

# “THE SILENT EMERGENCY: HIV/AIDS IN CONFLICTS AND DISASTERS”

Report of the seminar, London, June 1999  
held by the UK NGO AIDS Consortium

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# “Silent emergency: HIV/AIDS in conflicts and disasters”

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## 1. Introduction

### 1.1. Background

HIV/AIDS has rapidly become one – if not the - most alarming and devastating pandemics the world has ever seen. Not only is it a considerable health problem, but also a development problem that threatens the economic and social fabric of many nations.

Relatively little attention has been paid to HIV/AIDS prevention and care in the context of humanitarian responses. Traditionally, the priorities of such efforts have included the provision of food, water, sanitation, shelter and basic health services. Due its relative invisibility, HIV/AIDS has not been considered an immediate threat to life and has, therefore, not been considered a 'relief' issue. Meanwhile, studies have shown that the conditions associated with conflict and forced population displacement – including poverty, social instability and powerlessness - exacerbate HIV transmission considerably.

By the end of 1997, 12-14 million refugees were scattered across the globe. There were an additional 10-12 million 'others of concern', including internally displaced persons. The majority of these people were located in the developing world, 30% in Africa and 40% in Asia.

Roughly 42% of the refugee population in Africa and 60% in Asia are in the age group that is most sexually active and most heavily affected by HIV/AIDS.

It was not until after the crisis in Rwanda in 1994 that the face of humanitarian aid began to change. Never before had so large a relief operation been undertaken in an area of such high HIV prevalence. The association between conflict, increased vulnerability and HIV/AIDS could no longer be ignored.

### 1.2. The seminar

On 2<sup>nd</sup> June 1999, a one day seminar, "Silent Emergency: HIV/AIDS in Conflicts and Disasters", was held in London. It aimed to:

- Outline the combined impact of emergency situations and HIV/AIDS.
- Identify the factors in emergency situations which increase vulnerability to HIV and augment discrimination against people affected by HIV/AIDS.
- Develop awareness of existing policy and practice in emergency programmes that aim to prevent the spread of HIV and mitigate its impact, and to identify gaps.
- Enable participating organisations to explore future implications for their own policy and practice regarding HIV/AIDS and emergencies.

The seminar was organised by the Working Group on Emergencies and HIV/AIDS of the UK NGO AIDS Consortium. The group started in 1995 and held an earlier seminar in 1996. Here, various NGOs and international agencies met to discuss the impact of displacement on vulnerability to HIV

and to highlight appropriate responses. Three years later, the group decided to come together again to assess progress.

The “Silent Emergency” seminar was supported by ActionAid, ACORD, AMREF, British Red Cross, CAFOD, Oxfam, Save the Children (UK) and World Vision. It involved presentations, case studies, group work and discussions. It was primarily aimed at the staff of UK-based development and humanitarian NGOs engaged in emergency responses. Speakers and attendees also came from the United Nations, donors and NGOs in Africa, Asia, Latin America and Eastern Europe.

*“This [seminar] is not about doing something extra in an already pressurised response to an emergency. Nor is it about setting up parallel HIV/AIDS programmes on top of everything else. Rather, it is an invitation to examine afresh the effect of emergencies on people’s vulnerability to HIV and to look at what we already do, in order to see if, for people already hugely affected by HIV, we become part of the problem or part of the solution.”*

Julian Filochowski, Director, CAFOD

A literature review was commissioned in preparation for the seminar. This 17-page paper - *“The Silent Disaster: HIV and AIDS in Complex Emergencies: A review of current policy and responses”* [see below] - was compiled by Michaela Pfeiffer. It includes information on how HIV/AIDS does/does not inform the policies of key emergency actors and identifies policy gaps in relation to HIV/AIDS prevention and care for refugees and displaced people. The full text is available from the UK NGO AIDS Consortium.

*The Silent Disaster: HIV & AIDS in Complex Emergencies*  
*A review of current policy and responses*

**For the 1998-1999 Working Group  
on Refugees, Displaced People and  
HIV/AIDS**

**May 1999**



### **1.3. This report**

This report aims to summarise the key points raised and conclusions drawn at the “Silent Emergency” seminar. It does not provide a verbatim account of the event. However, the full texts of the presentations, papers and case studies are available from the UK NGO AIDS Consortium.

## 2. Opening speeches

The seminar was opened with speeches from the Chief Executives of two of the UK's largest development and humanitarian relief agencies:

### **2.1. "HIV: An emerging issue for CAFOD" by Julian Filochowski, Director, CAFOD**

In the early 1980s, CAFOD Programme Officers noticed an increase in sickness and death among young adults in countries in East Africa. In Uganda, this sickness became known Slim Disease and, in the North, as AIDS. Initially CAFOD staff saw it as a health problem and got on with their local development work. Soon, however, they began to notice that Slim Disease was impacting on programmes, for example with agricultural work not keeping up with seasonal deadlines. People were too sick to work and those who were well were taking time out to care for the sick or go to funerals. Education and health targets fell behind and economic productivity plummeted. Thus, CAFOD took on board that HIV/AIDS is not just a medical problem. Since 1986, it has been committed to addressing the issue as a priority for all of its development work. It has provided financial and technical support to over 100 programmes on HIV education, care and counselling, and has established a section focussing on HIV-related projects and training work with partners as well as Programme Officers.

Meanwhile, CAFOD continued its response to emergencies. While some programmes had an element of relevant education or health care, HIV/AIDS was not central to the organisation's framework on emergencies. However, 18 months ago, the organisation had a study day as part of an initiative by the UK NGO AIDS Consortium with Save the Children and ActionAid. There, it began to identify the complex range of circumstances that heighten people's vulnerability to HIV in emergencies. It realised that some of them were partly due to failing to recognise the relevance of HIV/AIDS. This was the case not only in relation to obvious considerations, such as blood supplies, but also other decisions, such as about camp layout, control of relief supplies and location of basic amenities.

This marked a turning point for CAFOD and the beginning of its recognition that HIV/AIDS needed to be an integral part of its work on emergencies. It meant re-visiting the organisation's emergencies policies and scrutinising its mode of operation. CAFOD had to ask itself some searching questions, a process that intensified its commitment to making HIV/AIDS a priority in all of its

*"It is no coincidence that a large proportion of people affected by HIV/AIDS are also in areas of the world affected by conflicts or natural disasters. The very conditions generated by emergencies are those that increase people's vulnerability to HIV, especially in situations where levels of infection are already high."*

emergency and development work. It is now central to the organisation's thinking, policy-making and strategies for all responses to conflicts and disasters.

**2.2. “Why is HIV/AIDS such an important issue and what is its relevance in emergency situations?” by Mike Aaronson, Director, Save the Children UK**

HIV/AIDS is an important global issue for three reasons. Firstly, it is devastating, with over 30 million people living with HIV/AIDS (PLHA) and 16,000 new infections every day. Secondly, the problem will not go away. It will take at least another 10 years to develop a vaccine and existing drugs are unaffordable in resource poor countries. AIDS is now the leading cause of death in Africa and is reversing the gains of 30 years of development. Thirdly, most infections result from sexual transmission and intravenous drug use, but there is a reluctance to address these issues – as well as gender - in prevention work.

HIV/AIDS is often neglected in emergencies where agencies concentrate on basic needs. However, is important in these situations because:

1. There is growing evidence linking war and forced migration to the spread of HIV. The breakdown in social and community structures and lack of physical and legal protection means increases sexual violence and new sexual relationships. HIV rates are often high among combatants, with soldiers using sex and drugs as coping mechanisms. Elevated HIV rates followed the wars in Mozambique, Angola and Liberia, with similar indicators for Bosnia.
2. In an emergency, there is a break down in basic services essential for preventing STIs and HIV/AIDS. Condoms are not available and there are few support services for women and girls who have been abused. There is stigma against PLHA, with many unable to access treatment and support. Also, when education services break down, young people and children lack opportunities to learn skills. As a result, many have sex at an earlier age and girls exchange sex for resources.
3. The impact of emergencies is particularly acute on women and children, the largest proportion of refugee and displaced people. Sexual violence and abuse occur in almost every emergency and have been used as a weapon of war. For example, 30-40,000 women were raped in Bosnia, where it was a deliberate policy to force young women to bear the enemy’s children. Younger girls are particularly vulnerable, with an increase in pregnancies common in camps. The frustrations and idleness of refugee men, complicated by alcohol, contribute to greater violence and abuse.

