

# **HIV/AIDS among Conflict-affected and Displaced Populations: Dispelling Myths and Taking Action**

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*Conflict, displacement, food insecurity and poverty make affected populations more vulnerable to HIV transmission. However, the common assumption that this vulnerability necessarily translates into more HIV infections and consequently fuels the HIV/AIDS epidemic is not supported by data. Whether or not conflict and displacement affect HIV transmission depends upon numerous competing and interacting factors. This paper explores and explains the epidemiology of HIV/AIDS in conflict and addresses the unique characteristics that must be addressed when planning and implementing HIV/AIDS interventions among populations affected by conflict as compared with those in resource-poor settings. These include targeting at-risk groups, protection, programming strategies, coordination and integration and monitoring and evaluation. Areas for future HIV/AIDS operational research in conflict are discussed.*

*Keywords:* HIV/AIDS, conflict, displaced persons, refugees.

## **Introduction**

Conflict, displacement, food insecurity and poverty have the potential to make affected populations more vulnerable to human immunodeficiency virus (HIV) transmission. The United Nations General Assembly Special Session (UNGASS) on HIV/AIDS passed the Declaration of Commitment on HIV/AIDS in June 2001, stating that ‘populations destabilized by armed conflict ... including refugees, internally displaced persons and in particular, women and children, are at increased risk of exposure to HIV infection’ (UN General Assembly, 2001). However, the common assumption that this vulnerability necessarily translates into more HIV infections and consequently fuels the HIV/AIDS epidemic is not supported by data. Whether or not conflict and displacement affect HIV transmission depends upon numerous competing and interacting factors.

Since the end of the cold war, armed conflicts, defined as open armed clashes between two or more centrally organised parties with continuity between the clashes in disputes about power over government and territory (Smith, 2000), have changed from being primarily interstate to intrastate. Of the 118 armed conflicts in over 80 states that occurred worldwide from 1990 to 1999, 10 (9 per cent) could be defined as interstate conflicts while 100 (85 per cent) were primarily or exclusively internal conflicts. The war in the Democratic Republic of Congo (DRC) was the only multi-state armed conflict in the 1990s. This increase in intrastate armed conflict brings new challenges

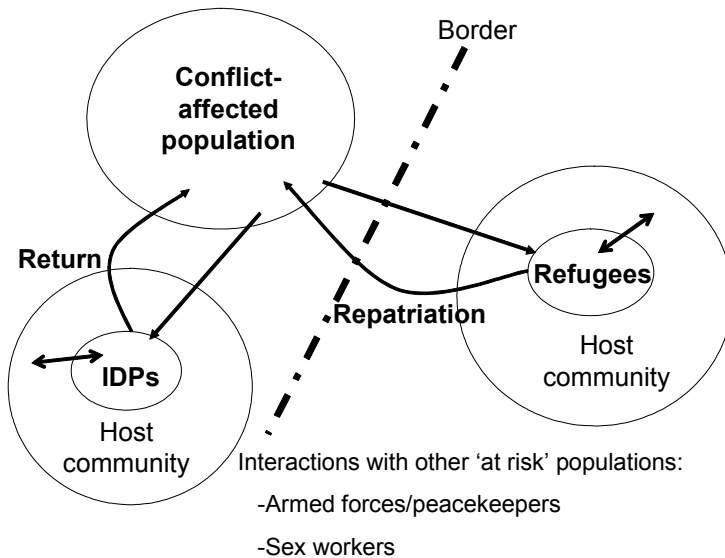
to the international community as issues of sovereignty may reduce access to affected populations (for example, Darfur, Chechnya).

Hundreds of millions of people worldwide are currently affected by armed conflict, both directly and indirectly. Conflict sends people fleeing to seek refuge either within their own country as internally displaced persons (IDPs) or across an international border to become refugees. By the end of 2002, there were approximately 40 million displaced people globally: 15 million refugees (UNHCR, 2003a; UNRWA, 2003) and 25 million IDPs (Global IDP Project, 2003). Many others are affected by the devastating consequences of conflict while remaining in their homes; their numbers are not known.

Sub-Saharan Africa is disproportionately affected by the HIV/AIDS epidemic, poverty and armed conflict. The epidemiology of HIV/AIDS during conflict is complicated, but conflict has been shown to be associated with several factors that render affected populations more vulnerable to HIV transmission, as described below. In addition, HIV/AIDS may reduce the coping mechanisms and resilience of populations affected by conflicts. While populations affected by conflict do not necessarily have high HIV-prevalence rates, they must be included in any successful effort to combat the epidemic (Lubbers, 2003). Forced-migrant populations have complex interactions with various communities and high-risk groups with whom they come into contact (see Figure 1).

