Refugees and AIDS

UNAIDS
point of view

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Facts and Figures

- There are around 40 million refugees and other displaced people in the world today. Forced from their original homes by emergencies – a flood, earthquake or drought, or even war or civil strife – they are often living in special camps. Some refugees have remained displaced for over 20 years.
- About 75% of all refugees and displaced people are women and children.
- AIDS is often overlooked in the immediate wake of a disaster, because there seem to be more important things to do. However, it is just at this time that AIDS threatens most.
- A serious danger for the spread of the human immunodeficiency virus (HIV) lies in transfusions of HIV-infected blood. Blood transfusions are often needed in large numbers, especially in situations of war and strife and because of the poor nutritional status of women and children.
- Sexual contact can present an important risk. In an emergency, people lose their families, regular sexual partners, possessions and source of income. Family and social ties break down. Prostitution, being one way for people to earn money to exchange for food, will often become established around refugee camps. Condoms – a key means of protection during sex against HIV infection – will almost certainly be lacking.
- Refugees are highly vulnerable, above all women and children. They risk possible sexual violence, rape and trafficking.
- Where armies are involved and in contact with the refugees, the risks of infection – through forced or consensual sex – are often high. Rates of infection among the military are frequently much higher than in the general population.
- In areas where drug injecting occurred before the emergency, it is likely to continue in the camps. Sharing injecting equipment presents a high risk of HIV infection.
- Refugees interact in many ways with the local host community. The problems of refugees will become those of the hosts, and vice versa.
- Much can be done to reduce the risk of HIV infection for refugees, the host community and relief workers alike. A key measure is to test *all* blood for transfusion for HIV.
- Relief workers should always follow universal medical precautions – including use of protective clothing when in contact with blood, sharp instruments or potentially infected body fluids; the safe disposal of needles and waste materials; and the disinfecting of medical instruments.
- Condoms must be made available in sufficient quantities early in an emergency.
- Relief agencies should provide information on HIV risks and safer sex, in the appropriate languages, as early as possible.
- After the acute phase of an emergency, health services should be set up. To reduce the risk of HIV transmission, it is essential to diagnose and treat sexually transmitted diseases (STDs). An untreated STD in either partner during unprotected sex greatly multiplies the risk of HIV transmission. Care should be provided for people with HIV and AIDS. A programme to diagnose and treat tuberculosis should also be launched.
- Strenuous efforts must be made to give refugees physical protection from violence and abuse.
- The interests of the host community, and their needs for HIV/AIDS prevention and care, should be given equal attention to those of the refugees.

What is special about emergency situations and the refugees they produce?

A precarious existence

There are some 40 million people in the world today who have been forced from their homes by emergencies. They are living – usually in camps – in foreign countries, or else displaced within their own country. Some have been in this state for over 20 years. However long it has been, there will always be things about their existence that are precarious and abnormal.

An emergency's triggering event

People are typically displaced from their homes by a natural disaster, such as an earthquake, flood, drought or volcanic eruption, or else a war or violent strife of some kind. In the aftermath of this disaster immediate action is required on many fronts. People need urgent medical attention, clean water, food and shelter. If there is a war going on, they will want protection. Usually, they will try to flee the disaster and end up in refugee camps, where diseases such as cholera and dysentery will soon threaten to spread.

> "We must act quickly to protect refugees from all forms of violence, abuse and intimidation from the very outset of a humanitarian emergency. Often the conditions prevailing during humanitarian crises – war, physical insecurity, human rights abuses, and especially rape – exacerbate the spread of HIV, notably for women and young girls. Therefore, preventing the transmission of HIV and other sexually transmitted diseases should be an essential part of effective refugee protection measures and of reproductive health programmes. Remember, refugees have the same rights as we do."
>
> *Mrs S. Ogata,*
> *United Nations*
> *High Commissioner for Refugees*

Those who have fled may still be in a state of shock or physically injured. They are also likely to be desperate, frightened and hungry.