Despite these facts, the response to HIV/AIDS remains limited by policy makers and practitioners. There is a need to take HIV/AIDS seriously, recognise its impact in emergencies and identify those who are most vulnerable. Any response must go beyond health to tackle protection and violence and address socio-economic vulnerabilities.

*“In SCF UK, our response in emergencies is about saving lives and protecting rights. If we ignore the HIV pandemic, we will not achieve either.”*

### 3. Overview papers

Participants were introduced to the key issues involved in HIV/AIDS and emergencies through overview papers given by representatives of CAFOD:

#### **3.1. “HIV and emergencies: An overview of the current situation” by Matthew Carter, Head of Emergencies Support Section, CAFOD**

HIV/AIDS has rapidly become one of the most devastating pandemics the world has ever seen. It is now acknowledged that the spread of HIV globally is associated with poverty, micro and macro economic issues, a breakdown in traditional social structures, gender status, cultural issues, migration and war. HIV/AIDS touches almost every country, but spreads very differently in different regions. 90% of PLHA are in the developing world. In some countries in sub-Saharan Africa, one fifth to one quarter of the adult population is positive. Due to limited access to counselling and testing, 9 out of 10 people who are HIV positive do not know their status.

The impact of HIV/AIDS is systematically eroding the benefits achieved from development initiatives. In Namibia, AIDS causes twice as many deaths as malaria. In Botswana, with 25–30% of adults infected, life expectancy is expected to drop back to levels seen in the late 1960s. By 2010, Zimbabwe’s infant mortality is expected to rise by 138%. The pandemic is also reducing the economically productive age group in many countries. Meanwhile, there is no cure for AIDS. Anti-retroviral drugs are benefiting many PLHA in the North, but are not accessible or affordable to people in resource poor countries.

The long symptom-free period associated with HIV means that it has not been accorded a high priority in emergencies, with attention focusing instead on meeting basic needs, shelter and the treatment of diseases such as measles, cholera and dysentery. However, there is growing evidence from Rwanda, Bosnia and Sierra Leone that links war and forced migration to the spread of HIV. The impact of this is particularly acute on women and children, who constitute 75% of the 40 million refugee and displaced people in the world.

HIV/AIDS can be very difficult to combat, even in stable societies. It is associated with stigma and often not freely discussed. This makes it hard to provide care and support to PLHA and those affected may be discriminated against. In emergencies, the situation for PLHA can be even worse, as they are particularly vulnerable to the higher levels of disease and the reduced availability of healthcare for treatment of opportunistic infections.

A problem tree can be used to analyse the factors that affect the spread of HIV in emergencies [see page 8]. The roots represent those that contribute to emergencies in the first instance. These include political and economic discrimination against groups of people, poverty and the search for resources and income, political instability, war, conflict and environmental problems.

Often, due to loss of local or national protection, displaced populations are vulnerable to increased violations of their human rights, economic and social vulnerability and gender discrimination. In emergency situations, people move. Where war, conflict or protection is involved, combatants and the military also move. These dynamics create populations that:

- Have lost access to basic needs like food, shelter, water and income.
- Have lost the protection of community, national forces and legislation.
- Have lost access to basic services such as health, education and welfare.
- Are at increased risk of sexual violence, exploitation and abuse.
- Are exposed to people that may harm or abuse them, such as combatants.

These effects are shown as the branches and leaves of the problem tree. All of them increase the vulnerability of displaced people to the spread of HIV.

Traditionally, emergency responses are confined to water and sanitation, basic needs, immediate health provision through disease treatment/prevention and camp management. Many of the factors contributing to the spread of HIV are not addressed, particularly at the preparedness and initial implementation stages. While agencies aim to protect refugees and displaced people and save lives, in failing to consider HIV/AIDS at the planning and initial stages, they may be perpetuating an epidemic with catastrophic impact on those that they aim to protect. This is particularly the case when refugee populations come from low HIV prevalence areas and settle in high prevalence areas, and where HIV is high among combatants and protectors.

The problem tree shows that a multi-sectoral response is required. It also indicates that traditional responses do not include crucial elements for addressing HIV/AIDS in existing sectoral responses. For example, integrating reproductive health services into health responses early on in an emergency would afford a structure to address both HIV transmission and gender-based sexual violence from the outset. However, early stage health responses traditionally focus on disease eradication/prevention and mother and child services.

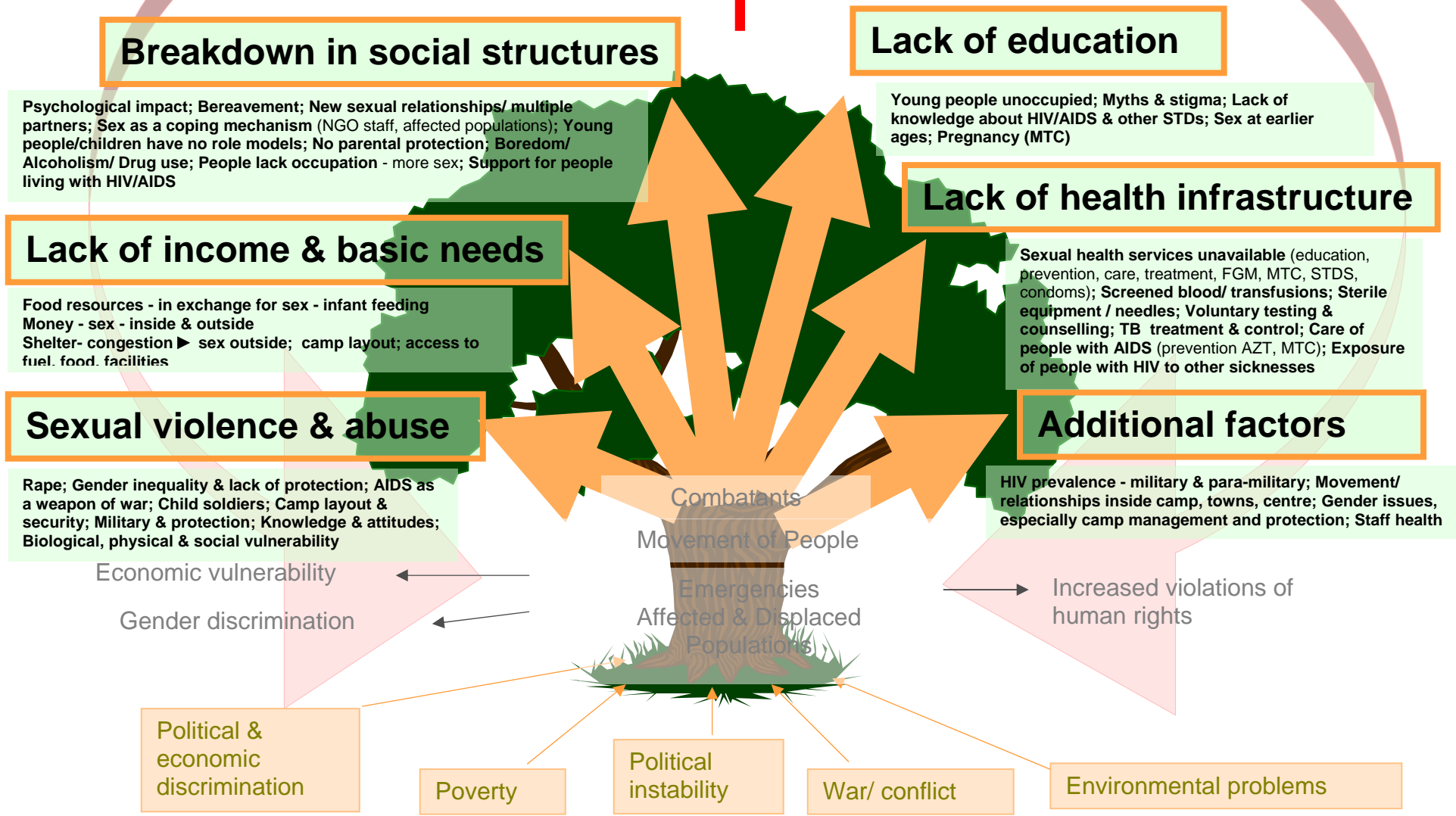
*“To address the spread and impact of HIV/AIDS in emergency and displaced situations, a multi-sectoral response is required that goes beyond the confines of traditional responses.”*