### Epidemiology of HIV/AIDS and conflict

The complex relationship between HIV/AIDS and conflict is still not well documented. Many recent publications have asserted that conflict is directly associated with an increase in HIV/AIDS transmission (Hooper, 1999; McGinn et al., 2001; US Institute



**Figure 1** Possible forced migration in conflict situations

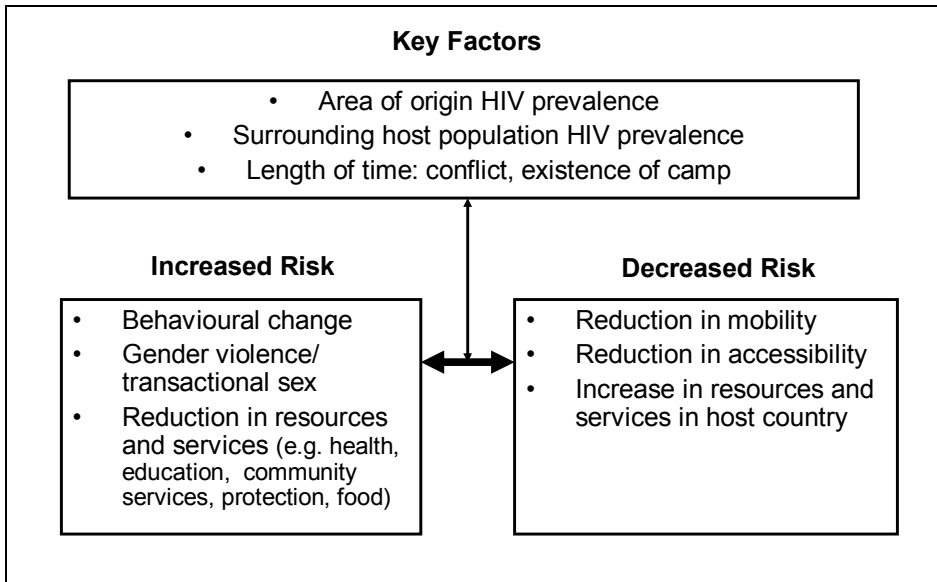
of Peace, 2001; Elbe, 2002; Save the Children, 2002; Pharoah and Schonteich, 2003). One paper claimed that women are six times more likely to contract HIV in a refugee camp than in the general population outside of the camp (Gardiner, 2001). However, when one examines available data, the picture is neither simple nor uniform. It must be clearly recognised at the outset that collecting data during and after conflict is difficult and fraught with biases (Salama and Dondero, 2001; Spiegel et al., 2001). Therefore, analysis and interpretation of these data must be undertaken carefully and biases clearly stated.

Factors that increase conflict-affected and forced-migrant populations' vulnerability are well documented (Khaw et al., 2000; Hankins et al., 2002; International Rescue Committee, 2002; Save the Children, 2002; Smith, 2002). These include breakdown in social structures, lack of income and basic needs, sexual violence and abuse, increased drug use and lack of health infrastructure and education. However, factors that may decrease HIV transmission in such situations are rarely considered. These include reduced mobility and accessibility (for example, destroyed infrastructure reducing travel to high-prevalence urban areas, displacement to remote locations and surviving in the 'bush') and in the case of many refugee camps, improved protection, health, education and social services. The ultimate influence of these factors is dependent on the HIV prevalence among the affected community pre-conflict, the HIV prevalence among the surrounding community for those who have been displaced, exposure to violence during conflict and flight and the level of interaction between the two communities. Complicating these factors are the duration of the conflict and the length of time the displaced population has resided in a particular camp (see Figure 2). The former may keep people isolated and inaccessible for years while the latter, depending upon the camp's location, may have the same result. Furthermore, long-term post-emergency refugee camps generally have better preventive and curative health services than do the surrounding local populations (Spiegel et al., 2002).

An analysis of available data has made it possible to describe several different scenarios in which the relationship between HIV/AIDS and conflict presents different epidemiological patterns.

### ***Prolonged conflict retarding the progression of HIV***

Population-based HIV behavioural and biological surveillance surveys from the US Centers for Disease Control and Prevention have shown lower than expected HIV-prevalence rates in Sierra Leone in 2002 (0.9 per cent in accessible areas covering 79 per cent of the adult population) and in southern Sudan in 2003 (2.3 per cent among pregnant women in antenatal clinics in both Yei town and surrounding villages with a population of approximately 100,000 and in Rumbek town with approximately 25,000 population (see Figure 3; Kaiser et al., 2002, 2003). These HIV-prevalence rates are lower than those in all of the respective surrounding countries, many of which have not been in conflict. Prior to these studies, both Sierra Leone and southern Sudan had been in protracted conflict situations for many years. Parts of their populations were isolated for long periods of time as accessibility and mobility were severely limited. Low HIV-prevalence rates relative to surrounding countries have also been reported in Angola, another country that endured decades of civil war (Spiegel and De Jong, 2003).

