



# HIV and Conflict: A double emergency

“Without war, we could fight AIDS”



**Save the Children**

In the decade ahead, HIV/AIDS is expected to kill ten times more people than conflict. In conflict situations, children and young people are most at risk – from both HIV/AIDS infection and violence.

In this report, Save the Children calls on governments, donors and humanitarian agencies to uphold children's rights and to channel resources into preventing – what for many young people is already – a 'double emergency'.

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“Without war, we could fight AIDS”

# Acknowledgements

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The individual testimonies and photographs in this report are of children and young people living in orphanages or internally displaced camps, or who are heading up households having lost their parents to HIV/AIDS or the civil war, in Burundi. Names have been changed to protect identities. The projects mentioned in the testimonies are supported by Save the Children.

The International Save the Children Alliance is the world's leading children's rights organisation, with Save the Children members in 32 countries and operational programmes in over 100.

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Save the Children UK  
17 Grove Lane  
London SE5 8RD

Tel +44 (0) 20 7703 5400  
email: [enquiries@scfuk.org.uk](mailto:enquiries@scfuk.org.uk)  
[www.savethechildren.org.uk](http://www.savethechildren.org.uk)

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# Abbreviations

AIDS	acquired immuno-deficiency syndrome
ARV	anti-retroviral
CAP	UN Consolidated Appeals Process
DRC	Democratic Republic of Congo
EU	European Union
HIV	human immuno-deficiency virus
IDP	internally displaced person
MTCT	mother-to-child transmission
NEPAD	New Partnership for Africa's Development
NGO	non-governmental organisation
PID	pelvic inflammatory disease
SRH	sexual and reproductive health
STI	sexually transmitted infection
UNAIDS	Joint United Nations Programme on AIDS
UNCRC	United Nations Convention on the Rights of the Child
UNDP	United Nations Development Programme
UNGASS	United Nations General Assembly Special Session
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
VCT	voluntary counselling and testing
WFP	World Food Programme
WHO	World Health Organization

# Executive Summary

In the decade ahead, HIV/AIDS is expected to kill ten times more people than conflict. Although the highest HIV rates are recorded in countries without conflicts, rates are suspected to be high, and growing, in Angola, Burundi, the Democratic Republic of Congo (DRC), Liberia, Sierra Leone, Sudan and other states where surveillance systems cannot function properly.

In conflict situations, young people are most at risk. HIV/AIDS and conflict are combining to threaten the lives of young people, especially girls. Many children have also lost their parents to warfare or to AIDS, and are living without protection and assistance. They are often denied their basic rights to food, shelter, education and healthcare. Children have a fundamental right to life, survival and development; in conflicts it is often denied.

In war, HIV/AIDS spreads rapidly as a result of sexual bartering, sexual violence, low awareness about HIV, and the breakdown of vital services in health and education. Children and young people are being denied their rights under the UN Convention on the Rights of the Child.

Children have the right to be protected from all forms of sexual exploitation and abuse. But many young women and girls in refugee and post-conflict settings are forced to use their bodies to get food and clothing for themselves and their families. Amid the violence of conflict situations, rape, domestic violence and sexual exploitation often go unchecked. Powerlessness and fear heighten the risk of HIV transmission.

These practices are all the more dangerous because, in most conflict situations, there is an acute lack of knowledge about and denial of HIV/AIDS. Children have a right to information and materials that will promote their well-being, reduce their vulnerability to HIV/AIDS and protect them from the stigma and discrimination associated with HIV/AIDS.

Behind the widespread lack of awareness is an

almost total absence of sexual and reproductive health services in most conflict situations and refugee camps. This seriously undermines prevention efforts, and HIV/AIDS care in conflict settings is almost non-existent. Children have the right to the highest attainable standard of health and to facilities that treat HIV/AIDS and rehabilitate their health.

Responses to the HIV/AIDS epidemic in conflict countries have so far been inadequate to slow down the spread of HIV. Governments in most conflict-affected countries are not responding adequately, due to a lack of resources, capacity and commitment. States like Sierra Leone, Liberia, Burundi and Angola are falling behind their neighbours in meeting targets agreed at the 2001 UN General Assembly Special Session on HIV/AIDS. Where they lack resources to uphold the rights of children, they must seek international co-operation. Associated with this, the lack of focus on the rights of children and young people in conflict situations leads to an increased risk for them of exposure to HIV infection.

A lack of international funding is the single largest obstacle to reducing the spread of HIV in conflict situations. Without a greatly enhanced response and funding, conflict-affected countries will not meet their UN commitments on HIV/AIDS to meet basic needs and provide prevention, care and support, to alleviate the impact and to assist children affected by AIDS. International financing remains grossly inadequate. Contributions to the Global Fund to Fight AIDS, Tuberculosis and Malaria by donor governments are severely lacking, and almost no payments have been made to states affected by conflicts. In the same countries, moreover, humanitarian programmes remain seriously under-funded.

Humanitarian agencies operating in most conflict settings are also failing to respond adequately to the threat of HIV/AIDS. Struggling to provide for basic needs, humanitarian agencies are neglecting their responsibility to provide refugees and displaced people with access to HIV prevention and treatment

services. This is endangering the lives of young people, whose vulnerability to HIV is strongly determined by the policies and practices of those wielding power over their lives. Children's best interests must be considered by humanitarian agencies in their programmes, and young people should participate in their design and implementation.

Humanitarian efforts to tackle HIV/AIDS have concentrated on preparing guidelines that field staff have often lacked the capacity and confidence to implement. Early intervention in the initial stages of an emergency is critical to success. But even where HIV/AIDS programmes have been implemented, they have been inadequate in scale. Co-ordination is lacking among humanitarian agencies, especially at field level. Integrated multi-agency initiatives are needed to address HIV at country level.

Young people are too often neglected in existing responses. Yet young people are so often the agents of change in difficult settings. Solutions must begin with strengthening their skills and defences, and supporting young parents and heads of households living without their parents. Save the Children is working to share its experience with donors and partners to build effective child rights-based responses to HIV/AIDS in conflict-affected countries.

Governments, donors and humanitarian agencies must take urgent action to protect the lives of an estimated 15 million young people directly threatened by HIV/AIDS in conflicts and related emergencies around the world. In failing to do so, governments and their international partners are renegeing on their obligations under the UN Convention on the Rights of the Child and the UN Declaration of Commitment on HIV/AIDS. Effective action relies on the world's wealthiest nations and private organisations making adequate contributions, through mechanisms such as the UN's Consolidated Humanitarian Appeals Process and the Global Fund to Fight AIDS, TB and Malaria.

This report reflects the International Save the Children Alliance's experience of HIV/AIDS and its effects on young people in conflict situations around the world. Direct experience comes from conflict situations in Angola, Burundi, Colombia, Liberia, Nepal, Rwanda, Sierra Leone, Southern Sudan, Sri Lanka and Uganda, and the refugee crises they have created. It is part of the Alliance's commitment to assisting donors and humanitarian agencies to deploy sufficient resources in an effective manner, to prevent the further spread of HIV.





*All children have the right to a healthy and safe childhood, protected from HIV/AIDS and conflict.*

**Geneviève, 18, asks donors to help sick children and orphans**

"I didn't know my father. My mother died when I was 13. I don't know what sickness my mum died of. We lived in Gitega. When she died, I went to my mum's home in Rutane. I was there, living alone with no one to help me. My uncle was working as a teacher in Makamba. He was a bachelor, and he died – I think of AIDS.

Another relative cared for me here in Bujumbura. She mistreated me, and then threw me out. I studied for a time, until I got sick. I had a skin condition. Then I came here. I don't know how I got the HIV virus. Perhaps I was born with it, or maybe I got it from a sharp object.

I get food and clothes from the Association for the Care of Children Orphaned by AIDS, but there are many children sick with AIDS in the country and there is no medicine.

AIDS is a great threat to young people in Burundi. If your parents die of AIDS, you are rejected by society. In my case, the lady I was living with saw blotches on my legs and began to distrust me. I hadn't even had an HIV test. Everyone agrees AIDS is the biggest problem here because there is no medicine to stop it, and when it gets into the family, it kills everyone.

If parents know they are sick, they should tell their children. And if a mother is infected, she must not pass it on to her baby. If we are aware of the virus, we can take more precautions against it.

I think girls are most at risk, because they are weak compared to boys. Boys can get by. If a girl is lacking things, a boy can offer to help – and keep offering things.

War has created many orphans, and forced many people to flee. I think war has spread AIDS. With so many widows and so much poverty, a lot of people are sleeping around. Soldiers away from home have money to pay girls for sex. And displaced people, especially those on the border, can do a lot of sex work with foreigners.

We would like to have medicines, the right ones. But we also need good quality food, clothes, shoes and school materials. We could also do with some space, as this house is small and we don't always have electricity.

People sick with AIDS need moral support. Researchers must keep working to find the cure.

The International AIDS Conference in Barcelona should think about young people here too. We need awareness raising, and we need respect for people with AIDS."

# 1. Double Emergency

Some 15 million children and young people are directly threatened by HIV/AIDS in conflict situations around the world. Young people without parents and young mothers are at particular risk of being infected. In conflicts and related emergencies, high-risk sexual behaviour, including sexual bartering and sexual violence, are contributing to the spread of HIV. In such settings, defences are weak. Awareness of HIV/AIDS is low; denial and stigma are widespread. Health services, destroyed or overwhelmed, are severely under-resourced and do not offer adequate care or effective protection against HIV/AIDS.