Finally, it is apparent that women and children are particularly vulnerable to HIV transmission through gender-based sexual violence and lack of protection, as well as exploitation and abuse perpetuated by gender insensitive camp management and exposure to the presence of combatants and would-be protectors. They constitute the largest and most vulnerable proportion of refugee and displaced people, but emergency responses are rarely based on gender-sensitive assessments of their problems and needs.



# Leads to further stigmatisation & increased abuse of human rights

## Further spread of HIV/AIDS



### **3.2. “Linkages between HIV and emergencies” by Beverley Jones, Head of Africa Section, CAFOD**

At least five types of conflict operate within Africa at this time. The ones that we are most used to associating with the continent are:

- 'Ethnicisation' or intra-societal conflict, such as the genocide in Rwanda, 1994.
- Intra-state or internal wars, such as the war between the Sudan People's Liberation Movement and the Government of Sudan.

However, new types have now become more prevalent, including:

- Inter-state wars between nation states, such as the Democratic Republic of Congo and Rwanda.
- International conflict - dubbed a 'clash of civilisations' - such as the West vs. Islam.

Also, paid military force is adding a fifth dimension as private military companies nourish conflict in some of the most vulnerable countries.

Yet these are not isolated or detached levels of conflict. Perhaps what has changed since August 2<sup>nd</sup> 1998, when the rebellion started in the eastern Democratic Republic of Congo, is our awareness of the extent to which these conflicts form part of a conflict system. This has greater links to regional and global systems of political and economic reorganisation than are visible from the perspective of local emergency/development initiatives.

As we monitor the regionalisation of the Sierra Leone war, we see a shift in emphasis in the last year in Africa to wars between countries now also being played out through wars within countries. Whereas people have naturally moved between the countries of West Africa for trade and other purposes, the forced movement of people through war, the extent of rape and other acts, is leading to an escalation of HIV transmission. It is only a matter of time before the HIV/AIDS profile of the region matches that of Eastern and Southern Africa.

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

On the face of it, these scenarios appear unbelievably volatile and fickle, a shift of alliance in one part of the system changing every other part, operating through state, insurgent and private military structures. Sudan, which has been at low-intensity wars with Eritrea and Ethiopia in recent years has re-opened relationships with Ethiopia now that Ethiopia and Eritrea are at war. At the same time, this endless shifting of alliances can be regarded as a virtual state of normality.

At least 3 principles of warfare are consistently used by rulers in the system: your enemy's enemy is your friend; border or fault-line populations are to be instrumentalised; and weak nation states resort to private military companies and use their natural resources to pay for them. There is a new 'Scramble for Africa' taking place, a century after the last. In the comfortable locations of Victoria Falls, Lusaka, Paris and elsewhere, a new Berlin Conference is in session as African leaders decide how to carve up the continent's populations and resources. In the global market free for all, some companies will capitalise on the weak states' need for military muscle to influence the outcome of this Scramble or, worse, will engender further chaos to exploit resources without international or governmental scrutiny.

Wide-scale troop movements within and between countries in Africa create easy routes for HIV in civilian populations where the disease may, through government and NGO intervention, have been brought under control through health education and behaviour change. On the whole, this is a predictable consequence of war strategies. However, there is concern that HIV infection has been added to the arsenal of weaponry, with some troops with high rates of HIV being instructed to rape and infect unwanted sectors of society.

This conflict system is not an aberration, but the means to fulfil planned objectives. The pursuit of stability as a prerequisite for state development seems hardly viable when so many other interests are served by conflict. It is possible that some of the emerging political complexes in the South no longer need actual nation states to survive. The legitimacy of the African nation-state is in crisis. The 1990s have witnessed the welfare role of African states diminish under the weight of economic mismanagement, the accumulation of unsustainable debt and some of the cost recovery programmes linked to structural adjustment. Indeed, many African countries have seen almost no return for their steps towards structural adjustment, debt repayments, deregulated markets and other demands made by the International Financial Institutions. Small wonder that the many African leaders are adopting other strategies for securing their uncertain futures.

Even weak nation states can provide at least a framework for civil society to promote HIV/AIDS prevention and treatment. However, with the demise of nation states, such opportunities for stemming the tide of HIV transmission in Africa, or providing proper treatment for PLHA, will become harder to find. Yet so much of our NGO programming is argued on the basis that a normative state of peace is achievable through community development, reconstruction and peace and reconciliation efforts. We continue to adhere faithfully to the relief-rehabilitation-development continuum, in which HIV/AIDS work is implemented in the latter two phases. We continue to plan our work on 'complementary activity' models that derive from our belief in the nation state as the framework within which different sectors play mutually reinforcing roles.

*"Surely, with the demise of nation states in an Africa that has become a continental complex emergency, it is time to rethink this approach - and to integrate our understanding of HIV/AIDS into all aspects of our programming - including the very early stages of emergency response."*

## 4. Case studies

Five case were presented to demonstrate how agencies have attempted to address HIV/AIDS in emergencies [see Annex 7.3. for details of presenters]:

### **4.1. “Sexual violence against women: Experiences from AVEGA's work in Kigali, Rwanda” by Ester Mujawayo, AVEGA, and Mary Kayitesi Blewitt, Programme Co-ordinator, Survivors Fund**

AVEGA is a Rwandan NGO with a membership of 12,000 widows of the genocide. Over the last 5 years, some 2,000 members opted for voluntary HIV testing. Nearly 80% tested positive, with indications that most had become infected as a result of rape and sexual violence during the genocide.

AVEGA feels that, during an emergency, the priority is to improve people's lives through providing food, clean water and sanitation, and preventing communicable diseases and opportunistic infections. To start, agency workers need to examine their own attitudes and to be well informed, including by learning from the experiences of PLHA. A key strategy is to use services and involvement to reach people who are frightened to seek support. However, identifying and working with such individuals in an emergency is challenging. So, agencies should try to set up structures and systems that are sensitive to local realities. These might include:

- **Supporting local structures to deal with HIV/AIDS:** Putting effort and resources into developing local leadership and existing communal practices that can provide information and support women who have experienced sexual violence and may be HIV positive.
- **Setting up health clubs:** Providing practical information, promoting local remedies, advising on dietary provision, providing education on safe sex and reducing stress through dialogue with affected groups.
- **Tackling alcohol excesses:** Looking for employment or income generating alternatives to reduce people's destitution and despair.
- **Raising awareness about opportunistic infections:** Building awareness among health professionals about common symptoms of immune deficiency that might manifest as opportunistic infections.