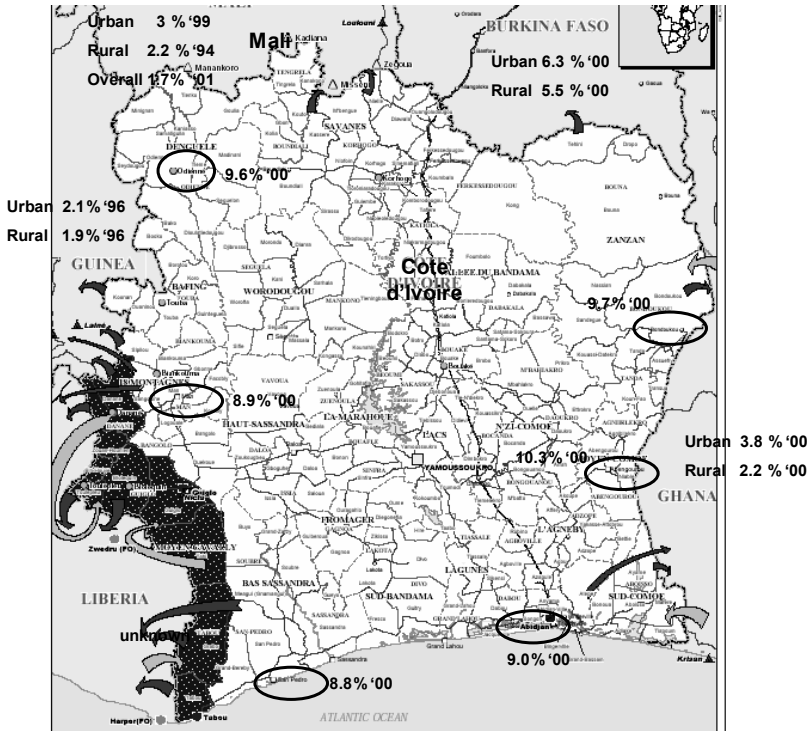


**Figure 2** HIV risk factors for conflict and displaced persons camps

Although sexual violence was reportedly high throughout all three wars, especially in Sierra Leone, the relatively low HIV prevalence among the pre-war populations and possibly the paramilitaries may not have been sufficient to accelerate HIV infection in the population. Despite the increased risk of HIV transmission due to rape as compared to consensual intercourse (Trisdale, 2003), perpetrators must be HIV positive to transmit the virus; the likelihood of this is low in a low-prevalence population. Furthermore, the number of people raped who become HIV positive must be compared to the total number of people in the country to estimate how these horrific acts affect the overall HIV incidence and prevalence.

### ***Conflict increasing the progression of HIV***

In contrast to Sierra Leone, southern Sudan and Angola, increases in HIV infection among the general population in eastern DRC (HIV prevalence is estimated to be between 15 and 24 per cent), primarily attributed to extensive sexual violence by paramilitary groups as well as foreign militaries (from, for example, Rwanda, Uganda and Zimbabwe) and a breakdown of health services, have been reported (Save the Children, 2001; Wax, 2003). However, many of the reports are anecdotal and further studies are needed to confirm these results and assess trends. In another scenario, there is concern that if the simmering instability in the Ivory Coast explodes and a large refugee crisis ensues, the HIV-infection rates may increase in the surrounding host countries. Ivory Coast had known stability and relative prosperity in West Africa for decades. Possibly because of these factors, it also has a higher HIV prevalence than do the countries surrounding it (Ghana, Mali, Burkina Faso and Guinea; the prevalence of HIV in Liberia is not known; see Figure 4) (UNAIDS, 2002).



**Figure 3** Scenario where conflict could possibly increase HIV progression

**HIV in refugee camp situations**

A common misperception is that refugees bring HIV with them into host countries thereby spreading the infection to the surrounding host population; this is often not the case. On the whole, refugees migrate from countries in conflict with lower HIV prevalence to more stable host countries with higher HIV prevalence (see Figure 5). However, as seen in the two scenarios discussed above, it is contextual and each situation must be analysed independently and conclusions drawn accordingly.

Since 2002, UNHCR and its partners have conducted HIV sentinel surveillance among pregnant women in more than 20 camps housing some 800,000 refugees in Kenya, Rwanda, Sudan and Tanzania. Refugees in three of the four countries (Kenya, Rwanda and Tanzania) examined had lower HIV-prevalence rates than did the surrounding host communities. Only in Sudan did the displaced and host communities have comparable rates (Lubbers, 2003). Furthermore, it is important to recognise the differences between refugees’ HIV-prevalence rates and those in their countries of origin, as Figure 6 shows, especially when there is contact between the two communities or when repatriation occurs. In all situations, tracking HIV-prevalence trends among refugees and surrounding host populations is essential when examining the long-term effectiveness of HIV/AIDS programmes.

## The unique situation of refugees

The declaration of the UN General Assembly Special Session on HIV/AIDS called upon:

all United Nations agencies, regional and international organisations, as well as non-governmental organisations (NGOs) involved with the provision and delivery of international assistance to countries and regions affected by conflicts ... to incorporate as a matter of emergency HIV/AIDS prevention, care and awareness elements into their plans and programmes (UN General Assembly, 2001).

Countries of asylum are ultimately responsible for the protection and well-being of people living on their soil, including refugees. However, refugees have been consistently excluded from many host countries' HIV/AIDS National Strategic Plans and their needs have not been addressed in proposals submitted to major donors (Spiegel and Nankoe, 2004; Lubbers, 2003). Their consistent exclusion is not only discriminatory but also undermines effective HIV/AIDS prevention and care efforts since refugees and local populations interact daily. Furthermore, refugees are often hosted in remote and inaccessible areas, far from cities where HIV/AIDS programmes are most developed. Improving HIV/AIDS interventions in an integrated manner for the refugees and surrounding host population will invariably improve services for both communities.

