender-related power relations. Efforts should be made to ensure that military personnel have access to HIV prevention initiatives, and that they are fully aware of their obligations under international law and their accountability for any crimes of sexual violence that they commit. Attention should also be given to the psycho-social pressures faced by young recruits placed in life-threatening situations. More problematically, those responsible must be held accountable for any acts of sexual violence or coercion. Many countries affected by an emergency do not have mechanisms for reporting abuse, arresting offenders and trying and convicting them. Given that this is a legal, and hence political, issue, international legal and human-rights organisations, rather than humanitarian agencies, may be better positioned to enforce such accountability. It is encouraging to note that accountability for sex crimes is becoming a subject for international courts; in February 2001, for instance, three Bosnian Serbs were convicted of rape and sexual enslavement at the war crimes tribunal in The Hague (Renaud, 2001).

Provision of health care

In any emergency caused by natural disasters or conflict, one of the first concerns of relief operations is likely to be to attend to the medical needs of the injured, and to contain the risks of infectious disease as a consequence of poor sanitation and hygiene. Thus, provision of medical care is essential from the first moment of intervention. According to the evidence gathered by this paper, medical initiatives – notably sterilisation, the screening of blood products and staff safety – are the most popular HIV-related programming responses. Yet there are other aspects to HIV-related health care for particularly vulnerable groups that agencies have perhaps not sufficiently considered.

What follows are among the key points for implementation from the first moment of engagement with an emergency. This is not a comprehensive or medically authoritative list, and it should be used in conjunction with the minimum guidelines set out by UNAIDS and by the *Interagency Field Manual for Reproductive Health in Refugee Situations* referred to earlier in this paper. The points listed here take account of five HIV-related concerns informing health care practice: the safety of blood transfusions; HIV-free surgical and other skin-piercing instruments; measures that minimise the risk of HIV infection from needlestick injuries or clinical waste; measures that minimise the risk of HIV infection through sex; and the provision of the same standards of care for people with HIV-related illnesses as for other sick people.

To ensure safety, all blood intended for transfusions or other treatments must be HIV tested. Health workers and voluntary carers must also apply universal precautions whenever they are handling blood, other body fluids or clinical waste. Systems must be in place to ensure the proper sterilisation of equipment, and the safe storage and disposal of clinical waste. Health workers should minimise their use of injections, and should consider ways to reduce the harmful impact of injecting drug use among the affected population. Sexual health care should be an essential part of the overall health service from the outset. UNAIDS recommends condom provision from the first point of intervention, as a prevention measure for HIV and other STIs. Treatment for existing STIs should also be provided as soon as possible, as should treatment and support for victims of sexual violence. Women traumatised by physical or sexual violence, for instance, need skilled psychological as well as medical support, and female interpreters should be on hand when women discuss sensitive issues around sexual health. Standards of pre- and post-partum care of pregnant women and their babies should be such as to minimise the risk of mother-to-child transmission of HIV. The decision to offer short-course anti-retroviral therapy to women who identify as HIV positive should be made in close consultation with the relevant national AIDS programme, with UNAIDS/WHO and in line with local policy.

In addition to these ‘technical’ aspects of health care and HIV safety, agencies also need to give some thought to the discriminatory aspects of infection and treatment, as well as to the environmental risk factors that attend HIV. To minimise discrimination against people with HIV, the mandatory testing required of blood donors should be anonymous if counselling services are not available; if voluntary HIV testing is offered to people affected by an emergency, fully confidential pre- and post-test counselling must be provided. Mandatory HIV testing for any purpose other than the screening of blood donors is unacceptable. Health and safety practices should not depend on knowing an individual’s HIV status, but should regard any contact with blood or sexual fluids as capable of transmitting HIV. Groups offering voluntary tests need to have given due consideration to the complex ethical and human rights issues involved. If, after due consideration and consultation, an agency decides to offer voluntary testing, it should ensure that HIV status is not made a basis for discrimination regarding the provision of relief supplies or medical treatments. Nor should it affect political entitlements or rights to refugee status, or lead to the segregation of individuals or communities. Any suggestion of testing for surveillance purposes should be given cautious and careful