Five years on, the widows still live with insecurity, economic challenges and psychological and physical disabilities. The vital post-emergency transition period has included many local options to support HIV/AIDS efforts, such as:

- **Breaking the circle of stigma:** Using PLHA to bring courage and richness to members of AVEGA and contribute to strategies. AVEGA reduces peoples stress by providing a supportive environment where those who suspect / know they are positive learn to manage their status until they are ready to seek support.
- **Providing a supportive environment:** AVEGA treats HIV/AIDS as any other health issue, makes it a household term and emphasises that it is OK to be positive. ‘Healthy Women’ seminars cover topics such as prevention methods and good diet. Some people just listen, while others ask questions – which builds the trust vital for reducing stigma. Women PLHA share their feelings and their reactions when diagnosed.
- **Providing practical help, including:**
  - **Raising income levels:** Poverty is the prime cause of stress, with inability to meet basic needs resulting in negative practices, such as prostitution. Providing credit for income generation enables some women to access basic family requirements and reduce destitution
  - **Supplementing the diet:** Raising awareness about staying healthy is not enough, so AVEGA provides high protein foods for PLHA.
  - **Providing medical support:** AVEGA runs a clinic where opportunistic infections are dealt with seriously, whether a woman is HIV positive or not. It also tries to meet the medical bills of PLHA members and provides a regular health monitoring service.
  - **Counselling support.** ‘Healthy Women’ seminars are run by survivors. They provide a listening ear for those experiencing symptoms and information about how to plan your life and your dependants' future. AVEGA also provides outreach to PLHA who are sick.
 

*“The involvement of PLHA in service and information delivery is a very important factor in reaching potentially affected groups and individuals.”*
  - **Voluntary HIV testing:** Women are free to have a test in their own time, usually once they have proved themselves ready and willing to live with HIV. By exploring their time limit - through testing and monitoring their health – they can plan for their dependants.

AVEGA’s conclusions include that agencies should develop transition strategies beyond the emergency phase, recognise the limits of the humanitarian mandate and secure further legal measures to protect women in conflict and mitigate HIV/AIDS. Also, agencies should aim to meet basic needs in a way that empowers local people, reduces stress and fosters a supportive environment for PLHA.

#### **4.2. “Forced migration, the military and HIV/AIDS in Burma” by Jackie Pollock, Joint Co-ordinator, Migrant Assistance Programme**

Burma has the second worst HIV/AIDS epidemic in Asia, with at least 440,000 PLHA and 14,000 orphans. Rates among intravenous drug users are among the highest worldwide, with 91% in Myitkyina on the border with China. The country has all the ingredients for an explosive epidemic, including 44 million vulnerable people and a military dictatorship that denies the problem. Also, there are over 150,000 refugees from Burma in neighbouring countries, up to one million illegal migrant workers in Thailand and 2-4 million internally displaced people. Their right to self-determination is seriously restricted and their access to information very limited. They receive only negligible health care and education services before being displaced. All live in fear. Such conditions are not conducive to HIV/AIDS education and care. There is inadequate implementation of programmes because, alongside little economic backing and infrastructure, there is a lack of political will.

Women in Burma face considerable health problems because of poor living conditions, inadequate health services and lack of basic education. Health care is even more deficient in ethnic minority regions, where constant relocations and the heavy loss of men's lives leave women with complete responsibility for raising their children. One million children are malnourished.

The situation for PLHA is unknown, except that health care for civilians is negligible, as medicines are used exclusively for the army. PLHA do not have symptomatic diseases treated. TB requires stable medical facilities to regularly supply drugs over a long period. However, even if the drugs were available, it is unlikely that medical services could provide the necessary support to ensure that patients took them for the whole period. This risks increased resistance to the drugs, with disastrous consequences.

The first major influx of refugees from Burma arrived in Thailand in 1984, with some 9,000 ethnic Karens fleeing fighting between the Burmese government and members of the KNU. Since 1988, when the SLORC took power in Burma, human rights abuses have increased. The new government doubled the size of its armed forces and established a permanent presence in territory formerly held by the ethnic armed groups. During the fighting, many villagers either fled to Thailand or hid in the jungle. By the end of May 1997, 114,800, Karen, Mon and Karenni refugees were in camps along the border. UNHCR cannot carry out its mandate in those camps as Thailand is not a signatory to the Convention on Refugees. So, it has no permanent presence in the camps. From June 1997, the Thai army closed the border to all new arrivals - thus denying asylum to those fleeing Burma. By November, both Thailand and Burma had new governments. In Thailand, the Chuan administration took a new attitude towards the Burmese government and the refugees on Thai soil. In February 1998, the government invited UNHCR to give a presentation on its work with a view to considering a presence on the Thai/Burma border. When refugee camps were attacked in March, the government immediately made enquiries to the Burmese embassy.

Cross-border aggression, the influx of refugees and illegal immigrants, plus the political situation across the border, have seriously threatened stability in Thailand. As a result, the government has tried to introduce greater flexibility in its dealings with Burma. In April, the two agreed to settle the disputed areas by beginning border demarcations. The Thai government has not prevented its army from keeping the border closed. It also became clear that any role for NHCR would be narrowly defined and restricted to only those persons who fell within the Thai definition of 'temporarily displaced persons', namely those already in established camps who had fled direct fighting.

Medical services in the camps are provided by international NGOs. HIV/AIDS education is included in most of the health education programmes, though sex education is challenging in communities desperately trying to keep their traditional culture. To get condoms, young women have to sign their own names and those of their parents at the clinic. Many camps are still in doubt over whether the screening of blood for transfusions should be anonymous or whether donors should be told their status. In such closed, isolated communities, ensuring confidentiality is very difficult. Also, counsellors prepared to deal with HIV/AIDS find that they also need training in counselling torture victims. Growing women's movements in the camps are approaching the issues of domestic violence and sexual violence by the authorities.

During March 1996 - April 1998, the Burmese regime forcibly relocated over 1,400 villages in Central Shan State. Over half of these people crossed the border illegally into Thailand. The refusal of the Thai authorities to allow them into camps means that they have to immediately look for work in terrible conditions. There are one million illegal migrants working on farms, rubber plantations and construction sites, as well as in the fishing and sex industries. Many of them left Burma as there were no jobs and they feared being forced by the army to work as porters in the fight against democracy groups and ethnic rebels or as labourers on government development projects. They crossed the border illegally, paying Thai police and brokers to transport them from the border to places of work.

In 1997, the Thai economic crisis led the government to send illegal workers back to their countries, so that their own citizens might find work. Only a small percentage of migrants have been able to register for temporary work. The rest are without documentation and, if arrested, can be immediately deported. Fear of this restricts their access to medical care because, although Thai hospitals will treat anyone, the bureaucracy deters the migrants. Young women working in brothels or as housekeepers are particularly at risk of sexual abuse. In addition, away from their normal cultural and family restrictions, young people on construction sites and in factories form sexual relations without information on or access to contraceptives or HIV barriers. Drugs are also easily available, with little information about the importance of clean needles.

*"Many young women are working in brothels where they are indebted to the owners, have no control over their work nor any rights. Threats of police arrest and deportation are the immediate concerns, which make it impossible for the young women to insist on condom use. The risk of contracting HIV in such working conditions is high."*

**4.3. “She doesn't want anyone to know .... except the women here” by Pauline Taylor McKeown, Programme Director, Marie Stopes International**

The Marie Stopes International ‘Self Help Community-Based Emergency Programme for Traumatized Displaced Women in Bosnia’ took place in 1993-5. It had a number of key characteristics, including:

- **Flexibility to adapt ‘on the ground’** and broaden the target group from rape victims to women who self selected as being in need of social and psychological support. This led to a reduction in stigma and increased take-up, as well as providing an opportunity to address specific needs.
- **Access to both reproductive health services and psychological support.**
- **A model of a women’s centre** with outreach work, ‘talking groups’, radio programmes, information leaflets and self-help booklets. The women decided and ran the activities themselves according to their own priorities, focusing on economic, educational and social opportunities for themselves and their children, particularly adolescents.
- **No pretensions to be therapeutic**, but the intention of reinforcing women’s protective factors and coping skills by rebuilding their self esteem. Recognition that this could not meet all of their needs, but was appropriate for an insecure and unstable situation.
- **Development of new community support systems**, however transitory, to replace former ones.