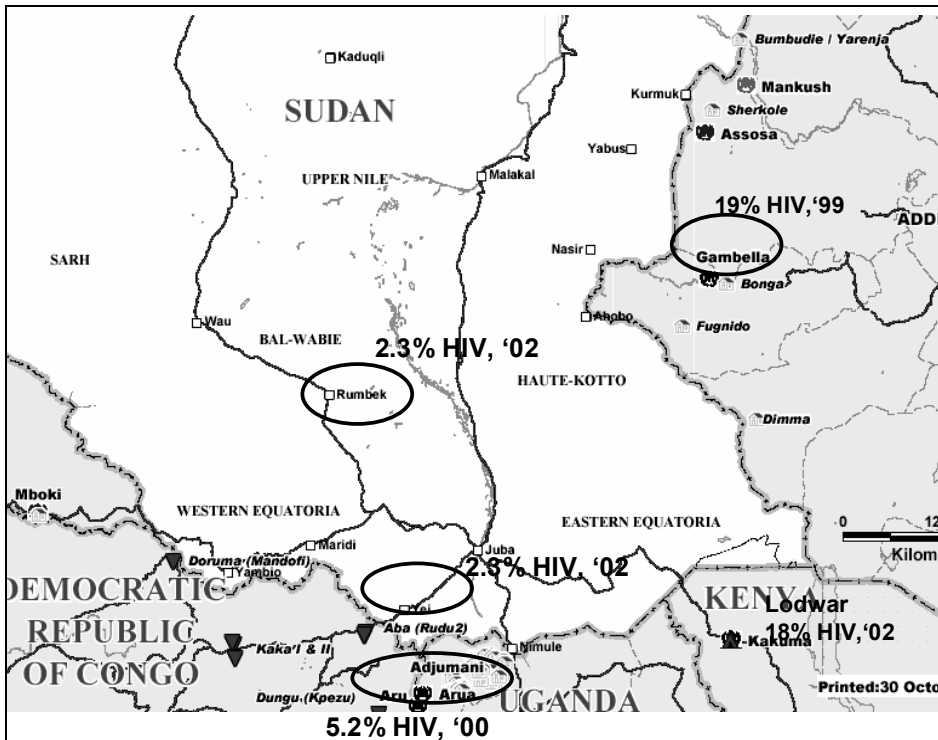
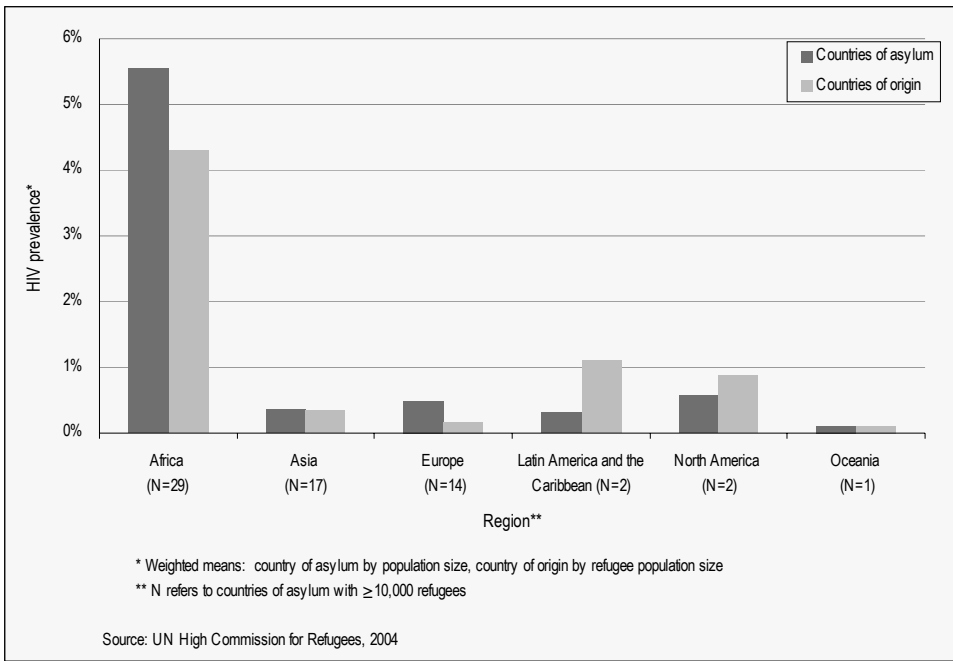
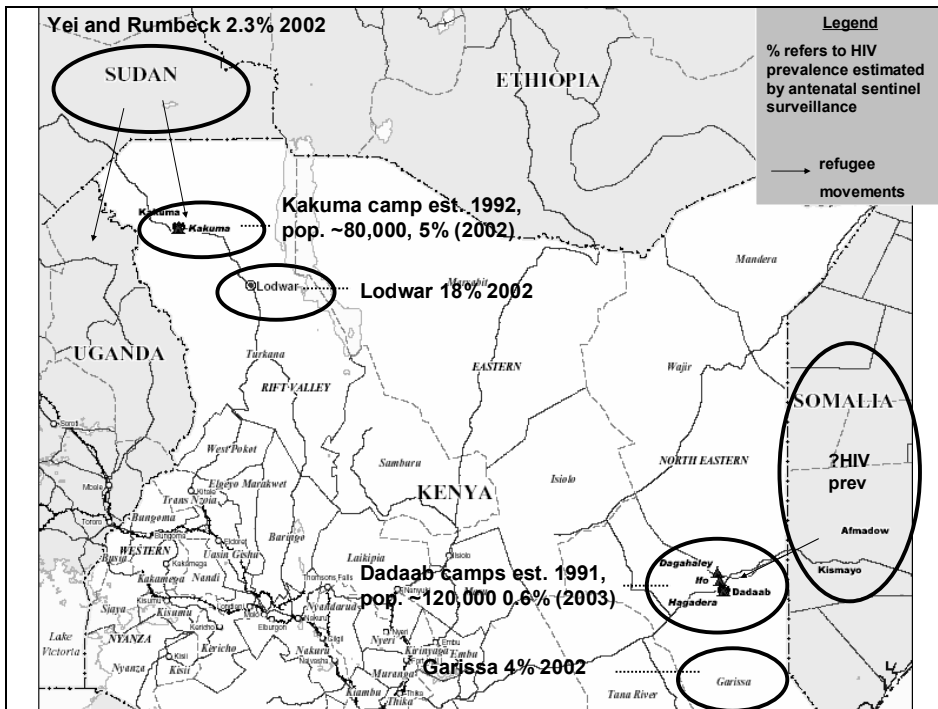