HIV/AIDS is expected to kill ten times more people than conflict in the decade ahead. What is often overlooked is that in the world's growing number of armed conflicts and humanitarian emergencies, HIV/AIDS is becoming a very significant threat to life. During conflicts, HIV/AIDS can create a 'double emergency' in some countries. Save the Children defines an emergency as a crisis that overwhelms the capacity of a society to cope using its resources alone. AIDS is the world's fourth biggest killer. In sub-Saharan Africa, it is now the leading cause of death, killing 2.3 million people in 2001. In 1999, warfare, homicide, violence and terrorism claimed an estimated 796,000 lives worldwide.<sup>1</sup>

HIV rates are suspected to be high in conflict and post-conflict settings but, because surveillance systems do not monitor prevalence accurately in conflict settings, it is impossible to know what the rates are and whether HIV spreads more rapidly in these areas. HIV prevalence is estimated to be high and growing rapidly in conflict countries like Angola, the DRC, Liberia and Sierra Leone, where the lack of reliable data makes assessment of epidemiological trends impossible.

Throughout North Africa and the Middle East, UNAIDS says the virus is spreading fastest in war-torn Somalia and Sudan. Cambodia, Thailand and Myanmar (Burma) also have large epidemics; all have been affected by conflicts. Nepal too, has

registered a marked increase in infection rates. In 2001 some 40 million people in the world were living with AIDS, 28 million of them in sub-Saharan Africa, where most of the world's conflicts are concentrated. Without an adequate response, the virus could take root in conflict areas and propagate unchecked.

Save the Children's findings correlate with evidence from elsewhere that war and sexual violence increase HIV risks. Many women were raped in Rwanda during the 1994 genocide, leaving an estimated 15,000 women pregnant. Of 2,000 women testing for HIV after the genocide, 80 per cent were HIV positive.<sup>2</sup> In Bosnia, 30,000-40,000 women were raped<sup>3</sup> and faced being infected, transmitting HIV to their partners and children, and then rejection from their communities. In northern Uganda, the Lord's Resistance Army (LRA) rebel forces have sexually abused thousands of girls. Soldiers in Uganda, by 1997, had a HIV prevalence rate of 27 per cent when the national adult prevalence was 9.5 per cent.<sup>4</sup> The spread of HIV in Uganda has been linked to the movement and especially the demobilisation of armed forces.<sup>5</sup>

## Combined killers

Children and young people are most at risk from HIV/AIDS. The disease threatens their rights to life, survival and development.

- Each day some 1,700 children die of AIDS, adding to the total of 3.8 million children who have already died.<sup>6</sup>
- AIDS has created an estimated 13 million orphans under the age of 15.<sup>7</sup>
- Mortality in infants will double in regions most affected by HIV.
- About 10.3 million young people live with HIV/AIDS, most of them in sub-Saharan Africa.<sup>8</sup>
- Most new infections occur in young people, especially girls and young women.<sup>9</sup>

“Everyone agrees AIDS is the biggest problem in Burundi because there is no medicine to stop it, and when it gets into the family, it kills everyone,” Geneviève, 18

Children and young people are also disproportionately affected by conflict.

- More than two million children were killed in conflicts during the last decade.
- Another 6 million are believed to have been wounded and 1 million orphaned.
- Children are killed in battle and by indirect consequences of war, like landmines or the breakdown of vital services, which can last for years after a conflict ends.<sup>10</sup>
- In recent decades, the number of civilians killed in wars has risen sharply, from 5 per cent to more than 90 per cent of the total killed.<sup>11</sup>

States recognise that “every child has the inherent right to life”, and must ensure the “survival and development” of children. Where resources are inadequate, states must seek international co-operation.

ARTICLES 6 AND 4, UNCRC

“War is very bad, but I believe that AIDS is worse than war for young Burundians. AIDS kills many people, more than war.” Gaétan, 17

Together, HIV/AIDS and conflict are now combining to pose an even more deadly menace. In Burundi, for example, up to 13 per cent of young women and 8 per cent of young men are believed to be living with HIV. Whereas some 200,000 civilians have already died in the conflict in Burundi,<sup>12</sup> AIDS has now become a leading cause of adult and infant mortality, and has left an estimated 160,000 orphans.<sup>13</sup> Burundian life expectancy has fallen from 60 to 40 years due to HIV/AIDS. Similar patterns are found in Angola, Ethiopia, Liberia, Rwanda and Sierra Leone. These combined killers are creating

double emergencies in most conflict countries, taking a heavy toll on children and their parents, threatening their lives and futures.

“The attackers killed both my parents in the conflict... [But] I think AIDS is the most important threat to children in Burundi.” Odette, 12

## Unprotected children

Many children have lost their parents as a result of conflict, and are living without protection and assistance. In Burundi again, conflict has uprooted over 1 million people and separated many children from their families since 1993. These children live alone, with siblings or on the streets. Officially, some 6,000 children are in formal care institutions, but the number of children cared for informally or living on their own is not known. National laws do not monitor these arrangements, nor child-headed households, nor the right of children to their parents’ property. Such orphans and separated children are in great need of care, protection and assistance.

“The war has caused many Burundian children to lose their parents, leave their homes and live in the town. They somehow have to earn a living. Many young people are homeless, and do bad things like take drugs and sleep around. Others have become street kids. Young boys without work have decided to enrol in the army. Many young girls are working as prostitutes in the towns and also in the displaced camps.” Gloriose, 18

Children affected by conflict are often denied their basic rights to food, shelter, education and healthcare. Forced prematurely to take on an adult role, they drop out of school and take up work to survive. In Rwanda, of an estimated 45,000 child-headed households, 90 per cent are headed by girls.<sup>14</sup> These children are the most vulnerable to

**Clemence, 11, made homeless and orphaned by the war, must care for her sisters Chantal, 6, and Rose, 4.**

"We are originally from another province – Ruyigi. We were displaced by the war and then arrived in a site for displaced people in Gitega. My father died in the 1993 war. We had to flee, leaving our home and land behind.

At that time, our mum was very sick with AIDS. She died soon afterwards. A neighbour agreed to care for us. But she was an old lady and died several weeks later. Her son kicked us out of the house. We were homeless. We then asked a young mother to care for us, but she also kicked us out after a while. Since then – for two years – we have been sleeping rough.

When our mum died, I had to leave school to look after my younger sisters as there was no other way. I was in third grade at the time.

There are many children living like us. Some sleep in the market, or in shop doorways. Others go to villages, ask for a place to stay and try to live there. We keep asking for a place to stay. The next day we try another place.

Today we don't feel very well because we are hungry. We get some maize, but we can't afford to have it ground into flour, so we can't eat it. Before we were helped by the Society for Women and AIDS in Africa, we often went without food.

We often get sick with stomach problems, we also catch colds and have trouble breathing sometimes. We don't have clothes or blankets to keep us warm at night.

Our first worry is finding a place to live, then it's food and then it's general care and protection. It's difficult to be courageous in this situation – I often feel discouraged.

My first request to leaders here is to help find my father's property. Then we need some clothes, some food and a chance to go to school again. We don't have enough money to go to school, because we couldn't afford to pay for the books and the uniform, and we would have nothing to eat at lunch time.

We ask the rich countries for all the help they can give to children like us. Is there any way to help us immediately?"

exploitation and HIV infection.<sup>15</sup> And within foster families, foster children sometimes experience discrimination, being burdened with more household work, disciplined more harshly and unfairly blamed.

States are responsible for providing "special protection and assistance" when a child is deprived of a family environment. This can include foster placement, adoption or placement in suitable institutions for the care of children.

ARTICLE 20, UNCRC

Many more children, however, have lost their parents to HIV/AIDS. In the DRC, the African country with the largest ongoing war, some 680,000 children have lost parents to AIDS. In Ethiopia, at the end of a long war with Eritrea, the figure reached a staggering 1.2 million.<sup>16</sup> Overall, 13 million children have lost parents to AIDS worldwide; 90 per cent of them in

Africa. Of the 17 countries with over 100,000 children orphaned by AIDS, 13 are in conflict or on the brink of emergency involving conflict.<sup>17</sup>

Humanitarian agencies have reconnected many separated children with their families. More than 67,000 children have been reunited with their families in Africa's Great Lakes region since 1994. But how many of the growing numbers of orphans and poverty-stricken children in Africa will take up arms as child soldiers? Approximately 300,000 girls and boys under the age of 18 are already used as child soldiers.<sup>18</sup>

## Running out of time

If present trends continue, waiting for peace will not be an option as a response to HIV/AIDS. In the last decade, deadly armed conflicts multiplied across the world, particularly in Africa. Of the world's 150 countries, over 72 are identified as unstable.<sup>19</sup> The



number of African states involved in deadly conflicts doubled from 11 in 1989 to 22 in 2000.<sup>20</sup> In 2002, more than 33 million people are suffering the consequences in 18 emergencies around the world. In their annual appeal for funds this year, the UN humanitarian agencies included the following countries: Afghanistan, Angola, Burundi, the DRC, Eritrea, Ethiopia, Liberia, Rwanda, Sierra Leone, Somalia, Tanzania and Uganda. In each of these, half of the population is under 18.<sup>21</sup> The UN High Commissioner for Refugees (UNHCR) supports 22.3 million people affected by conflict, and estimates that 10 million of these are children.<sup>22</sup> The real numbers of children affected by conflict in the world is surely far higher. As UNHCR recognises, there are some 50 million uprooted and internally displaced people in the world. Around half of them are children.

HIV/AIDS spread by conflicts is not just a health problem, and cannot be controlled by a humanitarian response alone. HIV/AIDS is a serious threat to global security, with the potential to destabilise many countries and spiral out of control. As the International Crisis Group notes, AIDS threatens all levels of security. It threatens personal security because it kills and undermines the lives of so many people.

It threatens economic security because it eats into a nation's workforce and production. If 10 per cent of adults are infected, says the World Bank, national income growth can shrink by a third. It threatens communal security because it disables the police, civil servants, teachers and healthcare professionals. It threatens national security because military forces are weakened by infection. And it threatens international security because such problems never stay inside national boundaries. Indeed, the United States National Intelligence Council has recognised HIV/AIDS as a security threat to US public health; as well as to US troops and peace-keeping operations, to states where the US has significant interests, and for its overall destabilising impact on African societies.