Through the programme, MSI learned that:

- **Many women did not feel that, in their hierarchy of experiences, rape and sexual violence was the worst thing that had happened to them.** This may have been an initial inability to recognise these experiences, but had implications for programming.
- **Initially, women were preoccupied with flight, loss, grief and separation from family members.** An agency’s failure to recognise these concerns hampers assistance and may increase dependency. There can be difficulty in accepting that women are survivors as well as victims, with agencies often responding to the latter - both for expediency and because grieving makes the individual uncomfortable and feel helpless. Once they were allowed to raise these worries and be listened to, women were realistic in their expectations of a response.
- **Women were preoccupied with health.** Whether concerns were real or psychosomatic was irrelevant to the individual, but significant for the



service providers. Often, reassurance and information by paramedics meets the need. Women have a right to clear, factual information to allay fears or confirm the need for medical help. Assumptions should not be made about the level of fantasy/myth. A sensitive medical examination, however long after the event, is an essential indicator for recovery for women who have been raped.

- **Women were preoccupied with protecting their children, especially adolescents.** Concerns were high about the effect on children of witnessing/experiencing sexual violence, often by people known to the family. There was often an inability to talk about it directly to the child, but the women could create situations that helped and protected the child. Also, other women could play a significant role in helping and, sometimes, parenting. There was some recognition that women's responses to protecting their children are not always rational, even if they are normal in an abnormal situation. It is vital for women to have discussions with others to address some of their misjudgements. Also, attention should be paid to the vulnerability of children - particularly to drugs, alcohol and propaganda – in the host community.
- **Attention to community attitudes to sexual violence and sex is needed.** Righteous outrage about what was happening to women was often used by civilian/military authorities to legitimise doing the same in revenge. There was apparent ambivalence among many community leaders and service providers, with public statements contradicting the reality of what they provided. Sex became a negotiating tool for economic and bureaucratic survival. As no community has to deal with mass rape and sexual violence in normal situations, relevant cultural patterns do not exist. There is a wide range of attitudes, but it is generally thought that pre-conflict conditions and geographical isolation were more significant contributors to a women's vulnerability than being raped during the conflict. Also, there is denial among some individuals in aid agencies that people have sex in extreme physical and emotional circumstances, with a severe lack of basic services.

It is impossible to see what can be done about HIV prevention when there is systematic rape as part of a military strategy. Apart from trying to stop the conflict, perhaps all that can be provided is medical care after the event. Also, there may be a reluctance to integrate HIV/AIDS into emergencies programming for fear of compounding vulnerability and stigma. However, people have a right to be informed and to be survivors as well as victims. In practice, basic reproductive health care and trauma programmes provide opportunities for HIV/AIDS to be integrated from the start. With this programme, MSI did not know if it was working with HIV positive women and children. However, a number of the responses would have been appropriate for beginning to both address the needs of PLHA and develop community prevention programmes.

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

**4.4. “Prevention and care in an emergency: STD/HIV/AIDS programme in Rwanda refugee camps in Tanzania” by Dr Philippe Mayaud, Senior Clinical Lecturer, London School of Hygiene and Tropical Medicine**

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

The assessment consisted of:

1. A literature review of epidemiology in Rwanda and NW Tanzania.
2. A review of facilities providing care in the camps - to assess the provision of STD and HIV/AIDS care.
3. A review of the health information system and STD statistics in the camps.
4. A rapid STD survey with 100 antenatal clients, 40 men from each of the 6 camps' outpatient clinics and 300 men in the community.
5. A rapid Knowledge Attitudes Beliefs and Practices (KABP) survey among men and women.

The epidemiology review indicated a high potential for the epidemic to spread, given the mix of the refugee population, with higher HIV rates among urban Rwandan populations (35%) compared to rural Rwandans (5%) and host populations in Tanzania (7%). STD rates were known to be high in both countries prior to the exodus, but the pattern of *N gonorrhoea* drug susceptibility was different, with widespread resistance to a larger panel of antibiotics in Rwanda. Meanwhile, the health facility survey confirmed the absence of STD guidelines and basic training for staff in camp clinics, while the rapid STD and KABP surveys, combined with observations, confirmed widespread use of alternative STD care providers, such as traditional healers.

In the baseline STD and KABP surveys, men and women reported frequent STDs and risky sexual behaviour beforehand, followed by a marked reduction of sexual activity during the exodus and the establishment of camps. Despite high levels of knowledge about HIV, only 16% of men reported using condoms during casual sex. Predictably, high levels of STDs were recorded. Over 50% of antenatal attendees were infected with vaginal pathogens and 3% with gonorrhoea, while the prevalence of urethritis was about 10% in men, of whom 3% had *N gonorrhoea* or *C trachomatis* infections. The prevalence of active syphilis was 4% in women and 6% in men.

The STD/HIV/AIDS programme was launched 4 months after the start of the Rwanda crisis in 1994. It consisted of:

- **IEC**, with materials produced in Kinyarwanda and regular mass education campaigns by 14 refugee health behaviour promoters.

- **Peer educators** working among bar and brothel workers.
- **Condoms** supplied through various outlets, including clinics, events and peer educators.
- **An STD intervention** focusing on providing drugs and training and supervising health workers at all outpatient clinics in syndromic STD management. Screening for syphilis was introduced at antenatal clinics and supported by a training programme for traditional birth attendants. Also, ophthalmia neonatorum was prevented at birth and the clinical efficacy of algorithms monitored, as well as drug susceptibility of *Neisseria gonorrhoea* and quality control of syphilis testing.
- **A community education and support programme for PLHA**, with home-based care and counselling by a network of about 100 AIDS community educators (ACEs) recruited from the refugees.

The impact was assessed 18 months later by repeating the rapid STD and KABP surveys and reviewing programmatic process indicators. This revealed that the number of self-reported STD cases at clinics increased from 20 to 250 per week, with over 11,000 cases treated in the first 12 months. Syphilis prevalence among ANC attendees remained low at 4-5%. The presence of multi-drug resistant gonococcal strains was observed, with 98% of strains resistant to tetracycline, 60% to penicillin and 15% to cotrimoxazole. Results from the follow-up STD survey showed little decrease in the levels of urethritis among men in the community or cervical infections among women attending antenatal clinics. However, the prevalence of vaginal infections decreased and the prevalence of syphilis remained low.

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

Some 120 IEC activities were conducted in 18 months, reaching about 230,000 sexually active people. Demand for condoms increased substantially, with about 1.5 million distributed in 12 months.

In conclusion, refugee populations are often exposed to increased risks of STDs, including HIV. Therefore, reproductive health issues should be addressed early during a crisis. STD case detection and management should be improved by having IEC campaigns to encourage attendance at clinics and training health workers in WHO's syndromic approach. Algorithms and the choice of highly effective drugs should be tailored to the situation and monitored. Efforts should also focus also on reaching vulnerable groups in the community, such as young people, women and PLHA. Furthermore, rapid situation analysis methods may provide quick and useful information at low cost in refugee camps. However, they should be refined and combined with other programme indicators to assess the process and quality of services, especially as the impact of specific interventions on the health status of refugees is not easily measured.

**4.5. “Socio-economic issues of HIV and emergencies in Honduras” by Maria Esther Artilles, Consultant, Save the Children and Lecturer, National University of Honduras**

Before tropical storm MITCH in October 1998, Honduras was already one of the poorest countries in Latin America. MITCH caused over US\$ 5 billion of damage and affected 560,000 people, including 280,000 children and young people. In Tegucigalpa, at least 40% of women in the informal sector lost their work. Throughout the country, people also lost their housing, land and transport, with the impact particularly severe on the urban poor. Six months later, over 5,000 families were still living in overcrowded communal shelters.