Figure 4 Scenario where conflict possibly retarded HIV progression



**Figure 5** HIV prevalence among refugees, surrounding communities in Kenya and their country of origin



**Figure 6** HIV prevalence by asylum country and country of origin by region, 2003

Of the 29 countries in Africa that host more than 10,000 refugees, UNHCR has been able to review 22 (76 per cent) National Strategic Plans (NSPs). While 14 (64 per cent) mention refugees, eight (36 per cent) fail to do so. Of those that do mention refugees, 10 (71 per cent) NSPs mention specific activities for refugees, while four (29 per cent) NSPs do not. The Global Fund for AIDS, Tuberculosis and Malaria (GFATM) and the Multi-Country HIV/AIDS Programmes (MAP) of the World Bank have funded HIV/AIDS projects in 25 (86 per cent) of these 29 refugee-hosting African states. Only a minority of proposals include refugees; in the 23 countries with approved GFATM proposals containing an HIV component only five (22 per cent) included activities for refugees while eight (55 per cent) of the 15 approved World Bank MAP projects included refugee-specific components (Spiegel and Nankoe, 2004).

The situation for refugees not living in camps (for example, urban refugees) as well as for IDPs is unknown but is likely to be worse than for refugees living in camps. Urban refugees are often undocumented, do not receive direct material support from UNHCR and rely upon existing host government services that may discriminate against refugees (Bruns and Spiegel, 2003a; Spiegel and Qassim, 2003). IDPs are often excluded from their governments' HIV/AIDS programmes and do not have a specialised agency to advocate for them and provide programmes to cover their needs, as the refugees have in UNHCR (Salama et al., 2001).

These conditions must be addressed when planning and implementing HIV/AIDS programmes among populations affected by conflict compared to those in resource-poor settings. The concerns include at-risk groups; protection needs; programming strategies; coordination and integration; and monitoring, evaluation and the need for future HIV/AIDS operational research in conflict.

## **At-risk groups**

### **Women**

In conflict and displacement, women are at increased risk of sexual violence and abuse (Amowitz et al., 2002). Food insecurity, hunger and unequal distribution of material goods put women and girls at risk of exploitation and abuse, including coercion into transactional sex for survival. Displacement may cause families and communities to split apart, destroying community structures and support systems that traditionally serve to protect women and children. This breakdown of communities may also lead men and women to engage in risky sexual behaviour. Displaced women often suddenly find themselves as heads of household, responsible for providing for their families in addition to caring for their children as male family members are more likely to be involved in the conflict itself. Targeted HIV/AIDS interventions that protect, train and educate women are essential.

### **Children**

In areas with high HIV prevalence and conflict, the vulnerability of children increases as can the number of children orphaned. Early efforts to identify vulnerable children, initiate family tracing and implement community-based programmes that provide care and support for orphans and other vulnerable children must be encouraged.

Educational opportunities may be limited in conflict situations, and thus, basic HIV-prevention messages targeting children must be a priority intervention. Displaced children, particularly orphans and children made vulnerable by HIV/AIDS, are at increased risk for many types of abuse and exploitation and may be coerced into transactional sex for survival. Additionally, the abusive use of children as soldiers and the extreme actions they are led to commit put this group at increased risk of contracting HIV.

### ***Armed personnel***

The presence of armed personnel may be a significant risk factor for the transmission of sexually transmitted infections (STIs), including HIV, among conflict-affected and displaced populations (Smallman-Raynor and Cliff, 1991; Hooper, 1999; Hankins et al., 2002). HIV-prevalence rates among military personnel in some countries have been documented to be two to five times greater than among their respective civilian populations (McGinn et al., 2001; Smith, 2002). Furthermore, many of the intra-state conflicts have undisciplined, irregular armies and militias. Finally, there is a risk that UN peacekeepers coming from countries with high HIV prevalence may also transmit HIV to conflict-affected and displaced populations because of their access to civilians, money and power. Conversely, those from low HIV-prevalence countries may be at increased risk of contracting the virus. HIV/AIDS prevention must be an important training component among militaries, demilitarisation efforts and UN peacekeepers.