The threat of HIV/AIDS to millions of people, especially young people, in conflict areas must be acknowledged by the international community as a double emergency and a widespread violation of children's fundamental rights to life, protection and assistance. Any international response should be based on children's rights, an understanding of the epidemiology and also of the very real threats posed to community, national and international security.



*In Burundi, 80 per cent of hospital beds are occupied by AIDS patients, but many families cannot afford the bill for regular hospitalisation.*

## 2. War Spreads HIV

A growing body of evidence links wars and mass displacement to the spread of HIV/AIDS. In war and related emergencies, the epidemic is fuelled by sexual bartering – mainly rooted in poverty and powerlessness, sexual violence and exploitation, low awareness about HIV, and the breakdown of services in health and education services. These are not the only determinants of HIV transmission in conflict, but they are important dynamics that must be addressed in any response. Although much of the evidence for this comes from refugee and displaced camps, it is worth noting that up to 75 per cent of Africa's refugees settle themselves in cities and with host communities.

### Sex for survival

Sexual bartering, rooted in food insecurity, poverty, powerlessness and displacement, is a widespread phenomenon in conflicts, post-conflict and refugee settings, and increases the risk of HIV/AIDS transmission. The law in conflict-affected countries often fails to protect children, particularly girls and young women, from having to use sex to obtain basic goods and services.

*“Many young girls displaced by the war are forced to sell themselves to survive. They don't say they have HIV because this would stop them from working.”* Gorette, 18, Burundi

Most refugees leave home with very few possessions, so food, shelter, water, medicines, money and protection often assume critical importance; many women and adolescent girls resort to sexual bartering to meet these needs. Chronic poverty and food insecurity can also increase vulnerability to infection. The stress, malnutrition and new pathogenic environment of refugee camps appear to weaken the immune system in individuals and speed the development of AIDS in those who are HIV positive.

In some camp settings, such as the Jhapa camp for Bhutanese refugees in Nepal, women and girls go

outside the camp to exchange sex for income with men in the local population. In these situations, condoms are rarely available, and women and young girls often lack the power to negotiate safe sex. HIV/AIDS prevention and care services are either non-existent or inaccessible.

In refugee camps in West Africa, sex is widely used as a trading commodity.<sup>1</sup> Girls in camps can use their bodies to access food, clothing and educational support for themselves, their parents and their siblings. The lack of basic items essential for survival, including food, is frequently cited as the reason for entering exploitative relationships. Some parents reported feeling that the exploitation of their daughters was the only way to make ends meet. Sexual bartering is compounded by the lack of alternative options.

Sierra Leonean girls in one camp described how they preferred having sex with older men who were able to offer financial support and food.<sup>2</sup> Typically in such transactions, payment is made in kind – with a few biscuits, a bar of soap, a plastic sheet, clothes, shoes, books or pencils. Girls have very little control over the ‘exchange rate’ or money they receive. They have little negotiating power over the use of condoms and were rarely found to use them; it appears that the offer of money can easily override the intention to practise safe sex.

States shall take measures to prevent “the inducement or coercion of a child to engage in any unlawful sexual activity” and “the exploitative use of children in prostitution or other unlawful sexual practices”. ARTICLE 34, UNCRC

States recognise the right of every child to a standard of living adequate for the child's physical, mental, spiritual, moral and social development. ARTICLE 27, UNCRC

States must also ensure that refugee children “receive appropriate protection and humanitarian assistance”. ARTICLE 22, UNCRC

**Goretti, 18, asks for medicines, food and income-generating activities for young girls**

"I'm not well, I don't have a good life... I left school because I lost my father and had no money. I had a baby at 16. I don't have a place to live, so I can't look after my child. I am HIV positive. My boyfriend has died of AIDS. My baby is two years old. He has not been tested yet.

I come from Nyabikere. I was displaced by the war, and fled with my mother. My boyfriend was a government official – I was with him for a year. We lived together but we didn't get married. When I heard about the Society for Women and AIDS in Africa, I went to get a test to find out if I was infected. In June 2001, I found that I had the virus.

In this area, many girls and young women are in the same situation. Mothers often don't dare to go for a test. Many young girls are forced to sell themselves to survive. We had no choice. Many girls sell themselves as prostitutes and sleep around, but do not say they have HIV because this would stop them from working or selling themselves. The girls go into bars and clubs and pick up men – truck drivers, soldiers, housekeepers – anyone with money. The girls who do this are 14 years old and over, mainly poor girls and girls displaced by the war. It is consensual. We are not taken by force. The war has definitely increased this sexual bartering.

To prevent the spread of HIV, girls should have a source of income. This way, we'd have money to live

and care for our children. I would prefer to trade vegetables, rice, beans, tomatoes and oil – instead of doing the bars and clubs. But to be able to trade, I need a place to live and some money. If I had money and a home, I wouldn't sell myself anymore, I'd live with my child.

I have heard about medicines that can cure HIV/AIDS. But these are only for the high officials. I wonder if poor people could have these drugs too?

My message to the International AIDS Conference is that many young girls in Burundi are infected by HIV, and many more are getting infected. Most are orphans or displaced people who have no housing, nothing to eat and nothing to do. They are forced to become infected to survive.

So I ask for medicines so we can live for a bit longer. We also need things like food and medicine; income-generating activities for young girls, especially. And if the conference responds, when will the medicines arrive? When will we be able to stop selling ourselves? When will we get out of this poverty?

I believe the biggest problem facing Burundi is AIDS, followed by poverty and war. HIV/AIDS is the main problem, and war is the cause. Everybody has to deal with war, but AIDS is personal. There are ways to protect yourself against war.

Before the war, prostitution was not so widespread. But because of the war, people lost their parents, became orphans and had to find a way to survive."

In Liberia, young people recognised that their extreme poverty made them more vulnerable to HIV. At one refugee camp, children said that survival is hard for them, especially for girls, as food rations make up only about half the amount required to survive.<sup>3</sup> Sexual bartering has increased significantly since the war upset what young people called 'normal life'.<sup>4</sup> In some cases, however, young people have acquired greater financial independence through sexual bartering. Girls in state-run schools said about 30 per cent of their female classmates had sex with a teacher for grades, small amounts of money or other favours. Young people said this was

'wrongful behaviour', but recognised it as an effective survival strategy.

"Young widows in displaced sites can't watch their children die of hunger, so they sell sex to get money." Claudine, 13, Burundi

While boys enjoyed better access to labour markets, girls found making a living much more difficult, and some of them were also caring for children. Many girls drifted between relationships with men, seemingly unable to make a living through petty trade, even after skills training. Many felt they could



only make a living through commercial sex. Female-headed households in one camp were particularly vulnerable to food and livelihood insecurity, and single adolescent mothers appeared to rely on selling sex. Save the Children is planning household food security and livelihood analyses in the region to advocate for changes in food rations and for alternative livelihood options.

Widespread sexual bartering has also been documented in Burundi, where poor households are particularly at risk of HIV transmission.<sup>5</sup> Young women and poor children without social protection are the first to be constrained into sexual transactions and prostitution by the lack of alternatives.

In western Uganda, displaced people said the spread of HIV/AIDS was hastened by poverty, crowded conditions in refugee camps, lack of occupation, and the lack of reproductive health services.<sup>6</sup> In camps, girls and women exchanged sex for food and resources from the few 'seemingly rich' men. Little information on HIV/AIDS was available. Elsewhere in Uganda, returned refugees from the DRC linked the exceptionally high prevalence of HIV/AIDS (27–30 per cent of adults) to disruption caused by conflict.

In the DRC, instability has apparently led to a significant rise in the number of women working in prostitution and a lowering of their age.<sup>7</sup> In war-affected parts of Sudan too, studies showed that 27 per cent of single mothers became sex workers to earn a living.<sup>8</sup> In Colombia, HIV prevalence has grown amid an upsurge in fighting in the last decade and large-scale population displacements.

Similar situations occur in conflict and emergency situations around the world, increasing the risk of HIV transmission for young women especially. This is particularly the case when HIV prevention and care is absent. Young people should not have to exchange sex for basic survival items.

## Violence breeds violence

"One day I arrived home from school and found my mother had been killed. I ran to my friends and some of their mothers had also been killed. We fled into the forest; there were ten of us. We were stopped by some soldiers and they raped us all. Seven of us were virgins and had never known a man." Fatou, 16, Liberian IDP

Brutality and disrespect for dignity characterise most conflicts, and can serve to 'normalise' sexual violence against women and girls, who become more vulnerable to rape and sexual exploitation. Condoms are not likely to be used, which increases the risk of HIV infection and transmission.

In Sierra Leone, Save the Children found that girls were infected with HIV after being raped by rebels terrorising civilians. The displacement and transit of internally displaced people (IDPs) and refugees left many girls vulnerable to rape and sexual exploitation. In Liberia, also, many girls and young women reported being raped in transit to an IDP camp, and receiving no medical help. In the camps, girls and young women still feel vulnerable at night because men had tried to rape them. Sierra Leonean refugee girls described similar worries about refugee camp layout increasing their vulnerability to rape when using the latrines.<sup>9</sup>

Rape by soldiers is systematic in some conflict-affected countries like the DRC, where 60 per cent of the armed forces are estimated to be HIV positive.<sup>10</sup> Elsewhere in Africa, there is anecdotal evidence that boys are also targeted for sexual violence, possibly much more than previously recognised because of associated taboos. Shame and stigma surround all experiences of sexual violence, so many children and their families keep quiet. In Colombia, Save the Children has found that child soldiers are especially vulnerable to HIV, either through sexual violence by older officers or through peer pressure that encourages risk-taking behaviour.<sup>11</sup>

In Liberia,<sup>12</sup> young people reported a sharp rise in violence as a result of the war, including domestic and sexual violence affecting children. Young people said some men were raping very young girls after getting used to committing such acts during the conflict. Widespread sexual atrocities during wars in Sierra Leone and Liberia, left unpunished, have eroded social attitudes and controls. Girls are most affected by acts of sexual violence, although most incidents still go unreported. The majority of girls affected were reportedly between the ages of three months and 11 years.<sup>13</sup>

“It was not so bad before the war. It got very bad during the war and while fleeing. It is not so bad now in the camps or community. Rape was occurring before the war but not as rampant as it is since the war.” Felicity, Sierra Leonean refugee, West Africa

Sexual abuse of children is also a serious problem in the conflict-affected Anuradhapura district of Sri Lanka.<sup>14</sup> Incest is rife in families where mothers have migrated abroad for employment, and girls who drop out of school and work as child labourers are often exploited. Some of these girls continue their lives as sex workers; others have been known to attempt suicide. Save the Children is working there to empower children and help them find alternatives.