Previously, Honduras had the third highest HIV prevalence in Latin America. There were an estimated 39,000 PLHA, with a concentration among young people and an increasing number of cases among women. Now, this situation has been affected by MITCH in terms of:

- **A 30-50% under-reporting of HIV/AIDS cases** due to the damage suffered by the health infrastructure, the displacement of people and the initial concentration of medical staff on other surveillance.
- **An increase in child labour/street children.** School attendance was difficult for those in shelters due to displacement and lack of resources. Once on the streets, children faced sexual violence and exploitation. In Comayagua, the two main markets were destroyed and, with them, the place used by street children for sleeping and getting money for basic needs by selling goods or helping shoppers carry their bags.
- **An increase in girls involved in/at risk of sexual exploitation.**
- **Nationwide migration**, particularly to the north coast where export factories provide employment, but the HIV epidemic is at its highest.
- **Busy traffic of people involved in commerce across the borders.** Mobile groups, such as sex workers, became more mobile to search for new customers at places where sexual tourism is high.
- **Increase in domestic violence and sexual violence.**
- **Very diminished capacity in the health and education sectors.** The school year was suspended and education buildings used as shelters. The Ministry of Health conducted a 3-month emergency intervention to attend to those affected and care for PLHA with opportunistic infections and children who had started anti-retroviral treatment.
- **No modification in sexual health behaviour** - despite significant efforts to provide HIV/AIDS education through the media – as MITCH was not perceived as a threat to HIV/AIDS. This reflects the Ministry of Health’s view that one of the largest challenges to address was the lack of empowerment of civil society.

Through INTERFOROS, civil society highlighted that central efforts emphasised the physical reconstruction of the country at the expense of social vulnerability, with the threat of HIV/AIDS not considered critical. Meanwhile, the Central American Meeting of Women for Reconstruction demanded that governments *"guarantee women the right to health, taking into consideration their vulnerability to HIV/AIDS as a cause of mortality"*.

An official emergency plan, funded by international co-operation agencies, was devised for the impact of MITCH on STDs and HIV/AIDS, including preventative action and direct assistance. This involved co-ordinating with other sectors to avoid duplication and maximise the use of resources.

Most international NGOs attempted, unsuccessfully, to face the emergency in a co-ordinated way. Mostly, each focused on its own target population, with many initially ceasing STD and HIV prevention in favour of providing food, shelter and medical care. In the Save the Children STD/HIV/AIDS prevention project, working in 10 provinces, the health staff could not continue their activities as they had to participate in the national campaign for the prevention of epidemics. Meanwhile, teachers were involved in activities in the shelters, but, with school year cancelled, the student HIV/AIDS counsellors could not conduct activities independently of their facilitator. However, Committees Against HIV/AIDS – involving students, teachers and health staff - implemented their action plans.

*"It is very important that agencies do not redirect funding originally planned for [HIV/AIDS], but that, on the contrary, more aggressive strategies are devised to address the problem on a mid-term basis."*

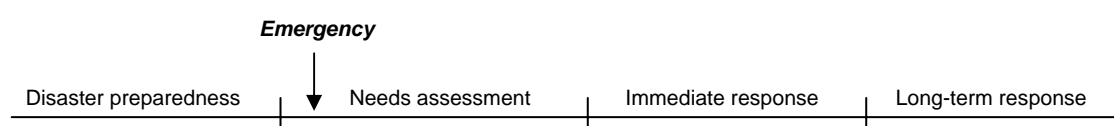
The lessons learned included that, with the country vulnerable to disasters, contingency plans must be devised within organisations working with vulnerable populations, such as women, children and the elderly. Also, child rights promotion - particularly the prevention of HIV and child violence – should occur simultaneously to providing basic needs and having an information strategy to communicate key messages to children in distress. In addition, national and international NGOs and government agencies must form strategic alliances in order to achieve greater impact.

The lessons also included that HIV prevention work needs to be coupled with care for PLHA and development projects need to integrate HIV prevention to ensure the sustainability of efforts. Also community-organised initiatives are vital for anti-stigma efforts for PLHA and work also needs to be done to avoid discrimination in the allocation of benefits to people who are infected/affected by HIV/AIDS.

## 5. Group work

Participants were divided into four small groups and asked to discuss key questions relating to their agencies' responses to HIV/AIDS and emergencies:

### **5.1. Question: "Has your experience of responding to emergencies included HIV/AIDS in any way? Where on the timeline? What was done?"**



The participants identified the stages along the 'timeline' of an emergency [see above] at which their agencies had taken action on HIV/AIDS:

Stage	Examples of action on HIV/AIDS
Disaster preparedness	<ul style="list-style-type: none"> <li>• HIV/AIDS incorporated into staff recruitment.</li> <li>• HIV/AIDS incorporated into agencies' policies.</li> <li>• HIV/AIDS included in training of military and peacekeepers.</li> <li>• Relevant medical policies and stocks ensured (eg. clean needles).</li> <li>• Broad agreement reached that HIV/AIDS requires a response.</li> </ul>
Needs assessment	<ul style="list-style-type: none"> <li>• STI rapid assessments.</li> <li>• Local HIV prevalence assessed.</li> <li>• KAP survey of new arrivals in a camp to assess health needs.</li> <li>• HIV/AIDS a priority of refugees involved in programme design.</li> <li>• Review of supplies needed to implement UNAIDS Essential Minimum Package.</li> </ul>
Immediate response	<ul style="list-style-type: none"> <li>• Links to medical measures (eg. blood safety, clean needles).</li> <li>• Training of health care workers.</li> <li>• In-service brief to peacekeepers.</li> <li>• Distribution of condoms.</li> <li>• Implementation of UNAIDS Essential Minimum Package.</li> <li>• Acknowledgement of brothels in UN compounds and HIV risks to women and troops.</li> <li>• Acknowledgment of problems of sexual violence and lobbying of armed factions to prevent human rights abuses.</li> <li>• Awareness raising among women and community leaders about gender and sexual violence.</li> <li>• Support and counselling for victims of sexual violence.</li> <li>• Involvement of women in the design of camp, eg. deciding location of water points and latrines to minimise sexual violence.</li> <li>• Treatment of STIs.</li> <li>• Empowerment of women through women's groups.</li> <li>• Provision of safe abortion kits.</li> </ul>

<b>Long-term response</b>	<ul style="list-style-type: none"> <li>• Awareness raising, training and counselling for staff.</li> <li>• Counselling for child soldiers.</li> <li>• Funding, support and skills training for vulnerable people (eg. PLHA).</li> <li>• Health education via clinics, peer education, media, posters, etc.</li> <li>• Campaign to improve health services and respect human rights.</li> <li>• Diversion of resources to HIV/AIDS when stability restored.</li> <li>• Acknowledgement that staff are away from families for too long.</li> <li>• Review of staff health policies.</li> <li>• Condoms provided in long-term camps.</li> <li>• HIV and TB prevention and care programmes, based on women's empowerment, community education and support for PLHA.</li> <li>• Sexual violence and gender programmes.</li> <li>• Counselling and translation services in hospitals.</li> <li>• Provision of pregnancy kits.</li> <li>• Following of host governments' policies (eg. for health education).</li> </ul>
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**5.2. Question: “How can your organisation initiate, develop and improve its relevant policies and practices?”**

To answer this question, the participants in the small groups focused on answering a number of sub-questions, namely:

***“What are the key gaps in relation to integrating HIV/AIDS?”***

The key gaps include:

- Political will, appropriate policies and expertise among NGOs and governments.
- Funds and appropriate targeting/timing of income generation projects.
- Initiatives to empower vulnerable people to take control of their lives, including through sex education and life skills training.
- Data to prove the importance of HIV/AIDS to governments and donors.
- An integrated, multi-sectoral approach, including advocacy about linking prevention and care and integrating HIV/AIDS into the EMP, rather than treating it as a separate issue.
- A framework to ensure the legal and human rights of individuals.
- Involvement of host governments and local organisations – which leads to parallel programmes being created.
- Efforts to specifically address the technical and personal needs of local and ex pat staff (eg. including HIV/AIDS in agencies' health policies).
- Specific attention to adolescents - who don't attend school and get bored – especially young men, including those involved in the conflict.
- Inclusion in the training of staff that anyone, including themselves, can become infected with HIV.
- Care for those already infected and affected by HIV/AIDS.
- Prioritisation of needs about security, sexual violence and protection.