AIDS and the emergency

In the immediate wake of the disaster, AIDS will usually be the last thing on the minds of the refugees. Relief workers dealing with the disaster will also generally feel that there are more urgent things to worry about. After all, the spread of the immunodeficiency virus (HIV), which causes AIDS, is not immediately visible – and may not be visible for years.

There should, however, be great concern over the epidemic. AIDS is a major problem facing many refugee populations. In many instances AIDS was already present in the original community – Rwanda in the emergency of 1994 is an example. In such cases, social instability, poverty and vulnerability will make the spread of HIV more rapid.

Why is HIV such a critical issue for refugees?

Lack of safe blood supply

There is usually an urgent need for blood transfusions in large numbers, especially in the immediate wake of the disaster. Transfusion with HIV-infected blood is a highly efficient means of transmitting the virus. Health workers are also at risk if they do not follow recommended precautions when giving transfusions or when they come into contact with blood.

Sexual contact

Fleeing populations usually contain many unaccompanied children and many single women. Worldwide, 75% of refugees are women and children. In emergency scenarios, family and social ties tend to break down, with a loosening of traditional values. These changes usually affect sexual behaviour.

Sexual relations can present major HIV risks for refugees in the following ways.

Sexual coercion, abuse or rape

Refugees are generally in a vulnerable position; women and children are at particular risk. They may often be pressured into having sex or actually raped. While sexual coercion concerns women and children especially, it can also often affect boys and men.

Prostitution

The need for food is paramount in refugee situations, particularly in the early stages of emergencies. Exchanging sex for money to buy food and other essentials is therefore not uncommon. The practice is further fuelled by the fact that men and women refugees are frequently lacking partners. Prostitution very often becomes established in or around refugee camps. It will inevitably involve both the refugee and host communities. Both sex workers and clients are at high risk of HIV infection if the sexual behaviour practised is not safe or protected by a condom.

Children

Children in refugee camps, with little to occupy themselves, will often start to experiment with sex earlier than children in other situations. They are then likely to engage in intercourse at an earlier age than would otherwise have been the case. At the same time they will probably be ignorant at such a young age of the risks of HIV infection.

Drug injecting

If the emergency occurs in an area where drug injecting is common, then injecting may continue in the settlements of the refugees or displaced people. In the typical conditions of an emergency, it is highly likely that drug injectors will be sharing needles. Sharing needles or syringes for injecting, without the equipment being properly sterilized, carries a very high risk of transmitting HIV, where the virus is present.

Mixing of populations

Refugee camps are often great melting pots in terms of where the inhabitants originally came from. Refugees who previously lived in urban settings may be well informed about the risks of HIV and have formulated their own ideas on self-protection. On the other hand, refugees in the same camp who lived in rural areas may not have had access to the same level of HIV prevention information.

Apart from differing levels of prior awareness of HIV in the camp, there can be huge differences between different groups in rates of actual infection. People who have fled from areas where HIV was not common may be living side by side in a crowded camp with refugees from areas with much higher HIV rates. While simply living side by side with others poses no risk at all to anyone, sexual contact between different groups can quickly spread the virus among all the groups.

In these situations, those who came from areas where HIV was uncommon may thus suddenly find themselves potentially exposed

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to a much higher HIV risk. If they also had little prior knowledge of HIV risks and prevention, they may be very vulnerable to infection.

The Rwanda emergency of 1994-95 illustrates this dilemma. Some of the refugees fleeing to the camps in Zaire came from Kigali, where rates of HIV before the crisis ranged from 20%-30%. Others were from rural areas, where infection rates had been much lower, between less than 1% and 9%.

Lack of access to condoms and to health care

Amid the chaos of the acute phase of the emergency, and the deprivations that continue even later, materials for HIV prevention, including particularly condoms, are likely to be lacking. People will also lack health care services, including care for HIV and AIDS, and for sexually transmitted diseases (STDs). In unprotected sexual intercourse, an untreated STD in either partner greatly multiplies the risk of acquiring HIV.