States must “protect the child from all forms of sexual exploitation and sexual abuse” and “all other forms of exploitation prejudicial to any aspects of the child’s welfare”. ARTICLE 12, UNCRC

Because of their physical and emotional vulnerability, children in conflict situations are particularly at risk of sexual exploitation. Especially vulnerable are girls from single-parent households, separated or unaccompanied children and single mothers. West African refugees in Liberia, Guinea and Sierra Leone reported very extensive sexual

exploitation of refugee children.<sup>15</sup> The most vulnerable are very young girls made to have sex with older men. Most are between 13-18, with the youngest reported case being five years old. Physically immature bodies, poverty, lack of negotiating power, unsafe sex, and disbelief about HIV/AIDS are factors that greatly increase the risk of HIV infection. There are also high rates of teenage pregnancies, abortions, maternal morbidity, infant mortality and sexual infections.

“Things have changed since the war. Before the war, men would not take advantage of young girls of 15–18 years old, it was very much forbidden. They would be punished. Women of about 40–50 also have sex with young people and give them HIV.” Gaétan, 17

Studies suggest that some staff from local and international NGOs, as well as UN agencies, sexually exploit refugee children,<sup>16</sup> often manipulating humanitarian assistance and services intended to benefit refugees. Security and military forces, including international and regional peacekeepers, national forces and police units, also contain people who abuse their power in this way. Teachers, camp leaders and other influential people, small businessmen, traders and men with jobs are also involved.

Organised prostitution is found in some camps, with pimps targeting adolescent girls. There have also been allegations of child trafficking for sexual exploitation. National laws are inadequate to protect these children when the age of consent is 14 in Sierra Leone, 16 in Liberia, and does not exist in Guinea. Even where adequate legal provisions do exist, weakened legal systems make successful prosecutions unlikely.

Widespread rape, domestic violence, and sexual exploitation of young people in conflicts and post-conflict settings are a serious violation of children’s rights, and greatly increase the risk of HIV transmission.

## Knowledge is power

The acute lack of HIV/AIDS knowledge in conflict situations increases vulnerability to infection, denies young people access to vital information and leads to discrimination. Although correct information is not sufficient for behaviour change, it is a necessary precondition. Low awareness is partly due to the fact that conflict undermines awareness raising and prevention efforts, and partly because, even where awareness is high, the daily realities of life under conflict can diminish the perceived risk of HIV infection.

In Liberia, for example, knowledge levels about HIV/AIDS are very low, and are combined with high levels of denial and stigma.<sup>17</sup> No national association exists for people living with HIV/AIDS, and access to voluntary counselling and testing (VCT) is minimal. Where testing is available, it is not accompanied by counselling. Test results are not given to patients because doctors feel they will have little treatment or support to protect them from stigma and rejection. This only contributes to fuelling denial and stigma within the country. In one survey, 60 per cent of respondents revealed that if they had a family member infected with HIV, they would isolate them for fear of stigma, fear of contagion and anxiety over the cost of care.<sup>18</sup>

In Sierra Leone, HIV knowledge is also low, especially outside urban areas, and denial is widespread. Boys living in a care centre in Daru town had not heard of HIV/AIDS, or were confused about what it is and how it is transmitted or prevented. The risk of HIV did not seem a particular concern to any of the boys, although they all said they would like to know more. Nurses working for an NGO were extremely concerned about the general low level of knowledge about HIV and sexual health among young people. Community leaders were concerned about the misinformation spread by some traditional healers and government medical staff. For instance, one medical officer said putting herbs into wounds could protect an individual from HIV.

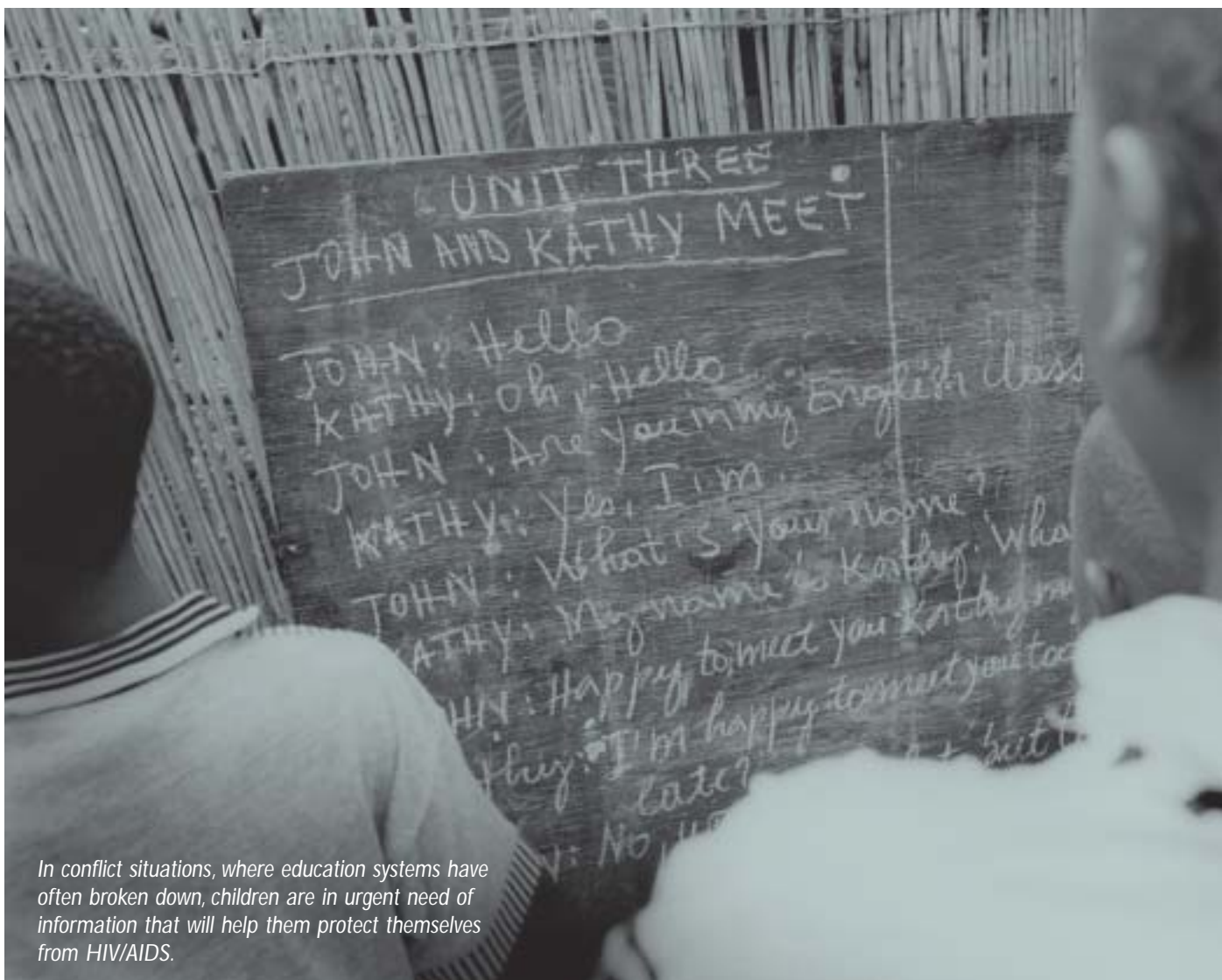
One UNICEF survey found that more than 40 per cent of adolescent girls aged 15–19 in Sierra Leone had not heard of AIDS.<sup>19</sup> And while 78 per cent of urban women knew of AIDS, 48 per cent of them did not know how to prevent infection. Just 7 per cent of boys and 6 per cent of girls were reported to know the three ways of transmitting HIV.<sup>20</sup> Among perceived risks were smoking marijuana and sharing a spoon with, or touching, an AIDS patient. According to UNICEF,<sup>21</sup> more than 70 per cent of adolescent girls (aged 15–19) in Somalia and more than 40 per cent in Guinea Bissau have also never heard of AIDS. In Angola, meanwhile, knowledge about HIV appears to be high in Luanda, but much lower in other cities.<sup>22</sup>

“We have heard that AIDS exists from the radio and magazines and that it is there in South Africa, but we have never seen a live person with AIDS. For us to believe, show us a person, bring a person with AIDS and we will believe.” Peter, Liberian refugee in Guinea

States shall ensure that the child has “access to information and material from a diversity of national and international sources”, especially those aimed at the promotion of his or her “social, spiritual and moral well-being and physical and mental health”. States shall encourage the production and dissemination of children’s books. ARTICLE 17, UNCRC

States must respect and ensure rights for each child “without discrimination of any kind”, irrespective of the child’s or parent’s race, colour, sex, language, religion, political or other opinion, national, ethnic, or social origin, property, disability, birth or other status. This means no child should be subject to discrimination on the basis of their HIV status, or any member of their family.