- Baseline data of HIV rates of host population, refugees and the military.
- Co-ordination and sharing of good ideas between NGOs.
- Women-centred approach to the layout of camps, ensuring that vulnerable women are close to resources.
- Willingness to address chronic sickness, rather than focus on 'quick diseases', such as diarrhoea.
- Recognition that risk behaviours – such as sex work – occur very quickly in camps and need urgent attention.
- Agencies recognising local experience and building local capacity, rather than bringing everything – including values – in from outside.

***“What are the key constraints in relation to integrating HIV/AIDS?”***

Participants identified the constraints as including:

- 'Emergency paradigms'/NGO cultures that focus on short-term responses and view HIV/AIDS as a development rather than emergency issue.
- No awareness about the future impact of HIV/AIDS.
- Difficulty of controlling HIV in a conflict setting due to issues of power and violence.
- Medical issues (eg. drug resistant STIs and AIDS-related illnesses).
- HIV remains invisible, a death sentence and highly stigmatised.
- Difficulty in accessing and involving women.
- Poor co-ordination between agencies and ill-defined roles/responsibilities.
- Attitudes to treating PLHA, in terms of “why waste money?”
- Resistance to addressing HIV/AIDS in church organisations.
- Not knowing who is/is not positive and, therefore, who needs care.
- Short-term funding when a long-term response is needed.
- Lack of credible counterparts due to deteriorated State infrastructure.
- Priorities changing when you are 'on the ground' in a refugee camp.
- High turnover of staff, with new people not knowing what to do.
- Inappropriateness/impossibility of distinguishing between host and refugee populations.
- Reality of refugees having to sell sex for food - as their need for day-to-day survival is more powerful than thoughts of long-term effects.
- Agencies react with 'add-ons' rather than having structured policies about issues relating to sexual relations and abuse.

***“What are the key priorities in relation to integrating HIV/AIDS?”***

The priorities were identified as including:

- Raising awareness in NGOs, refugee populations and donors about the importance and relevance of HIV/AIDS.
- Establishing a reproductive health coordinator from day one of an emergency – to raise HIV/AIDS at meetings and keep the topic alive.
- Taking practical measures to prevent sexual violence.



- Mobilising resources and establishing a budget line for reproductive health and HIV/AIDS.
- Specifically targeting men as well as women.
- Ensuring that prevention is accompanied by care and support for PLHA.
- Ensuring that interventions are community-based.
- Carrying out evaluations to make appropriate strategy changes.
- Focusing on practical/simple things, rather than taking on everything.
- Building awareness of HIV/AIDS as a crosscutting issue in all areas of an agency's work, so commitment is already there when emergencies occur.
- Involving PLHA as a resource and solution.
- Forming support groups for PLHA that maintain confidentiality and allow them to feel safe enough to come out about their status.
- Getting NGOs to sit together and identify priorities for a holistic solution.
- Sharing lessons learned between organisations.
- Ensuring a simple 'minimum package' for emergency situations, including universal precautions in relation to HIV/AIDS.
- Developing indicators to measure the impact of HIV/AIDS responses and to inform programme development, including 'proxy' indicators (eg. community attitudes) and more measurable ones (eg. STIs rates).
- Recognising that, in some parts of the world, conflict and HIV/AIDS are 'normality' - which needs a shift from just prevention to 'living with HIV/AIDS'.
- Making responses context-sensitive – by taking on board factors such as the previous HIV prevalence among the refugee/host community.
- Using HIV/AIDS interventions as an opportunity to include the host population and, where possible, address their problems as well.
- Starting with non-HIV/AIDS specific programmes, due to stigma, and focusing on issues such as improving security and reducing boredom.
- Treating PLHA the same as everyone else - in terms of enabling them to receive medical care for illnesses and not be excluded.
- Encouraging community participation and empowerment – so that programmes can work effectively.
- Preventing sexual violence through female-friendly site planning and camp layout, supporting women who are most vulnerable, advocating for human rights and training relevant groups (eg. police and soldiers).
- Making peacekeepers and the military accountable for sexual misconduct, enforcing the 'rules of war' and punishing perpetrators.
- Raising awareness among all those involved, including the Chief Executives of agencies and inter-agency groups (eg. Disasters Emergency Committee).
- Combining the training of people (eg. counsellors and PLHA) with securing relevant materials on site (eg. condoms and drugs).
- Ensuring the personal security of both staff and the victims of violence.
- Ensuring co-ordination and communication among agencies.

## **6. Conclusions and recommendations**

### **6.1. Conclusions**

The seminar demonstrated that a number of agencies have considered HIV/AIDS in responses to emergencies, with initiatives varying from rapid STI assessments in refugee camps to providing clean needles in medical units. However, it also showed that, overall, the response has been limited, with the pandemic receiving little attention from policy makers and practitioners alike. This was seen to be due to a number of factors, including the low visibility of the problem, the lack of capacity among staff busy responding to other urgent needs and the 'compartmentalisation' of HIV/AIDS as a health issue.

The detailed conclusions of the seminar can be seen in the key gaps, restraints and priorities outlined on the previous pages. However, overall, the event demonstrated that agencies have most experience of addressing HIV/AIDS within efforts implemented *after* an emergency has abated. These include programmes to reduce the level of sexual violence and to care for PLHA. Teams responding to an immediate crisis often think that HIV/AIDS is not their business and that it should be left to those following after them with longer-term, development programmes.

### **6.2. Recommendations**

Based upon the discussions and conclusions of the seminar, it is recommended that humanitarian agencies:

#### **6.2.1. Develop an HIV/AIDS policy/integrate HIV/AIDS into existing policies**

Often, field workers are concerned about HIV/AIDS, but unaware of their agency's position on the issue or how to address it in their everyday work. Agencies and donors need to look at the 'big picture' and develop a strategic vision to ensure that prevention and care are truly integrated into emergency programmes. HIV/AIDS must become integral to both emergency preparedness and programming. This can be achieved through measures such as developing monitoring indicators to reflect the impact of HIV/AIDS interventions and training staff on international instruments - such as the UN Convention on the Rights of the Child - that protect the rights of refugees and displaced people.

#### **6.2.2. Review existing policies and distribute up to date resources**

Many policies and guidelines are not updated to integrate HIV/AIDS, sometimes due to reluctance within organisations. Agencies need guidance in reviewing their policies and putting them into practice. With new materials constantly available, they need to prioritise useful policies and guidelines and distribute them, especially to field practitioners.

### **6.2.3. Ensure the provision of relevant health care**

In any emergency, one of the first concerns of a humanitarian agency is to attend to the medical needs of the injured and contain the risk of infectious disease. Thus, medical care – including measures to prevent HIV infection - is essential from the first moment. Sterilisation, the screening of blood products and the use of universal precautions by staff are among the ‘minimum package’ that agencies should provide. In addition to these ‘technical’ aspects, agencies need to consider social and environmental factors, such as how discrimination affects the access of women and PLHA to health care.

### **6.2.4. Evaluate what does/doesn’t work and document experiences of integrating HIV/AIDS care and support into different sectors**

There is a lack of documentation about what does/doesn’t work in HIV/AIDS planning and programming in emergencies. Further research is needed to gather materials to inform agencies about good practice, not only in relation to HIV prevention, but also care and support. Where appropriate, it should take on board experiences from non-emergency settings that can be learned from and adapted. Also, policy makers and practitioners – who often need to integrate HIV/AIDS into existing sectoral work – do not have the appropriate capacity or know-how. Again, further user-friendly guidance is necessary.