### ***Humanitarian workers***

Humanitarian staff working in conflict situations often find themselves in isolated, unstable and unfamiliar surroundings. They may face increased occupational exposure to HIV in the health-care setting as well as increased exposure to sexual violence. They may take sexual risks which they might normally avoid. Furthermore, humanitarian workers are placed in a position of power in relation to refugees and sexual abuse instigated by the workers themselves has occurred (UN General Assembly, 2002). Humanitarian workers should receive training in and follow a code of conduct (Inter-Agency Standing Committee on Sexual Exploitation and Abuse in Humanitarian Crises, 2003; International Federation of Red Cross and Crescent Societies, 2003; UNHCR, 2003) as well as the humanitarian charter (Steering Committee for Humanitarian Response, 2004). As with UN peacekeepers and other military forces, adequate education and training must be provided to this group before their missions, and counselling and condoms should be available throughout their time in the field. Universal precautions and disposal of medical waste in a safe manner must be followed scrupulously.

## **Protection**

The link between the protection of human rights and effective HIV/AIDS programmes is apparent. People will not seek HIV-related counselling, testing, treatment and care when lack of confidentiality, discrimination, denial of access to the asylum procedure, threat of refoulement, restrictions to freedom of movement or other negative

consequences (real or perceived) exist. For these reasons, an essential component of any HIV/AIDS strategy is the facilitation and creation of a legal and ethical environment that aids in protecting human rights. Situations of conflict and displaced people are often more prone to human rights abuses, including sexual violence (Amowitz et al., 2002; Amnesty International, 2004; Human Rights Watch, 2003). Therefore, specific protection policies and programmes dealing with HIV/AIDS must be implemented in conflict-affected settings where human rights are frequently violated. Seven essential protection issues needed include:

- No denial of access to asylum procedure, refoulement or denial of right to return on the basis of HIV status.
- No mandatory HIV testing of displaced persons under any circumstances.
- When required by countries in which refugees have requested resettlement, HIV testing conducted in accordance with established standards (i.e., accompanied by pre- and post-test counselling and appropriate referral for follow-up support and services).
- Effective procedures in place to maintain confidentiality of individuals' HIV status.
- Informed consent by clients for disclosure of their HIV status if such disclosure is necessary to obtain community or protection services.
- Policies, laws and programmes in place to combat stigma and discrimination against people living with HIV/AIDS.
- No laws or regulations prohibiting displaced persons access to public sector HIV/AIDS programmes.

## **HIV/AIDS programmes**

In the past, HIV/AIDS interventions were generally not included in humanitarian organisations' immediate response to conflict and emergencies. It was considered a developmental and health issue and not an immediate life-threatening disease such as malaria or cholera. However, thinking has evolved and it is now generally accepted that HIV/AIDS interventions must be multisectoral, begin at the onset of a conflict or emergency and be continued through every stage (Inter-Agency Standing Committee, 2003; Steering Committee for Humanitarian Response, 2004). The Inter-Agency Standing Committee (IASC) reference group for HIV/AIDS in emergency settings recently completed guidelines that provide a step-wise approach for implementing HIV/AIDS interventions (IASC, 2003). They include response in a range of areas including behaviour-change communication and HIV/AIDS in the workplace<sup>1</sup> for: first, emergency preparedness; second, minimum response; and third, comprehensive response. A multisectoral response with emphasis on coordination was adopted. In 2004, the Sphere Project, which includes a humanitarian charter and minimum standards for disaster response, revised its manual to include HIV/AIDS as a cross-cutting issue (Steering Committee for Humanitarian Response, 2004).

A structured approach to the assessment and planning of HIV/AIDS programmes is needed to ensure that well-planned, multisectoral and integrated HIV/AIDS interventions are implemented in an appropriate manner. The IASC matrix discussed above is one such structured approach (IASC, 2003). UNHCR has developed a framework for assessment of and planning for HIV/AIDS in conflict and

displaced person situations (see Box 1; Bruns and Spiegel, 2003b). Like the IASC guidelines, the UNHCR framework ensures that the most important HIV/AIDS interventions are assessed and allows for the evaluation of programmes over time as well as for comparison across different programmes. This framework has been used by UNHCR to undertake HIV/AIDS assessment and planning missions in over 15 countries throughout Africa.

As stated in the IASC guidelines, minimum essential HIV/AIDS interventions must be provided before comprehensive activities are initiated. This focused, hierarchal approach is essential given the security and resource constraints in, and the remoteness of, most conflict and displaced persons situations. Essential services (for example, including but not limited to, safe blood supply, universal precautions, treatment for STIs, condom distribution and information/education/communication materials) must be made available before more complicated and resource-intensive interventions, such as the prevention of mother-to-child transmission (PMTCT) or long-term anti-retroviral therapy (ART), are provided.