ARTICLE 2, UNCRC



*In conflict situations, where education systems have often broken down, children are in urgent need of information that will help them protect themselves from HIV/AIDS.*

Knowledge levels also vary between neighbouring populations. For example, people in refugee camps in West Africa appear to have higher levels of knowledge about HIV/AIDS than those in IDP camps, especially in newly established ones.<sup>23</sup> The lowest levels of knowledge are found in rural areas isolated by the conflict. This is probably due to greater humanitarian agency presence and HIV information dissemination in the refugee camps. In the IDP camps, children and adults said one could identify an HIV-positive person with signs like their skin getting dark, or if they had visible veins on

their arms. Generally, refugee girls and women had weaker knowledge in comparison to the male population. Some adults and children felt that HIV/AIDS 'prevention' could be best achieved by killing the infected person.

In the camps, condom use as a means of protecting oneself is shrouded in mythology. Even where there is a high level of knowledge, adolescents very quickly agree to discard the condom if their partner objects. Awareness raising carried out by humanitarian agencies apparently did not include



negotiating skills. These misperceptions are not restricted to conflict situations, but the absence of effective prevention outreach work means that these ideas go unchallenged.

“Children in Burundi are more scared of war than AIDS” Cyrille, 17, Burundi

Even where HIV prevention work is underway, it can easily be disrupted. Save the Children’s work to raise awareness about HIV/AIDS in Nepal’s Achham district has been hindered by fighting between Maoist rebels and government forces.<sup>24</sup> The programme had managed to reduce stigma in the whole district by enlisting hundreds of volunteers. In September 2001, some 856 people were volunteering, half of them children. Since February 2002, however, most of Achham has been under Maoist control. All NGO offices have been burned to the ground; infrastructure and government offices have been destroyed. NGO workers and volunteers are afraid to work, and the programme’s impact is under threat. As a strong community-based programme, however, with little input from outside, it is hoped that the programme will survive amid the conflict. Achhami people are determined that the programme will carry on as best it can.

States recognise the right of the child “to the enjoyment of the highest attainable standard of health” and to “facilities for the treatment of illness and rehabilitation of health”. States must strive to ensure that no child is deprived of their right of access to such healthcare services. They must also provide healthcare to all children, combat diseases and malnutrition; and ensure pre-natal and post-natal health care for mothers.

ARTICLE 24, UNCRC

“A lot of people don’t take AIDS seriously enough, although it’s destroying young people.” Gloriose, 18, Burundi

## Services breakdown

The lack of access to education and health services in conflicts and post-conflict settings increases young people’s vulnerability to HIV/AIDS. In conflicts, social services are starved of funds, which go to armies and armaments. Conflicts also weaken or completely destroy health, education and communication systems, which otherwise could respond to the HIV epidemic. This situation denies the fundamental right of young people to even basic healthcare. The continuum of HIV/AIDS care in conflict settings is limited to basic and inconsistent prevention work, usually confined to medical settings.

## Sexual and reproductive health

Importantly, war-affected populations often lack access to antenatal services and screening for HIV, syphilis and hepatitis. Prevention of mother-to-child transmission programmes would be located at antenatal clinics, but this option is unlikely in conflict areas. Governments and humanitarian agencies in many cases appear to lack the capacity to provide such services. Where sexual and reproductive health (SRH) services are available, they are not designed for children and young people, and may not offer services for prevention or care against sexually transmitted infections (STIs), including HIV.

A lack of SRH services denies basic protections against HIV and STIs. In Angola, there is little data available about STIs, although rates of untreated infection are thought to be high. In Sierra Leone, National STI Treatment Service workers in Connaught Hospital in Freetown lacked the recommended treatment for gonorrhoea and had to issue prescriptions for the treatment of choice, Ciprofloxacin, that many could not afford.<sup>25</sup> Maternal mortality figures are the worst in Africa, with 1,500 to 1,800 maternal deaths per 100,000 births. Teenage pregnancy rates are high; the national fertility rate is high at 6.7 births, and 11.2 in the refugee population.<sup>26</sup>

“I’m worried because I don’t have any money to go to the hospital to give birth. I need money to give birth in safety. I want to have a Caesarean so the baby does not get infected with HIV. And I want milk for the baby so it is not infected by me.” Regine, 28, Burundi

In Liberia, access to reproductive health services is variable and inadequate. A high incidence of pelvic inflammatory disease (PID) among young women in refugee camps and IDP sites indicates poor diagnosis and recognition of STIs. Local health workers reported the high incidence of PID but lacked appropriate or adequate antibiotics for treatment. They also reported that they had not succeeded in treating any men for STIs. In addition, there is virtually no testing for syphilis at antenatal clinics or within blood transfusion services. Despite efforts made to ensure that condoms are readily available, distribution problems often mean that access to them is denied, particularly in rural areas.

### HIV prevention work

Information work and condom distribution are important parts of any HIV/AIDS prevention campaign. In Thailand and Uganda, extensive and effective use was made of radio, television, billboards, newspapers, and community media to inform populations about HIV. But in countries embroiled in conflict, communication networks are often interrupted, electricity lines may be cut and batteries scarce. Some areas, including those under rebel control, may be completely isolated. Effective prevention depends on a holistic approach, using education and peer-based training, life skills for young people, voluntary counselling and testing (VCT), treatment of STIs, adolescent-friendly sexual and reproductive health services, empowerment of girls and women and economic development.

In emergencies, HIV prevention efforts are also complicated by a lack of testing services. VCT is an important means of assisting prevention, allowing

people living with HIV/AIDS to access care and support, and of combating stigma. In a survey of refugee settings worldwide, UNHCR found that VCT is not available in most cases.<sup>27</sup> VCT is also severely restricted in Angola, Burundi, Liberia and Sierra Leone, and probably in most conflicts and emergencies.

### HIV care and treatment

Care and treatment services for people living with HIV/AIDS are especially limited in countries undergoing conflict. In Sierra Leone, 62 per cent of peripheral health units do not function.<sup>28</sup> There is also a massive shortage of treatments for opportunistic infections and anti-retroviral drugs. Healthcare workers have received no training or information about AIDS.<sup>29</sup> As there is only one hospice in the country, most people are sent back to their families to be cared for, and there they are often rejected because of the stigma attached to the disease.

In Angola, 29 organisations currently work around HIV/AIDS; 80 per cent are involved in prevention and 20 per cent in care and support. But many appear to exist only in name.<sup>30</sup> Care and support structures work best when they are integrated into pre-existing medical services, but in countries affected by warfare, health systems, even where they existed, are often destroyed.

“We have to help people with AIDS keep up hope. It’s vital to talk with them, and have a few laughs with them” Mireille, 19, Burundi

In Burundi, where 80 per cent of hospital beds are occupied by AIDS patients, local associations have had to step in to offer support to people living with HIV/AIDS. Working with irregular funds and motivated members, they offer basic counselling, food, home visits, some drugs and work around prevention. When formal support systems are out of reach to many, informal community associations can together form a continuum of basic care.

“People here who are sick with AIDS need help, because medicines are expensive.” Cyrillic, 17, Burundi

Where services are available, the cost of healthcare denies access to poor people. In Burundi, HIV/AIDS patients can get free or subsidised medical drugs and healthcare from local associations. The average length of the sickness stage for a person with access to preventive care, ie, antibiotics on a daily basis, is two to five years.<sup>31</sup> When free health services are saturated, poor people purchase medical drugs in pharmacies or go into debt. Regular hospitalisation is not an option for poor households. The admission fee is 5,000 Burundian Francs (BIF). The average cost for two weeks of hospital care is 60,000 BIF (admission fee included). Local associations’ records show that on average, AIDS patients with access to preventive and home-care still need to be hospitalised twice a year.<sup>32</sup> Poor families can afford admission, but cannot cover 120,000 BIF a year. Widows said they went into considerable debt during their husbands’ hospitalisation and some described how they had to abandon their husband’s corpses in hospital because they could not pay the hospital bill.

The treatment and care of children living with HIV/AIDS in conflict situations, or orphaned by it, have so far been excluded from policy discussion. An adequate response must consider this growing population and integrate their concerns into existing work. Reaching these children will not be easy, but access can be through childcare centres, family-tracing programmes, home care services and eventually through VCT structures. The focus must be on active foster placements, avoiding institutionalisation, where possible.

Home care structures for chronically ill adults can be adapted to identify vulnerable children, provide psychosocial and paediatric healthcare and, in the medium term, look at succession planning, to ensure the inheritance of property and livelihood skills by children. The identification and monitoring of vulnerable households and children

can be facilitated by rapid, participatory assessments using community criteria for vulnerability, with food insecurity as a priority concern.

### Blood transfusion

In conflict-affected countries, there is an increased need for transfusions, and blood is less likely to be screened, increasing the risk of HIV transmission. District hospitals, when they exist, lack needles and gloves and have poor hygienic standards. In Angola, donated blood is not screened for HIV outside large urban centres, and even in Luanda not all blood is screened. Overall, in countries low on UNDP’s human development index, only 57 per cent of donated blood is tested for HIV.<sup>33</sup> International medical charities systematically screen blood before they transfuse, but they are not always present.

### HIV surveillance

In conflict situations, monitoring HIV prevalence and the spread of the virus is very difficult. To evaluate trends over time, the population needs to be relatively stable and the sites where monitoring takes place, consistent.<sup>34</sup> This may be achievable in some protracted refugee situations, but is unlikely in most conflict situations.

Some surveillance may be possible through second generation techniques such as population-based surveys and collection of data from secondary sources. Cluster surveys are frequently used in forced migrant populations, and can be adapted to provide valid results even in the absence of precise population sampling frames. But sometimes researchers may not travel to areas because of security concerns. In Angola, for example, there is no information regarding much of the country that has been rebel-held territory. HIV prevalence in Afghanistan also is almost unknown. To date, only ten cases of HIV/AIDS inside Afghanistan have been reported.<sup>35</sup>

## Education

Education helps protect children, but in conflict situations education systems have often been destroyed. In Angola, less than 50 per cent of school-age children are currently enrolled in school.<sup>36</sup> Access to formal education is limited. Forty-three per cent of adult women have never attended school and the total adult literacy rate is 43 per cent.<sup>37</sup> In the DRC, 2.5 million children of school-going age are not learning to read or write.<sup>38</sup> In Colombia, 85 per cent of IDP children do not receive primary education.<sup>39</sup> In conflict countries, school buildings, like teachers and children, are targeted. During the Mozambique conflict in the 1980s-90s, for instance, 45 per cent of schools were destroyed.