### **6.2.5. Foster a holistic, integrated and multi-sectoral response**

It is necessary to have a holistic response and address all the factors that affect the spread of HIV in emergencies, including ones as diverse as TB, sexual violence and boredom. Agencies that only respond to one or two aspects risk merely addressing selected symptoms. If different sectors are involved, they can, together, ensure action such as:

- Protection of legal/human rights for refugees and displaced people.
- Gender-sensitive layout of camps and access to food, water and fuel.
- Provision of reproductive health services, including gender-sensitive condom distribution and care for PLHA.
- Use of universal precautions for all contact with blood or clinical waste.
- Staff training to overcome fears and prejudices about HIV/AIDS.
- Education and economic opportunities for women and young people.

### **6.2.6. Actively involve community leaders and members, including PLHA, in programme planning and implementation**

Every effort should be made to ensure that displaced people retain some power, autonomy and self-esteem. It is vital to involve the community and/or programme beneficiaries in planning HIV/AIDS responses in emergencies and other situations. In particular, the involvement of key local stakeholders – such as traditional healers, community leaders, religious leaders and PLHA - is key to ensuring that prevention and care initiatives are both culturally appropriate and technically effective.

### **6.2.7. Start with gender-sensitive needs assessments**

HIV/AIDS must be addressed at the assessment stage, rather than after basic needs have been met when it is harder to set up a relevant response and get funding. Gender issues need to be prioritised, as the majority of refugees are women and children. As such, information should be collected on areas such as: prevalence of STIs and HIV in the home/host communities; risk situations that require tailored initiatives; cultural beliefs/practices about sexuality and HIV/AIDS; factors that influence different populations' vulnerability to HIV; the forms of sexual and gender-based violence taking place; and ways of earning an income except through sex.

### **6.2.8. Ensure a greater focus on gender-based sexual violence**

Sexual violence is a highly sensitive area in emergencies and needs to be addressed at policy and practice levels. Agencies often deny that it is an issue – which hampers interventions to support victims. Issues related to gender and sexual violence need to be incorporated into the recruitment and training of staff. Agencies also need to put gender-sensitivity into practice, for example by arranging camps to reduce the risk of women becoming victims of abuse.

### **6.2.9. Encourage a greater focus on the military and combatants**

The military and combatants play a major role in conflict and post-conflict situations. National infrastructure needs to ensure that military personnel have both access to HIV prevention initiatives and knowledge about international law relating to rape and sexual violence, particularly as regards children and young people. Also, military and peacekeeping forces – and international agencies that use such forces - must be held accountable for any sexual misconduct or crimes of sexual violence that their members commit.

### **6.2.10. Focus on children and young people, especially child soldiers**

Very often, children and young people involved in emergency situations are denied their rights to HIV prevention, care and support. They are not targeted effectively and are left vulnerable to sexual abuse and exploitation, boredom, isolation and trauma, or are forced into fighting as child soldiers. There is a need to both address their vulnerability to HIV and to provide appropriate care and support for those already living with HIV/AIDS.

### **6.2.11. Increase staff training on relevant issues**

Staff need a thorough understanding about HIV transmission and the factors that affect the vulnerability of refugees and displaced people. They need relevant guidelines and policies and to be aware of the role of the military, combatants and camp leaders in violations of protection. They also need to be aware of their own vulnerability, both professionally (in terms of dealing with blood, etc) and personally (in terms of their sexual health). The trauma suffered by workers should be acknowledged and support systems provided to reduce the risk of seeking unsafe sexual relations as a coping mechanism.

## **7. Annexes**

### **7.1. Timetable for the day**

- 09.00 – 09.30 **Registration**
- 09.30 – 09.45 **Introduction, aims and objectives** (Julian Filochowski, Director, CAFOD; Mike Aaronson, Save the Children UK)
- 09.45 – 10.00 **Overview of existing guidelines and policies in relation to HIV/AIDS and emergencies** (Monica Wernettes, UNAIDS and UNHCR)
- 10.00 – 10.30 **Overview of present trends of emergencies and HIV/AIDS** (Mathew Carter, CAFOD; Beverly Jones, CAFOD)
- 10.30 – 11.15 **The implications of HIV/AIDS in emergency settings** (small group work)
- 11.15 – 11.30 **Break**
- 11.30 - 12.00 **The implications of HIV/AIDS in emergency settings** (report back and discussion)
- 12.00 – 13.00 **Case studies of present interventions in emergencies** (Ester Mujawayo, AVEGA, and Mary Kayitesi Blewitt, Survivors Fund; Jackie Pollock, Migrant Assistance Programme; Pauline Taylor McKeown, Marie Stopes International; Dr Philippe Mayaud, London School of Hygiene and Tropical Medicine; Maria Esther Artiles, Save the Children and National University of Honduras)
- 13.00 – 14.00 **Lunch**
- 14.00 – 15.00 **Case studies of present interventions in emergencies** (continued)
- 15.00 – 15.30 **Break**
- 15.30 – 16.45 **The way forward** (small group work and report back)
- 16.45 – 17.00 **Summary, conclusion and follow up**

## **7.2. Details of speakers**

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

**Mary Blewitt** is currently a Programme Co-ordinator for SURVIVORS FUND (SURF), a registered charity that represents AVEGA (an association of the widows of genocide in Rwanda) in the UK and supports survivors of genocide. She has previously worked as a personal secretary to the Ambassador of Rwanda in the UK following eight months' volunteer work with the Ministry of Rehabilitation in Rwanda.

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

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

**Dr. Philippe Mayaud MD, MSc**, is a Senior Clinical Lecturer at the Department of Infections & Tropical Diseases, London School of Hygiene & Tropical Medicine. His research primarily focuses on aspects of STD/HIV control in developing countries. He is the organiser of the MSc in STDs/HIV run by LSHTM and the Department of STD, University College London. Philippe trained and graduated as a MD (GP) in France. He then worked in French Guyana, the Commonwealth of Dominica and the Mwanza Region of Tanzania - where, for 6 years, he worked on a large international STD/HIV intervention and research programme run by LSHTM in collaboration with AMREF and the Tanzanian government. During this period, he and colleagues from AMREF established STD/HIV programmes in Rwandan, Burundian and Zairian refugee camps in response to the influx of refugees in Northwest Tanzania.

**Jackie Pollock**, after graduating, spent two years with VSO at a teacher training college in Thailand. After six years as a residential child care officer and EFL teacher in Hastings, she returned to Thailand to work for a language school. She became involved with Empower, a Thai NGO working with sex-workers in the red-light district of Bangkok and volunteered with them, joining HIV education campaigns and other activities for 5 years. Having set up a branch in Chiang Mai, Jackie worked full time with Empower from 1991-1996 and is now a voluntary advisor. In 1997 a group of local NGOs responded to the needs of migrant workers from Burma in Chiang Mai and set up a new NGO, MAP (Migrant Assistance Programme), which a Thai colleague and Jackie jointly co-ordinate. She has worked on a report for the UN on the trafficking of women and children in the Mekong Greater Sub-Region and is now working on a similar report on the trafficking of women and children from Nepal to India.

Pauline Taylor McKeown is a qualified social worker with 12 years of experience working in development. Overseas long-term postings have included Indonesia, Romania, Bosnia and the Lao PDR. Currently she is the Save the Children Fund's Programme Director for Sri Lanka. The presentation will focus on experiences gained in the former Yugoslavia between 1993 and 1995,

where she worked for Marie Stopes International, both as a Field Manager establishing the programme and as the Programme Director.

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The UK Consortium on AIDS & International Development is a group of more than 50 UK based organisations working together to understand and develop effective approaches to the problems created by the HIV epidemic in developing countries. It enables each agency to bring its own experience to be shared and used to help all the members improve their responses to the epidemic, through: information exchange - networking - advocacy - and campaigning.