However, comprehensive programmes that link HIV/AIDS prevention with care and treatment programmes are essential to combat the epidemic (Mukherjee et al., 2003) and conflict-affected and displaced populations should not be excluded from these approaches once the minimum HIV/AIDS activities have been implemented. Interventions ranging from voluntary counselling and testing (VCT), PMTCT, behavioural and sentinel surveillance, population-based surveys and ART have been implemented among refugee populations in the past few years (Kaiser et al., 2002; Spiegel, 2002a, 2002b; Kaiser et al., 2003; Médecins Sans Frontières, 2003).

The issue of ART is more complex in humanitarian settings than in typical resource-poor settings due to migration and the consequent difficulties with access and follow-up. Although there are some similarities to the treatment of tuberculosis (TB) in such situations, such as the need for a stable security environment, population in situ for at least six months and sufficient funds (WHO and UNHCR, 1997), there are also distinct differences in delivering ART. These include more complicated diagnosis and follow-up, life-long treatment and significantly more funding. In situations of repatriation, people undergoing TB treatment and their families are recommended to finish their treatment before returning home. This is not applicable to HIV/AIDS as treatment is life-long and numerous problems may arise, including the possibility of increased drug resistance, if refugees on ART repatriate to areas where ART is not available. Pilot projects are necessary to examine modalities of drug distribution and other logistical factors, laboratory, compliance, surveillance, side-effects and resistance. A community-based infrastructure adapted to the specific situation should be employed when providing ART.

HIV/AIDS programming for refugees presents unique challenges. UNHCR's HIV/AIDS and Refugees Strategic Plan for 2002–04 requires '...UNHCR to work with governments through their National AIDS Control Programmes' (2002). Together with its implementing partners, UNHCR follows the existing national protocols and guidelines of the host country. However, at times, such protocols and guidelines do not exist, are outdated or are not being implemented in the remote areas in which refugees and displaced persons are often situated. Different languages and cultures require a modification of educational materials and other interventions to suit the populations that are mixed together in conflict settings. The interaction between displaced people and the surrounding population requires strong coordination and cooperation among the host government, international and local organisations and the communities themselves.

## **Box 1 Conflict and Displaced Persons Assessment and Planning Tool Framework**

### **1. Policies**

Existing national AIDS control policy, guidelines and manuals.

Displaced persons specifically targeted as a vulnerable population under National AIDS Control Strategic Plans.

### **2. Protection**

No mandatory HIV testing of displaced persons under any circumstances.

No denial of access to asylum procedure, refoulement or denial of right to return on basis of HIV status.

When required by resettlement countries, HIV testing conducted in accordance with established standards (i.e., accompanied by pre- and post-test counselling and appropriate referral for follow-up support and services).

No laws or regulations prohibiting refugee access to public sector HIV/AIDS programmes in countries of asylum.

Specific programmes in place to combat stigma and discrimination against people living with HIV/AIDS.

Programmes in place to prevent and respond to sexual violence.\*

### **3. Coordination and supervision**

Regular meetings among various partners in the field and in capital.

HIV/AIDS programmes specifically included in planning, implementation, monitoring and evaluation stages of programme cycle.

Regular attendance at meetings of UN Theme Group on HIV/AIDS and associated Technical Working Groups at capital level.

### **4. Prevention**

Safe blood supply.

Universal precautions.

Condom promotion and distribution.

Behavioural change and communication (including development of educational/awareness materials in appropriate languages; programmes for in-school and out-of-school youth; peer education; youth centres; sports/drama groups; programmes aimed at reducing teen-age pregnancy and combating sexual violence).

Voluntary counselling and testing.\*

Prevention of mother-to-child transmission.

Prophylaxis of opportunistic infections.

Post-exposure prophylaxis.

### **5. Care, support and treatment**

Sexually transmitted infections.\*

Opportunistic infections, including tuberculosis.

Nutrition and food.\*

Home-based care.

People living with HIV/AIDS.

Orphans and child-headed households.  
Anti-retroviral therapy.

#### **6. Surveillance, monitoring and evaluation**

Behavioural surveillance surveys.  
AIDS clinical case and mortality reporting.  
Blood donors.  
Syphilis among antenatal-clinic attendees.  
Sexually transmitted infections (by syndrome).  
Condom distribution.  
Opportunistic infections, including incidence of pulmonary tuberculosis.  
HIV sentinel surveillance among pregnant women and high-risk groups such as those attending sexually transmitted infection clinics.  
Voluntary counselling and testing.  
Prevention of mother-to-child transmission.  
Sexual violence.  
Post-exposure prophylaxis.

\* Activity has both prevention as well as care and treatment components

*Source:* Bruns and Spiegel (2003b).

The global community must adopt a broader and more innovative approach to fighting the HIV/AIDS epidemic across international boundaries. Recent conflicts in Ivory Coast, Liberia and DRC, for example, saw armed military groups, refugees and economic migrants moving across many borders in West and Central Africa. Individual country plans are not enough; subregional approaches must be undertaken in conflict and displaced persons situations to combat the epidemic effectively. Some subregional initiatives, such as the Great Lakes Initiative on AIDS (UNAIDS, 2003a), the Oubangui-Chari HIV/AIDS Initiative and the Mano River Union Initiative on HIV/AIDS (UNAIDS, 2003b) exist but need more international support and government cooperation. The current repatriation of Angolan refugees from numerous countries including Namibia, Zambia and DRC to Angola has shown the importance of subregional programming (Bruns and Spiegel, 2003; Spiegel and De Jong, 2003).