Young people have the right to knowledge and skills that reduce their vulnerability to HIV/AIDS. Programmes that respect and involve young people – both in their planning and implementation – are more likely to succeed.

Sexual bartering rooted in poverty and powerlessness, sexual violence and exploitation, low awareness about HIV/AIDS, and the breakdown of vital state services increase the spread of HIV in conflicts and related emergencies. Each of these HIV risks corresponds to denied rights under the UN Convention on the Rights of the Child. Any adequate response to HIV/AIDS in these settings must take appropriate measures to jointly fulfil children's rights and to combat HIV/AIDS.

### Eric, 18, says war has spread HIV in Burundi

"AIDS and war are both threats to young people in Burundi. War means people are displaced and we can't get on with our normal activities. Conditions are bad in displaced sites, and there are many orphans.

Without a chance to improve their lives, girls ask boys for things – like money and clothes. Girls want a better life. Even if boys have AIDS, the girls go after them because they want something.

Abstinence is easier in rich countries. In times of crisis and war, things get worse and life becomes very hard. Girls, in particular, have nothing, so they use sex to get basic things to improve their lives.

Everybody can be attacked by AIDS if they do not protect themselves. Most of the boys I know use condoms. But young people, especially girls, are most at risk. The youngest are believed not to be infected.

AIDS has no medicine, but war can always be resolved by talking. So the solution is firstly to stop the war.

War is causing the disease to spread. So we have to get people together and ask them to talk and make peace.

Also young people need occupations. After they finish school, there are no jobs for them. So what do they do? They turn to banditry and sexual bartering.

Without war, we could fight AIDS properly. It would mean no sexual bartering and young people could get on with their lives. Poverty would be reduced. Young people would take in AIDS prevention messages.

The worst thing for people sick with AIDS is being abandoned. We have to help them, both materially and emotionally.

My message to the International AIDS Conference is first, we must at all costs find a way to stop war. Secondly, we must make sure young people can go to school where they can learn about AIDS. Thirdly, leaders should help Burundi and other countries to develop. If we develop, there will be industry and young people can get jobs."



## 3. So Far, So Little

Responses to the HIV/AIDS epidemic in conflict-affected countries have been inadequate to reduce HIV rates so far. National governments in conflict-affected countries will need to upgrade their responses to HIV/AIDS if they are to meet their UN commitments. Most often, this will require supporting local efforts to provide a full range of HIV prevention and care services to tackle the epidemic amid conflict. Major international donors must support these efforts, with sufficient and sustained funding, backed by political commitment equal to the task. The richest nations have a duty to help poor nations meet UNGASS targets to fight HIV/AIDS, uphold children's rights and strengthen security.

### Government obligations

States shall undertake all appropriate legislative, administrative, and other measures for the implementation of the rights recognised in the present Convention. States shall undertake such measures to the maximum extent of their available resources and, where needed, within the framework of international co-operation.

ARTICLE 4, UNCRIC

### Conflict-affected countries lag on HIV/AIDS

Governments in most conflict-affected countries are not responding adequately to the threat of HIV/AIDS, due to a lack of commitment and capacity. Distracted by warfare and humanitarian needs, states in conflict are making slow progress in implementing plans to fight HIV/AIDS. The threat of HIV/AIDS is widely underestimated in conflict-affected countries, and insufficient national resources are directed at tackling the problem to mount an adequate response. Good quality sexual health education can help protect sexually active young people from HIV, but this remains a distant prospect in war-affected countries.

Sierra Leone is at a critical stage in its response to the growing HIV/AIDS problem. The Government has yet to produce a national strategic response to HIV/AIDS, although work has been in progress. As a result, national NGOs have taken the lead in developing HIV/AIDS programmes. But, lacking funding, they have no plans to expand into newly disarmed rebel areas. Funding is urgently needed for HIV/AIDS education, counselling, condoms, and healthcare throughout the country. In Liberia, there is a committed National AIDS Control Programme, but it is severely constrained by the lack of any real government support and totally inadequate funding.

In Burundi, funding is also a major obstacle. The National AIDS Control Programme has been unable at times to provide condoms due to a lack of donor support, and prevention and assistance efforts are currently run by local associations with inconsistent support from a range of community and national structures, international organisations, and faith-based groups. To date these efforts have been insufficient to deal with the country's large and complex HIV epidemic.

In Angola, the national response is beset by a lack of funds and confusion. The Government has prepared a situation analysis and a National HIV Strategic Plan; but implementation of the Plan's recommendations has been slow, causing frustration among partner organisations. The overall response to date has been mainly ineffective, unco-ordinated and lacking in commitment.

These countries are falling behind their African neighbours in their commitments to fight HIV/AIDS. Thirty-one African countries now have national HIV/AIDS strategic plans. Regional initiatives are also under way in the Great Lakes and West Africa for refugees and migrants. At an African Unity summit in April 2001, states agreed to devote at least 15 per cent of annual budgets to improving health sectors and fighting HIV/AIDS. Responses in conflict-affected countries remain weak and underfunded.

Elsewhere, positive outcomes have already been achieved: for example HIV infection rates are dropping among young people in urban areas of Zambia and in Uganda.<sup>1</sup> Botswana has become the first country to provide anti-retroviral drugs through its public health system. Senegal has also succeeded in sustaining low infection rates through extensive education and prevention programmes, providing care and support, legalising prostitution and mobilising national political leadership.

### International commitments

Without a greatly enhanced response and funding, conflict-affected countries will not meet their UN commitments on HIV/AIDS. In June 2001, the UN General Assembly Special Session (UNGASS) on HIV/AIDS made a Declaration of Commitment to increase their efforts to respond to the global pandemic. Governments pledged to take action on prevention, care and support and treatment, and to assist children infected and affected by HIV/AIDS. They also committed themselves to implementing national strategies with HIV/AIDS awareness, prevention, care and treatment elements in their responses to emergency situations. The Declaration also urges UN agencies, peacekeepers and NGOs to incorporate HIV/AIDS training for their staff; and recognises that populations destabilised by armed conflict, humanitarian emergencies and natural disasters are at increased risk of exposure to HIV. This high level of commitment is certainly welcome, but the reality of the response is still far from the rhetoric.

### Inadequate financing

Despite political commitments to fight HIV/AIDS, international financing remains grossly inadequate. Resources are being mobilised through the Global Fund to Fight AIDS, Tuberculosis and Malaria, which was set up in late 2001. But the UN Secretary General's call for a total contribution of \$7–10 billion per year has fallen mainly on deaf ears, with only \$1.8 billion pledged by May 2002.

The projected figure would have to be increased to as much as US\$30–40 billion per year to provide a basic package of primary healthcare services, which is crucial to effectively respond to HIV/AIDS.

Under the current system of ad hoc voluntary donations, no donor country has yet given to the Fund at a level appropriate to its wealth.<sup>2</sup>

Contributions from the private sector have also been disappointing, with no significant pledge since the Bill & Melinda Gates Foundation offered \$100 million. The system is failing. To have an impact on the global epidemic, sufficient and sustained global resources need to be mobilised.

International financing to fight HIV/AIDS is almost entirely absent from countries most affected by conflicts. The first round of disbursements from the Fund in early 2002 has largely by-passed conflict-affected countries. Only Burundi and Rwanda are to receive \$8.6 and \$14.6 million respectively for HIV/AIDS prevention and care work. Cambodia will receive \$15.9 million. Ethiopia, Sri Lanka, Tanzania and Thailand will receive funding for malaria and TB programmes. The funding patterns suggest a preference for developed health systems, and reticence about funding countries affected by conflict. Priority must be given to countries affected by conflict in order to support them in applying for funds and in subsequent disbursements.

### Security threat to civilians

While the UN recognises HIV/AIDS as a 'security' threat, most emphasis has been on the threat to military forces. Too little attention is being paid to the threat HIV/AIDS poses to 'human security', civilians and especially children. In January 2000, when the UN Security Council discussed the HIV/AIDS pandemic, it was the first time a 'health issue' was placed squarely on the international security agenda. The Council, in July 2000, adopted resolution 1308 to strengthen HIV/AIDS education for peacekeepers through the UN. In the United States, both the Bush and Clinton administrations have identified the AIDS epidemic as a national

security concern with the potential to threaten US interests abroad.<sup>3</sup> At the UN Secretariat, the UNAIDS Initiative on HIV/AIDS and Security is building capacities internationally and addressing the epidemic as a concern for national security, including national uniformed services such as armed forces and civil defence forces. It is also looking at community security, including vulnerable populations affected by conflict; and international security, including international peacekeepers and humanitarian workers. Lacking in this framework is a body with a mandate to promote and monitor UN commitments on children and HIV in armed conflicts.

### The challenge to donors

Governments and private donors can and must make adequate financial contributions to reverse the spread of HIV/AIDS in conflict countries. In so doing, they will be defending the rights of children and strengthening international security. But donor track records in the countries concerned give little cause for optimism. 'Silent emergencies',<sup>4</sup> so called because of international indifference from donors,

media and even humanitarian agencies themselves, continue to unfold across the world. The UN is trying to respond to 'complex emergencies' in 19 countries and regions in 2002, but donor funding remains weak and unequal. Humanitarian agencies have appealed for \$3.6 billion to respond to HIV/AIDS in emergencies, but only \$1.2 billion has been pledged.<sup>5</sup>

This appears to be part of a trend. Between 1994 and 1999, the UN requested \$13.5 billion in emergency relief funding, but received less than \$9 billion.<sup>6</sup> Donors provided the equivalent of \$0.59 per person per day for 3.5 million people in Kosovo and Southeastern Europe in 1999, compared with \$0.13 for 12 million Africans. In the last decade, humanitarian aid from the world's wealthiest countries dropped from 0.03 per cent to 0.022 per cent of GNP, and only five of the world's main 22 donors reached the UN target for aid spending of 0.7 per cent in 1999. Aid was 12 per cent lower in real terms than it was in 1992.<sup>7</sup> Sufficient and sustained financial commitments, backed by real political engagement, are needed to tackle this double emergency, and the threat it poses.