consideration; should only be undertaken in consultation with the relevant national AIDS programmes and with UNAIDS/UNHCR; should be anonymous; and must not become grounds for discrimination. Similarly, the segregation of people with HIV-related illnesses is unacceptable, except in cases where the concern is to contain a potentially infectious disease such as tuberculosis. People with HIV-related illnesses should be treated according to the same criteria used to care for other sick people. This should depend on the availability of medication and the possibility of adhering to treatment regimes, and not on HIV status. The same applies to nutritional needs and the provision of supplementary food supplies. Home-care programmes should not single out and further stigmatise people with HIV-related illnesses. Any ill or disabled person should receive the same home-care service as required, regardless of whether the illness is HIV-related.

The need for a multi-sectoral and integrated response

A multi-sectoral approach is called for because of the complex and wide-ranging issues highlighted by HIV. No one agency can hope to do everything, nor can organisations afford to work in isolation. Agencies need to supplement their own area of expertise with that of other groups where necessary. A narrow focus on just one aspect of relief work is inadequate and ineffective in the longer term. For example, health workers may effectively treat STIs or the clinical consequences of sexual violence, but they will need to recognise that other expertise is called for to simultaneously address gender-based power imbalances, or to support people traumatised by violence or bereavement. Such a multi-sectoral approach calls for collaboration and coordination between all the key groups responding to the emergency, whether they are local or international. Agencies also need to work collaboratively with local and national HIV-related authorities to ensure that their initiatives comply with existing strategies.

Implications for humanitarian agencies

Agencies reacting to emergencies are perhaps more accustomed to providing an immediate, pragmatic response to the most evident and immediate needs. HIV calls on organisations to look beyond technical and logistical responses and, in addition to meeting immediate need, to direct their efforts to addressing the underlying factors that heighten people's vulnerability to HIV in emergencies. To do this, agencies may need to review the preparation and training they offer staff and volunteers, whether expatriate or local. Such preparation should include, as appropriate, training in universal precautions, education and awareness-raising about HIV and related considerations; training in

gender issues; and the acquisition of the skills needed to facilitate discussion of sexual matters (whether from a health or wider social/behavioural perspective). Staff and volunteers will also need a thorough understanding of the specific vulnerabilities to HIV of all refugee and displaced people, and more particularly of women, young girls and young boys. Training in sexual health and in STI detection and management should also be improved, and health workers should be trained to use the WHO syndromic approach. Staff and volunteers will also need training on the rights of refugees and displaced people in the event of rape and sexual violence.

Staff may also need help in overcoming their own fears and prejudices towards people infected with, or affected by, HIV. Human resources departments need to ask questions about attitudes to HIV/AIDS, gender, ageism, disability and sexual violence when recruiting staff to work in emergencies. Staff working with blood, skin-piercing instruments and clinical waste need to be aware of their own vulnerability to HIV/AIDS. The sexual health of staff and volunteers should also be taken into account. The traumatising effect of emergencies on aid workers needs to be acknowledged, and a support system provided that minimises the risk that staff will seek out unsafe sexual relations as a coping mechanism.

At an institutional level, agencies need to foster more discussion with and between organisations, so as to encourage the development of clear, user-friendly and easily-applicable guidelines and policies. This can be facilitated through special fora, akin to the seminars reported on in this paper, but it can also happen through existing networks and working groups where aid agencies meet. International agencies need a concerted effort to prioritise, fund and distribute useful guidelines to organisations and field practitioners. Agencies should document their experiences and share the lessons learnt. Finally, a more active advocacy and lobbying presence might be required. International agencies are often well-placed to pursue some of the advocacy issues highlighted by HIV in emergency situations, such as the abuse of human rights through crimes of sexual violence; discrimination on the basis of HIV status, whether known or suspected; and the inappropriate use of mandatory HIV testing.

The key argument of this paper is that HIV needs to be seen as a cross-cutting issue, with implications for existing relief programmes and modes of responding to an emergency. HIV considerations need to be integrated into these already-existing channels, rather than being addressed in a 'stand-alone', isolated HIV programme. If this is to happen, an accurate under-

standing and strong commitment from senior managers is required at the strategic and policy levels. This needs to be accompanied by the financial and personnel resources to ensure that such policies are acted on in every emergency situation where HIV is present, or potentially so. This applies to emergencies caused by natural disaster just as it does to emergencies brought on by conflict.