The host community

Most refugees do not flee into a vacuum. Wherever they settle, there will nearly always be other people already living. The two groups will mix and interact, especially in the later stages of the emergency when services are being set up. With HIV issues, as with most other matters, the problems of the host community will become the problems of the refugees, and vice versa.

> “I arrived in Kigali during the Rwanda genocide in mid-1994. Huge numbers of Rwandan refugees were continuing to pour into the camps in Zaire, specifically in Goma. It was a great surprise for me to see that one of the first things many refugees did was to ask for condoms – not food, not medicine, but condoms. Within two weeks we were able to get two million condoms delivered through a collaborative WHO/ UNHCR effort.”
>
> *Monica Wernette, UNAIDS Planning Management Specialist, Refugee Focal Point*

What can be done to overcome these problems?

Something that one should definitely *not* do is mandatory testing for HIV. Unfortunately, it is sometimes carried out, where authorities fear that displaced people may infect the local population. Mandatory testing will not stop the spread of HIV infection, which is in any case already present in all populations. Instead, testing diverts resources from important prevention programmes involving education, condom distribution and the diagnosis and treatment of STDs – all of which are far more effective. In addition, testing does not identify all those infected, because of false results or because of the ''window period'', during which a person may be infected and infectious, but the antibodies to the disease have not yet developed and do not register on the test. Also, a person who tests negative may become infected any time after the test. Furthermore, mandatory testing violates people's basic rights, including their right to privacy and security.

There are various ways, though, in which the problems related to HIV/AIDS facing refugees and displaced people, the local host communities and relief workers, *can* be overcome. They include what is known as the ''minimum package'' for prevention and care of HIV/AIDS in an emergency setting – covered in the first four measures listed below. This package is relevant for the early, acute stages of the emergency, as well as for the later stages.

Ensuring a safe blood supply

This is vitally important, and at all stages of an emergency. Blood for transfusion must always be tested for HIV. However, in the acute – and often chaotic – period it is necessary to use special emergency procedures. Rapid HIV tests, which may be less accurate than more sophisticated tests but are quicker and cheaper to administer, should be used if necessary to test the blood of potential donors. Alternatively, short interviews can determine the likely suitability of donors for giving safe blood.

Provision of supplies for ''universal medical precautions''

Universal medical precautions are essential in emergencies to prevent the transmission of HIV. To follow these precautions, health workers need sufficient supplies of a range of materials, from ordinary soap to various kinds of protective clothing. Universal medical precautions are considered to include the following:

a) washing hands thoroughly with soap and water, especially after contact with wounds or body fluids;

b) using protective gloves of various types whenever there is contact with blood or potentially infected body fluids, and in disposing of materials and sharp objects;

c) using protective clothing when there is likely to be exposure to large amounts of blood;

d) safely handling and disposing of needles and other sharp instruments;

e) safely disposing of waste materials;

f) properly cleaning and disinfecting medical instruments.

Provision of condoms

However much the relief workers may be concentrating on other things, it is very important indeed – from the earliest possible moment – to make condoms available, and in sufficient quantities. Refugees from urban areas often already have a high degree of awareness of the risks of HIV in sexual behaviour and of the importance of condoms.

Provision of basic HIV/AIDS information

Information on HIV risks is also very important, and – like condoms – should be provided early in an emergency. Information should be provided in the language or languages of both the refugees and the host community. Refugees often listen to the radio, and so this is an important medium for messages on HIV and AIDS.

What can be done to overcome these problems?

Physical protection of refugees

Refugees and displaced people, and above all women and children who are the most vulnerable, must be protected from violence and abuse. The physical protection of vulnerable people is not only an important principle of human rights, but is also essential for reducing the risk of HIV infection for the refugee and host communities alike. Often, organizations such as the United Nations High Commissioner for Refugees (UNHCR) take on the responsibility of protection in and around refugee settlements.