## UN Declaration of Commitment on HIV/AIDS

### UN pledges for 2003

- To develop national strategies to strengthen healthcare systems and address factors affecting the provision of HIV-related drugs
- To urgently make every effort to provide the highest attainable standard of treatment for HIV/AIDS, including anti-retroviral therapy in a careful and monitored manner to reduce the risk of developing resistance
- To develop and, by 2005, implement national strategies to provide a supportive environment for orphans and children infected and affected by HIV/AIDS
- To have in place strategies that begin to address the factors that make individuals particularly vulnerable to HIV infection including

poverty, lack of empowerment of women, lack of education, social exclusion, illiteracy, discrimination, lack of information for self-protection, and all types of sexual exploitation

- To develop multi-sectoral strategies to address the impact of the HIV/AIDS epidemic at the individual, family, community and national levels

### UN pledges for 2005

- To reduce HIV infection among 15–24-year-olds by 25 per cent in the most affected countries and, globally, by 2010
- To reduce the proportion of infants infected with HIV by 20 per cent, and by 50 per cent by 2010

## Humanitarian neglect

Although governments have the prime responsibility to respond to HIV/AIDS, humanitarian agencies operating in most conflict settings are also failing to respond adequately to the problem. Experience to date clearly demonstrates their inability to cope with the growing incidence of HIV/AIDS and its effects on conflict-affected populations, especially children and women. While humanitarian programmes aim to protect children and save lives, the reverse may be true when basic HIV/AIDS services are not integrated into their operations.

### HIV/AIDS a low priority

Despite improved public health responses in complex emergencies, humanitarian agencies are neglecting their responsibility to provide refugees and displaced people with systematic access to HIV and STI prevention and treatment services. For refugees and displaced people, HIV vulnerability is strongly determined by the policies and practices of those wielding power over their lives. This includes humanitarian agencies and their staff. HIV/AIDS remains a low priority in most emergencies as agencies struggle to provide for basic needs.

Throughout Liberia, Guinea and Sierra Leone, for example, despite the presence of dozens of international agencies, STI/HIV services are very limited for over one million refugees and IDPs. VCT services, surveillance information and prevention of mother-to-child transmission are absent. National medical facilities are relied upon, despite their limited capacity for HIV testing. Despite high pregnancy rates among teenagers, girls are not offered testing for HIV; neither are they offered anti-retroviral drugs during pregnancy to reduce mother-to-child transmission. As of mid-2002, there is no data on prevalence rates of HIV among refugees and IDPs in the region; which in itself may contribute to the low priority that STI/HIV prevention programmes have received.

In all actions concerning children, whether undertaken by public or private social welfare institutions, courts of law or legislative bodies, the best interests of the child shall be a primary consideration. ARTICLE 3, UNCRC

### Guidelines, but no action

Humanitarian agency efforts have largely focused on preparing guidelines for HIV/AIDS interventions in conflicts and emergencies. Their impact has yet to be felt on the ground. Guidelines have been produced with insufficient attention to ensuring their implementation. Among these efforts are the *Guidelines for HIV Interventions in Emergency Settings*<sup>8</sup> produced by UNAIDS, UNHCR and the World Health Organization, which set out the five stages for intervention during an emergency, namely: the destabilising event; the loss of essential services; restoration of essential services; relative stability; and return to normality. WHO, UNFPA, and UNHCR have also produced a field manual on reproductive health in refugee situations. WHO, in April 2000, produced guidelines on controlling HIV/AIDS in complex emergencies in Africa<sup>9</sup> for the UN's Inter Agency Standing Committee on Humanitarian Affairs.

NGOs have also produced guidelines. The International Rescue Committee is preparing a guide to HIV work in refugee situations, the Sphere Project, (an alliance of European and American humanitarian agencies focusing on conduct and standards in disaster responses) is revising its guidelines, and Médecins Sans Frontières have produced a guide on clinical AIDS care in resource-poor settings.<sup>10</sup> Despite all these efforts, action on the ground has been minimal to date.

In many cases, humanitarian staff lack the capacity and confidence to implement the available guidelines on HIV/AIDS, and interventions are seen as a longer-term development or a clinical health question beyond their mandate. HIV/AIDS is rarely recognised as a possible symptom of the



emergency itself. Generally, NGOs have approached HIV/AIDS as a health risk to staff, or purely as an operational challenge, to be seen in biomedical terms only.

### Too little, too late

Where HIV/AIDS programmes have been implemented by humanitarian agencies, they have been inadequate in scale to tackle the problem. Such approaches are limited, and tend to emphasise the immediate aspects of vulnerability and transmission, without adequately tackling the underlying social and economic causal factors that spread HIV in emergencies. These responses allow the virus to move unchecked among high-risk populations, including large numbers of children and young people. Agencies need to consider HIV risks in conflicts and emergencies, and to reform existing practices within all their work, regardless of whether they have a specific HIV-focused programme.

Early intervention, in the initial stages of an emergency, is critical. This is the main lesson for humanitarian agencies from the experience of hundreds of thousands of Rwandan refugees in Tanzania from 1994-96. At the time, HIV/AIDS work was not a priority, although prevalence was high in Rwanda and among local Tanzanians. Many refugee women also sold sex outside the camps, men visited local sex workers and refugee girls were raped when collecting firewood. Humanitarian responses, when they came, were late and narrowly focused. Virtually no agencies had integrated HIV/AIDS into need assessments before developing interventions, and few acknowledged the importance of sexual violence and other gender dynamics.

### Lack of co-ordination

Despite increased action on HIV/AIDS in emergencies, co-ordination at all levels is still lacking among humanitarian agencies. Current efforts tend to be restricted to headquarters, at the expense of improved field level interaction. A multitude of actors means that no single agency has

overall responsibility for HIV/AIDS in conflicts, and therefore no clear international leadership yet exists to ensure results on the ground.

In March 2002, a formal Inter-Agency Standing Committee Reference Group was created with 14 agencies, mainly from the UN, to address HIV/AIDS in emergencies. The group will finalise the revised UNAIDS/UNHCR/WHO Guidelines and a minimum package for HIV/AIDS intervention in conflict and post-conflict phases. It has also pledged to strengthen field co-ordination, links with NGOs, and to bring HIV/AIDS needs into the UN Consolidated Appeals Process (CAP). The Reference Group has been working informally, chaired by WHO, since February 2000.

UNHCR, collaborating with UNAIDS, has also developed a Strategic Plan on HIV/AIDS for 2002-2004, which is to become operational in the context of the Mano River Union Initiative on HIV/AIDS and in the Great Lakes region. WHO has opened an HIV/AIDS department, and supports the UN group working on HIV/AIDS in conflicts.

Agencies also agreed to integrate HIV/AIDS into programmes for children in armed conflict and to include child-specific recommendations in the updated UNAIDS/UNHCR/WHO guidelines. Each agency would develop a list of commitments and improve data collection on HIV/AIDS and children in conflicts. Humanitarian staff capacity would be strengthened on HIV, and UNAIDS plan to send advisers to country programmes in conflict-affected countries.

While such co-ordination efforts are welcome, the ideal of integrated, multi-agency initiatives addressing HIV at country level remains a distant prospect.

### Young people – the problem and the solution

Young people, although most vulnerable to HIV, are often neglected in existing responses. Although

UNHCR<sup>11</sup> recognises that women, adolescent girls and young people are vulnerable groups at high risk of infection, and require special attention, it plans no specific care options for young people living with or affected by HIV/AIDS.

States shall assure to the child capable of forming her or his own views the right to express those views freely in all matters affecting the child, the views of the child being given due weight in accordance with the age and maturity of the child. The child shall in particular be provided the opportunity to be heard in any judicial and administrative proceedings affecting the child.

ARTICLE 3, UNCRC

No youth-specific prevention programmes are available for millions of refugees in Burundi, Congo, Central African Republic, the DRC, Gambia, Nepal, Somalia and for most refugees in Guinea. Some activities, often minimal, are under way in Croatia, Eritrea, Ethiopia, Kenya, Rwanda, Sudan, Tanzania, Uganda and throughout Central Asia, North Africa and the Middle East. Youth-specific actions for refugees are only well-developed in Ghana. The Plan, while wide-ranging, lacks a necessary focus on young people and is unlikely to meet the needs of adolescent girls.

Young people are most vulnerable to HIV in conflicts, but solutions must begin with strengthening their skills and defences. Aid agencies, in particular, must support young people who are parents or heads of households after losing their parents. While involving young people is not always easy, they must always be involved in assessing the situation. A number of agencies have successfully

developed child-centred responses by training adolescents to work as peer educators; involving young people in sexual and reproductive health screening; working with young people as community monitors on sexual violence and exploitation, and as community-based condom distributors.

### Save the Children's role

Save the Children is working to share its experience with donors and partners to build effective, proportional and timely rights-based responses to HIV/AIDS in conflict-affected countries. Its programmes aim to involve children at all stages of project design, implementation, monitoring and evaluation. The organisation continues to build on its worldwide experience, including increasing access to youth-friendly reproductive health services and work to tackle gender violence and sexual abuse, especially with displaced people and war-affected children.

Through HIV/AIDS pilot programmes, including those in Angola, Sierra Leone, Liberia and Burundi, Save the Children is strengthening co-ordination, training staff, supporting prevention and care activities and monitoring impacts to strengthen operations. In Burundi, this work includes protecting the rights of orphaned and vulnerable children, and advising carers, local authorities and ministries on how to respond to the crisis.