HIV has been referred to as the silent emergency, occurring as a backdrop to natural disasters and

conflicts. The issues highlighted by HIV touch on taboos, fears and signs of human frailty that could more comfortably be ignored. It is time to break this silence. By working to address the issues raised by HIV within their habitual mode of response to emergencies, agencies are taking giant strides towards breaking that silence, and so ensuring that people affected by emergencies will be in greater possession of their rights to HIV prevention, care and support. Equally, aid agencies are more likely to fulfil their mandate to save lives.

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Network Papers

Network Papers are contributions on specific experiences or issues prepared either by HPN members or contributing specialists.

- 1 *MSF-CIS (Celula Inter-Secções), Mozambique: A Data Collecting System Focused on Food Security and Population Movements* by T. Dusauchoit (1994)
- 2 *Responding to the 1991/92 Drought in Zambia: The Programme to Prevent Malnutrition (PPM)* by D. Mukupo (1994)
- 3 *An Account of Relief Operations in Bosnia* by M. Duffield (1994)
- 4 *Bad Borders Make Bad Neighbours - The Political Economy of Relief and Rehabilitation in the Somali Region 5, Eastern Ethiopia* by K. Van Brabant (1994)
- 5 *Advancing Preventive Diplomacy in a Post-Cold War Era: Suggested Roles for Governments and NGOs* by K. Rupesinghe (1994)
- 6 *The Rwandan Refugee Crisis in Tanzania: initial successes and failures in food assistance* by S. Jaspars (1994)
- 7 *Code of Conduct for the International Red Cross and Red Crescent Movement and NGOs in Disaster Relief* ed. J. Borton (1994)
- 8 *Targeting the Poor in Northern Iraq: The Role of Formal and Informal Research Methods in Relief Operations* by P. Ward and M. Rimmer (1995)
- 9 *Development in Conflict: the Experience of ACORD in Uganda, Sudan, Mali and Angola* by ACORD (1995)
- 10 *Room for Improvement: the Management and Support of Relief Workers* by R. Macnair (1995)
- 11 *Cash-for-Work and Food Insecurity in Koisha, Southern Ethiopia* by P. Jenden (1995)
- 12 *Dilemmas of 'Post'-Conflict Transition: Lessons from the Health Sector* by J. Macrae (1995)
- 13 *Getting On-Line in Emergencies: A Guide and Directory to the Internet for Agencies involved in Relief and Rehabilitation* by L. Aris, P. Gee and M. Perkins (1996)
- 14 *The Impact of War and Atrocity on Civilian Populations: Basic Principles for NGO Interventions and a Critique of Psychosocial Trauma Projects* by D. Summerfield (1996)
- 15 *Cost-effectiveness Analysis: A Useful Tool for the Assessment and Evaluation of Relief Operations?* by A. Hallam (1996)
- 16 *The Joint Evaluation of Emergency Assistance to Rwanda: Study III* ed. J. Borton (1996)
- 17 *Monetisation: Linkages to Food Security?* by J. Cekan, A. MacNeil and S. Loegering (1996)
- 18 *Beyond Working in Conflict: Understanding Conflict and Building Peace (The CODEP Workshop Report)*, by J. Bennett and M. Kayitesi Blewitt (1996)
- 19 *Human Rights and International Legal Standards: what relief workers need to know* by J. Darcy (1997)
- 20 *People in Aid Code of Best Practice in the Management and Support of Aid Personnel* ed. S. Davidson (1997)
- 21 *Humanitarian Principles: The Southern Sudan Experience* by I. Levine (1997)
- 22 *The War Economy in Liberia: A Political Analysis* by P. Atkinson (1997)
- 23 *The Coordination of Humanitarian Action: the case of Sri Lanka* by K. Van Brabant (1997)
- 24 *Reproductive Health for Displaced Populations* by C. Palmer (1998)
- 25 *Humanitarian Action in Protracted Crises: the new relief 'agenda' and its limits* by D. Hendrickson (1998)
- 26 *The Food Economy Approach: a framework for understanding rural livelihoods* by T. Boudreau (1998)
- 27 *Between Relief and Development: targeting food aid for disaster prevention in Ethiopia* by K. Sharp (1998)
- 28 *North Korea: The Politics of Food Aid* by J. Bennett (1999)
- 29 *Participatory Review in Chronic Instability: The Experience of the IKAFFE Refugee Settlement Programme, Uganda* by K. Neefjes (1999)
- 30 *Protection in Practice: Field Level Strategies for Protecting Civilians from Deliberate Harm* by D. Paul (1999)
- 31 *The Impact of Economic Sanctions on Health and Well-being* by R. Garfield (1999)
- 32 *Humanitarian Mine Action: The First Decade of a New Sector in Humanitarian Aid* by C. Horwood (2000)
- 33 *The Political Economy of War: What Relief Agencies Need to Know* by P. Le Billon (2000)
- 34 *NGO Responses to Hurricane Mitch: Evaluations for Accountability and Learning* by F. Grunewald, V. de Geoffroy & S. Lister (2000)
- 35 *Cash Transfers in Emergencies: Evaluating Benefits and Assessing Risks* by D. Peppiatt, J. Mitchell and P. Holzmann (2001)
- 36 *Food-security Assessments in Emergencies: A Livelihoods Approach* by H. Young, S. Jaspars, R. Brown, J. Frize and H. Khogali (2001)
- 37 *A Bridge Too Far: Aid Agencies and the Military in Humanitarian Response* by J. Barry with A. Jefferys (2002)
- 38 *HIV/AIDS and Emergencies: Analysis and Recommendations for Practice* by A. Smith (2002)