Harm reduction where there is drug injecting

Where drug injecting is known to be taking place in refugee settlements, the response of ''harm reduction'' is called for. The idea is to acknowledge the existence of injecting, and – rather than trying to ban it, which is very rarely effective – try to make it much less of a risk for the transmission of HIV, as well as for other blood-borne diseases such as hepatitis B, hepatitis C and syphilis. Harm reduction for drug injectors involves providing either or both of two things:

- supplies of household liquid bleach, in order to sterilize needles and syringes, together with instructions on the proper method of doing so;
- a needle exchange programme, in which needles and syringes are used a single time and then exchanged for sterilized ones.

In the post-acute stages of the emergency, it is important to build on the foundations already laid earlier on and to provide as full a range of services as possible. Some of the responses here include the following.

Access to health facilities

It is vital to provide health services as soon as possible after the acute phase of an emergency. The services available to the local host community should, if necessary, be raised to the level of those being provided to the refugees or displaced people.

To reduce the risk of HIV transmission, it is essential to set up STD facilities.

Comprehensive care for people with HIV and AIDS

Comprehensive care for people with HIV-related illnesses is important, and particularly so when refugees come from an area where such illnesses have become a predominant cause of death.

Tuberculosis is one of the most frequent and lethal opportunistic infections in people with AIDS. Because the bacteria can spread through coughing or sneezing, it is also easily transmitted to people who are not HIV-positive, especially in the overcrowded conditions often found in refugee camps. A programme of tuberculosis diagnosis and cure should therefore be seriously considered in the post-acute phase.

Materials in schools, promotional campaigns and planning

In the post-acute stages of the emergency, one can introduce other things to help prevent HIV transmission – the sort of facilities that exist in stable societies. These include school materials, and promotional campaigns on AIDS in newspapers, radio and television. There will also be scope to plan things in a more systematic way – such as the adoption of condom programming, or monitoring STD cases.

Advocacy and communication: reassuring the host community and country

Emergencies do not occur in a political vacuum. For the smooth running of any relief or humanitarian operation, there must be good communications with the host country's national and local authorities, if they still exist, and especially with the military. It is also vital to consider the host community while planning responses to refugee problems, including those on HIV. If this is not done, the problems will be only

What can be done to overcome these problems?

partially addressed and will persist. Furthermore, local people must receive *equal* treatment to the treatment given to refugees, otherwise they may feel aggrieved.

Host governments need reassurance that the international community is aware of the extra burden being imposed on them and will do its best to help them shoulder the burden. When it comes to AIDS, this means listening carefully to the concerns of host governments. It also means collaborating with them on interventions. Working together with the host government, refugee agencies should make their actions on AIDS prevention and care compatible with the local national AIDS programme.

Equally important, the host country must be reassured that the international community will not ignore the needs of populations living with or alongside refugees. These various communities will inevitably come into a great deal of contact with one another. So to avoid local resentment and maximize the chances for successful HIV prevention, AIDS-related prevention and care services should be provided in a coordinated way to both the refugees and the host community.

UNAIDS *Best Practice* materials

The Joint United Nations Programme on HIV/AIDS (UNAIDS) is preparing materials on subjects of relevance to HIV infection and AIDS, the causes and consequences of the epidemic, and best practices in AIDS prevention, care and support. A *Best Practice* Collection on any one subject typically includes a short publication for journalists and community leaders (Point of View); a technical summary of the issues, challenges and solutions (Technical Update); case studies from around the world (*Best Practice* Case Studies); a set of presentation graphics; and a listing of key materials (reports, articles, books, audiovisuals, etc.) on the subject. These documents are updated as necessary.

Technical Updates and Points of View are being published in English, French, Russian and Spanish. Single copies of *Best Practice* publications are available free from UNAIDS Information Centres. To find the closest one, visit UNAIDS on the Internet (http://www.unaids.org), contact UNAIDS by email (unaids@unaids.org) or telephone (+41 22 791 4651), or write to the UNAIDS Information Centre, 20 Avenue Appia, 1211 Geneva 27, Switzerland.

Journalists seeking more information about a UNAIDS Point of View are invited to contact the UNAIDS Geneva Press Information Office (+41 22 791 4577 or 791 3387).

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1. Acquired immunodeficiency syndrome – transmission
2. Acquired immunodeficiency syndrome – prevention and control
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