Globally, Save the Children is integrating HIV/AIDS programmes into existing activities for children in armed conflict situations, and strengthening staff capacity to respond to HIV/AIDS in conflict and post-conflict situations.

**Gloriose, 18, and brothers Gaétan and Alphonse, both 17, ask for drugs and treatment that will help their younger sister**

**Gaétan** “The first problem is that we have no parents and life is very difficult for us. Our father died in 1995; and our mother died in 1998. Our youngest sister died in 2001. She and the second youngest sister were infected with HIV. We live like children without parents. We all go to school, and we get food and other help for now from a local organisation, the National Association for People with HIV/AIDS. We also receive from support from our uncle who lives in Bubanza.

Before the war, we lived in Kinama, a mainly Hutu area. When the conflict broke out in October 1993, after the death of President Melchior Ndadaye, we took refuge in another area before moving here to Mutakura. We saw bullets flying, and there was a lot of shooting. People were being killed because of their ethnic group. We were very scared. All of us fled with our mother. My dad was sick in hospital at the time. Many other children in Burundi have had similar experiences. War is very bad, but I believe that AIDS is worse than war for us. AIDS kills many people, more than war.

Behaviour has changed since the war. Before the war men would not exploit young girls of 15-18 years old; it was very much forbidden. They would have been punished. Women of about 40-50 also have sex now with young boys and give them HIV.

I ask rich countries to send us some medicines for AIDS at a price we can afford to pay. As it is, many AIDS patients are sick in hospital. If they cannot pay the hospital fee (about \$500 a month), they are detained in hospital until they do.”

**Gloriose** “The war has caused many children to lose their parents, leave their homes and live in the town. They somehow have to earn a living. Many young people are homeless, and doing bad things like taking drugs and prostitution. Others have become street kids. Young boys without work have also enrolled in the army. Many young girls are working as prostitutes in the towns and also in the displaced camps. Many soldiers have roots in the country, and several girlfriends.

The worst problem is sexual promiscuity and infidelity. And a lot of people don't take AIDS seriously enough, although it's decimating young people. We have to look at behaviour. Another change that came with war was the arrival of foreign armies [as peacekeepers] like the South Africans and West Africans before them in 1993. The peacekeepers pressed young girls into prostitution, which they did to earn some money.

Not enough is being done to tackle the problems of AIDS and conflict. Young people have many problems – no parents, no one to care for them in their daily lives. If we had more support, things would be a lot better.

For example, the organisation that has cared for us now doesn't work anymore. They paid for our school fees, and helped with rent. We don't know what we will do now that they have stopped helping us.

Rich countries, if they are creating conflict in poor countries and causing people to kill each other, should please stop. They should stop manufacturing weapons. Instead, they should intervene to disarm the armed groups. Rich countries should support public work so people can get jobs, and help raise the standard of living.

The International AIDS Conference should help AIDS patients (like my little sister) to get treatment. AIDS widows and orphans must get help so they can survive.”

**Alphonse** “Many young girls of 15 and over prostitute themselves in displaced camps. Some girls go around sleeping with older men and bosses. These men tell the girls they will give them a little present or something to eat in exchange for sex. Instead, they infect the girls with HIV. They are often the same men who tell people to stop spreading AIDS; but they are also the first to spread it with young girls. Even in hospital, people could find themselves maliciously infected by a nurse from another ethnic group.

Another problem is ignorance. We were put in quarantine and excluded after our mother died. Everybody looked at us as if we were dogs, or somehow damned. People blamed us when our mother died, whispering that our family had brought it on with dishonesty and infidelity. People were afraid to approach us and offer us even a little help. Perhaps they thought they couldn't give us all the help we ►

needed, when they found out that two of our sisters were sick.

Before the war, 'police mineur' would stop young people going out too late. But now they are the very ones who exploit young people. I heard about one man who went to a nightclub and, to his surprise, met his own daughter selling herself.

The war has caused so many women to become widows. Those who sell sex say things like: "I'm happy now, I don't have to look for men; they just come to me." Some are now demanding that their rights be respected and organising themselves into associations.

Some organisations don't realise that children affected by HIV need moral support, not just physical and

material help. We would like more people to be aware of what we are going through. The first thing is to put children first, and hear what they need.

Even now, I don't know what we will do next: we are telling you this, but will you help us? Sometimes we are sent home from school because we are unable to pay our school fees. Meanwhile we have a house in Kinama, where rent is low. But we cannot go there because there is ethnic hatred, and robbery is widespread. We'd like to go home. If we could, our problems would be partly resolved.

The rich countries must stop backing warring parties in Africa and supplying weapons. Instead, they should help to rebuild the countries."



*Children who have lost their parents to HIV/AIDS in conflict situations are often forced to take on adult responsibilities.*



# Recommendations

## Governments, donors and humanitarian agencies

The governments of countries affected by conflict and HIV/AIDS, along with international donors both to humanitarian causes and HIV/AIDS, and the humanitarian agencies active in these double emergencies, should:

**Declare** what they will do to protect an estimated 15 million young people directly threatened by HIV/AIDS in armed conflicts and humanitarian emergencies around the world.

**Acknowledge** that to make no response constitutes neglect, and that governments, agencies and donors have a responsibility not to contribute to the spread of HIV/AIDS, however unwittingly.

**Uphold** children's rights, as agreed under the UN Convention on the Rights of the Child, including those to:

- life, protection and assistance
- healthcare
- vital information on means of protection from HIV/AIDS
- livelihoods and food security
- freedom from sexual violence and exploitation
- participate in decisions that affect them.

**Stop** the spread of HIV in conflict situations, by funding and supporting the provision of:

- basic healthcare
- essential information
- food security
- livelihoods support measures, and by reducing sexual exploitation, as agreed in the UN Declaration of Commitment on HIV/AIDS made in June 2001 and reaffirmed in May 2002 at the UN Special Session on Children.

**Commit** their power and resources to hold their own organisations to account for actions and inaction that:

- fail to protect children and young people from HIV/AIDS or provide related care

- prevent children and young people participating in decisions about HIV prevention or related care
- fail to help children and young people to protect themselves from HIV/AIDS.

## Governments (and non-state actors)

Governments of all countries affected by conflicts, humanitarian crises and refugee situations, and rebel groups where applicable, should:

**Uphold** children's rights, as agreed under the UN Convention on the Rights of the Child and international humanitarian law, including those to:

- survival and development
- healthcare
- vital information on means of protection from HIV/AIDS
- livelihoods and food security
- freedom from sexual violence and exploitation
- participate in decisions that affect them.

**Meet** international commitments (agreed in the UN Declaration of Commitment on HIV/AIDS in June 2001 and reaffirmed in May 2002 at the UN Special Session on Children) to ensure that HIV does not cluster within their borders and populations under their control. This includes requesting international co-operation through viable proposals to the Global Fund to Fight AIDS, TB and Malaria.

**Devote** adequate resources to fighting HIV/AIDS. In the case of African governments, it was agreed at an African Unity Summit in April 2001 in Abuja that at least 15 per cent of their annual budgets should go towards fighting HIV/AIDS and strengthening healthcare.

**Ensure** young people play a central role in the development and implementation of National Strategic Frameworks to fight HIV/AIDS, developed with local associations and international partners.

## Donors

The European Union, the United States and Japan, along with all governments and private entities willing and able to disburse funds to save lives in humanitarian crises and to reduce the impact of HIV/AIDS, should:

**Increase** funding to the UN's Consolidated Inter-Agency Appeals Process so that basic services and protection can be provided to populations most affected by war.

**Give** generously to UN agencies and NGOs working effectively to safeguard human security, including those in conflicts not mentioned in the UN Consolidated Appeals Process.

**Increase** funding to the Global Fund to Fight AIDS, TB and Malaria, in order to build the capacity of conflict-affected countries to respond to the crisis. The Fund itself should consider earmarking funding for this cause to ensure that HIV does not cluster in conflict areas and thereby threaten efforts of neighbouring nations to fight HIV/AIDS.

**Encourage** the New Partnership for Africa's Development (NEPAD) to address HIV prevention in conflict situations.

The UK and France should use their political influence with the UN Security Council to ensure that partner governments respond effectively by:

- upholding the rights of children under the UN Convention on the Rights of the Child, and
- working to meet UNGASS targets to reduce HIV/AIDS worldwide.

Both governments are well-placed to offer joint political leadership to drive these concerns onto the global security agenda.

## Humanitarian agencies

All UN agencies and international NGOs active in conflict and refugee situations, coming under the

authority of the UN country representative/humanitarian co-ordinator, should make HIV/AIDS a central part of their programmes and appeals to donors. They should:

**Implement** guidelines prepared by UNAIDS/UNHCR/WHO on HIV/AIDS in conflicts by:

- building the capacity of staff in all programmes to provide timely responses to the threat of HIV/AIDS, and
- involving children and young people in preparing, implementing and evaluating programmes.

**Develop and implement** codes of conduct for all staff and personnel to protect young people from abuses and exploitation resulting from their need for food and other essential items. Codes of conduct should include training in sexual and reproductive health and HIV/AIDS, and monitoring to ensure staff are aware and competent to work to prevent HIV transmission.

**Include** HIV/AIDS in emergency assessments. HIV/AIDS must be considered as central to an emergency response to ensure that appropriate immediate HIV prevention measures are prioritised. Save the Children has developed tools on how to include HIV/AIDS in emergency assessments (see Appendix 1).

**Provide** care and support to people living with HIV/AIDS and their children, through both international and local partners, including:

- much higher standards of treatment for HIV/AIDS
- the prevention and treatment of opportunistic infections, and
- the provision of adequate diet and social support.

**Ensure** food and livelihood security, through the World Food Programme and other key relief agencies meeting essential needs of poor households. This would reduce HIV risks, especially among girls and young women, who are forced to trade sex to survive, and who are vulnerable to sexual exploitation.



*Only through providing access to education, health and recreational services, can governments, donors and humanitarian agencies reduce young people's vulnerability to HIV/AIDS.*

# Notes

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