Good Practice Reviews

Good Practice Reviews are commissioned 'state of the art' reviews on different sectors or activities within the relief and rehabilitation field. Prepared by recognised specialists, and subject to peer review, they are produced in a format that is readily accessible to field-based personnel.

- 1 *Water and Sanitation in Emergencies* by A. Chalinder (1994)
- 2 *Emergency Supplementary Feeding Programmes* by J. Shoham (1994)
- 3 *General Food Distribution in Emergencies: from Nutritional Needs to Political Priorities* by S. Jaspars and H. Young (1996)
- 4 *Seed Provision During and After Emergencies* by the ODI Seeds and Biodiversity Programme (1996)
- 5 *Counting and Identification of Beneficiary Populations in Emergency Operations: Registration and its Alternatives* by J. Telford (1997)
- 6 *Temporary Human Settlement Planning for Displaced Populations in Emergencies* by A. Chalinder (1998)
- 7 *The Evaluation of Humanitarian Assistance Programmes in Complex Emergencies* by A. Hallam (1998)
- 8 *Operational Security Management in Violent Environments* by K. Van Brabant (200)

HUMANITARIAN PRACTICE NETWORK

Background

The **Humanitarian Practice Network (HPN)** was established by the Overseas Development Institute (ODI) in 1994 under the name Relief and Rehabilitation Network (RRN). It is run as part of ODI's Humanitarian Policy Group (HPG).

Purpose

To stimulate critical analysis, advance the professional learning and development of those engaged in and around humanitarian action, and improve practice.

Objectives

To provide relevant and useable analysis and guidance for humanitarian practice, as well as summary information on relevant policy and institutional developments in the humanitarian sector.

Activities

- **Publishing in three formats:** Good Practice Reviews (one per year), Network Papers (four to six per year) and Humanitarian Exchange (two per year). All materials are produced in English and French.
- **Operating a resource website:** this is one of the key reference sites for humanitarian actors.
- **Collaborating with international 'partner' networks:** this increases the reach of the **HPN**, and brings mutual benefit to the participating networks.
- **Holding occasional seminars on topical issues:** these bring together practitioners, policy-makers and analysts.

HPN target audience

Individuals and organisations actively engaged in humanitarian action. Also those involved in the improvement of performance at international, national and local level – in particular mid-level operational managers, staff in policy departments, and trainers.

While a project and Network with its own identity, the **HPN** exists within the Humanitarian Policy Group at the ODI. This not only ensures extended networking and dissemination opportunities, but also positions the **HPN** in a wider 'centre of excellence' which enhances the impact of the **HPN's** work.

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