## **Coordination and integration**

Coordination and integration are key components for all HIV/AIDS strategies, policies and programmes. They are essential for HIV/AIDS in conflict and displaced settings given the multisectoral and cross-border programming needs. In these settings, numerous disparate groups must come together to improve their communication and coordination and to integrate their activities. This must occur at all levels: at the international level (for example, UN System Strategic Plan for HIV/AIDS); at the regional/subregional level (UNAIDS Inter-country Teams); at the country level (UN Theme Group on HIV/AIDS and national AIDS control programmes); and at the field level (multisectoral HIV/AIDS committees that include service providers, political and religious leaders, women's group representatives, students, youth, teachers, NGO representatives and representatives from the host community).

The development of coordinated, integrated HIV/AIDS strategies would be given an enormous boost if donor governments would permit their funds to be used more flexibly to provide services to both displaced persons and local communities through both humanitarian and development organisations. This is currently being done in Uganda where a self-reliance strategy includes delivery of numerous HIV/AIDS activities, including VCT, for refugees and local populations.

## **Assessment, monitoring, evaluation and operational research**

Despite the difficulties of undertaking assessments, monitoring and evaluation as well as operational research in conflict and displaced persons settings, it is imperative to do so. Recent work by UNHCR, Save the Children, the International Rescue Committee and the Centers for Disease Control and Prevention, among other organisations, shows that it is possible to carry out HIV sentinel surveillance surveys, HIV population-based surveys and HIV behavioural surveillance surveys in conflict and displaced persons settings (Save the Children, 2001; Kaiser et al., 2002; Spiegel, 2002b; Kaiser et al., 2003). Although outside technical expertise may be required for many organisations to undertake such activities, behavioural and serological surveillance have allowed organisations to prioritise and target their programmes, provide a baseline and trends to evaluate their effectiveness and act as an advocacy tool. Finally, such data have allowed us to understand better the complex interactions among conflict, displacement and the transmission of HIV that will ultimately allow us to combat the epidemic more effectively.

Recently UNHCR, the World Food Programme (WFP) and Unicef have undertaken a joint HIV/AIDS, food and nutrition operational research project in Zambia and Uganda to explore options for the effective use of food aid to improve HIV/AIDS prevention, care and treatment in refugee camp settings. There are numerous other areas of research requiring examination, including the effects of interactions among armed groups, conflict-affected populations (displaced and non-displaced populations) and surrounding communities on intra-country and inter-country HIV transmission; methods to improve integration of HIV/AIDS programmes in displaced and non-displaced populations; policies and programmes to reduce HIV/AIDS stigma and discrimination towards displaced populations from local communities and governments; development of innovative prevention, care and support strategies that utilise the unique context of conflict and disaster-affected settings (including food distribution, reception centres, censuses); and provision and compliance of ART to conflict-affected populations including post-exposure prophylaxis to refugees following sexual violence or occupational exposure, PMTCT and long-term ART.

## **Conclusion**

An examination of new epidemiologic data sheds light on the complex relationship between HIV and conflict. It is a misperception that refugees' HIV rates are always higher than those in their host countries; in fact, evidence suggests that the opposite is more likely, but it is always context-specific (see Figure 6).

The well-documented factors that increase the vulnerability to HIV of conflict-affected and forced migrant populations must be considered alongside other key factors, such as reduced mobility and accessibility of the population, that may work to decrease HIV transmission. HIV-prevalence levels among the forced migrant and surrounding communities also influence HIV transmission as do the levels of interaction between the two communities and their exposure to violence. Collection and examination of data have permitted documentation of situations in which prolonged conflict has retarded the progression of HIV (for example, Sierra Leone, southern Sudan and Angola) and in which conflict may have increased the progression of HIV (for example, eastern Congo). The context-specific circumstances in which forced migrants live must be better understood and used to guide HIV/AIDS programmes.

Collecting data in harsh forced-migration settings is difficult but critical, and has been successfully carried out as discussed above. Despite the similar difficulties in providing HIV/AIDS interventions in such settings, it is imperative that comprehensive programmes linking HIV/AIDS prevention with care and treatment be made available to conflict-affected populations. Guidelines and frameworks have been developed as tools for good HIV/AIDS programming. The interaction between the displaced and surrounding populations requires strong coordination and integration among the host government, international and local organisations and the communities themselves. On a broader scale, coordination, communication and integration at the international, regional, country and field levels are key components for all HIV/AIDS strategies, policies, proposals and programmes globally.

The development of coordinated, integrated HIV/AIDS strategies could be given an enormous boost if donor governments would permit their funds to be used more flexibly to provide services to both displaced persons and local communities through both humanitarian and development organisations. The global community must adopt a subregional and more innovative approach to fighting the HIV/AIDS epidemic across international boundaries.

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### **Note**

1. The sectors covered in the Inter-Agency Standing Committee (IASC) guidelines for HIV/AIDS in emergency settings are coordination, assessment and monitoring, protection, water and sanitation, food security and nutrition, shelter and site planning, health, education, behavioural-communication change and information/education/communication and HIV/AIDS in the workplace.

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