



# POLICY BRIEF

## HIV and REFUGEES

### Context

Conflict, persecution and violence affect millions of people worldwide, forcing them to uproot their lives. Refugees are those who flee their country of origin across national borders, often to a neighbouring country.<sup>1</sup> This policy brief focuses specifically on actions required to address the spread and effect of HIV on refugees and their host communities.<sup>2</sup>

At the end of 2005, there were 8.4 million refugees worldwide. Of these, approximately 30% were in sub-Saharan Africa, 29% in Central and South-West Asia, North Africa and the Middle East and 23% in Europe.<sup>3</sup> While demographic profiles differ across regions, the most recent analysis in 2001 showed that in some regions women and children are disproportionately affected.<sup>4</sup>

### Conflict, displacement and HIV

Far too often refugees face an untenable situation: they are no longer guaranteed the protection of their country of origin and do not receive assistance from host countries. Many host countries are already overburdened by the effect of HIV, and are often unable or unwilling to provide the HIV-related services refugees need and to which they have a right under international refugee and human rights law. Refugees often do not have access to HIV prevention commodities and programmes. Access to basic HIV-related care and support is also rarely given adequate attention. Despite improvements in the availability of antiretroviral therapy in low- and middle-income countries, very few refugees have access to it. Displacement of people from their country of origin has an enormous effect on their lives, as well as upon the lives of host communities. Increased risk of HIV infection and poor access to HIV-related prevention, treatment, care and support are an avoidable part of this effect.

Refugees frequently face stigma, both because of their status as refugees and because of the common

misconception that HIV prevalence is higher among refugees than in host communities. In fact, historical evidence shows that refugees have often migrated from countries with lower HIV prevalence to countries with higher HIV prevalence.<sup>5</sup> Stigma and discrimination need to be tackled as an integral part of responding effectively to HIV among refugees and host communities. While knowledge about the comparative HIV prevalence among refugees and host communities can assist in programme design and implementation, such information does not alter the action that is required to tackle stigma and discrimination. The provision of a comprehensive and integrated national response, that addresses the HIV-related prevention, treatment, care and support needs of refugees and host communities, is the most effective way to reduce the risk of HIV transmission and address the effects of HIV.

The factors that affect HIV transmission vary by context and arise during different phases of the cycle of displacement. The three phases in the cycle of displacement are:

- the emergency phase, associated with the onset of conflict or some other emergency and flight of those affected;
- the post-emergency phase, marked by greater stability; and
- the final phase, when durable solutions are secured, and refugees return home, are resettled in a third country, or are permanently integrated within their host country.<sup>6</sup>

The many factors that can contribute to the increased risk of HIV transmission among refugees in emergency and post-emergency phases are relatively well understood. Refugees are uprooted from their homes and communities. Livelihoods are lost. The breakdown of social networks and institutions reduces community cohesion, weakening the social and sexual norms that regulate behaviour. Disruption to health and education services

<sup>1</sup> "A refugee is a person who, owing to a well-founded fear of persecution for reasons of race, religion, nationality or political opinion, is outside the country of his nationality and is unable or, owing to such fear, unwilling to avail himself of the protection of that country". The 1951 Convention relating to the Status of Refugees. There are some regional variations of this definition.

<sup>2</sup> Those who seek safety elsewhere within their own country are called Internally Displaced Persons. The policy actors and actions for refugees and IDPs are sometimes different. UNAIDS and UNHCR intend to develop a separate policy brief on HIV and IDPs.

<sup>3</sup> UNHCR (2006). 2005 Global refugee trends: statistical overview. This figure excludes an additional 4 375 050 Palestinian refugees, see <http://www.un.org/unrwa/index.html>

<sup>4</sup> UNHCR (2002). Statistical yearbook 2001. Also see Op cit 3, pages 20–21.

<sup>5</sup> Spiegel P (2004). HIV/AIDS among conflict-affected and displaced populations: dispelling myths and taking action, *Disasters*, 28(3): 322–339.

<sup>6</sup> This policy brief focuses on the actions required to address the needs of refugees and host communities in the emergency and post emergency phases. It does not address the situation once durable solutions are secured; that is, when refugees are repatriated, permanently integrated within host countries or resettled in another country, as in this phase, they are no longer refugees.

reduces access to HIV prevention information and commodities, sexual and reproductive health services, as well as HIV-related treatment and care for those who need it. Exposure to mass trauma such as conflict can increase alcohol and other drug use and influence people's attitudes towards risk.

Conflict and displacement make women and children, particularly girls, disproportionately vulnerable to the risk of HIV. During conflict, rape is often used as a weapon of war.<sup>7</sup> Women and girls are also subject to sexual violence and exploitation in refugee settings.<sup>8</sup> As refugees struggle to meet their basic needs such as food, water and shelter, women and girls are often forced to exchange sexual services for money, food or protection.<sup>9</sup> Children living without parental support, whether due to separation from or death of family members, are also particularly vulnerable to sexual and physical violence and exploitation.

Factors that can limit the transmission of HIV among refugees are less well studied, but some have been identified—these include reduced mobility to high prevalence

urban areas, the isolation and inaccessibility of some refugee populations, and in some circumstances, especially in the post-emergency phase, the availability of better protection and other HIV-related services than in countries of origin or in host communities.<sup>10</sup>

The HIV implications for host communities are not yet fully understood and depend on the comparative HIV prevalence among refugee and host communities and on the extent and nature of contact between host communities and refugees. The majority of refugees live within host communities, not in camps.<sup>11</sup> Refugees are also staying longer in their host countries. The average estimated length of stay has increased from nine years in 1993 to seventeen years in 2003.<sup>12</sup> As refugees stay a long time in host countries and live in close contact with host communities, failure to address their HIV-related needs not only denies refugees their rights, it also undermines efforts to address HIV among host communities. The post-emergency phase in particular, provides critical opportunities for refugees to access HIV-related programmes. Yet, refugees are often overlooked in the HIV National Strategic Plans in many host countries.<sup>13</sup>

### **Integrating refugees into HIV programmes<sup>14</sup>**

In Guinea, funds for refugee health care were paid to the government to provide refugee care through the local health system on a fee for service basis. The overall yearly cost per person in the local health system was much lower than in the refugee camps—approximately US\$ 4 compared with US\$ 20. The resources saved were used to fund new health centres and to upgrade existing centres in the areas where refugees had settled, also improving services for host communities. Avoiding the creation of parallel services for refugees helps to reduce stigma and discrimination by addressing the misconception that HIV is only an issue for refugees.

### **Implementing subregional initiatives**

As refugees move within a region, a subregional approach is vital to prevent HIV transmission and ensure continuity in treatment, care and support services across national borders. The Great Lakes Initiative on AIDS<sup>15</sup> has forged strong partnerships across Burundi, Democratic Republic of the Congo, Kenya, Rwanda, Uganda and United Republic of Tanzania improving regional health-sector collaboration. Standard protocols have been developed to enable consistency in prevention programmes for HIV and other sexually transmitted infections, and continuity of care and treatment including antiretroviral therapy, when refugees move to another country within the subregion. A standardized behavioural surveillance survey for displaced and surrounding host communities has also been developed, field tested and implemented in four of the six countries. Subregional collaboration improves efficiency, lowers costs and enables countries to attract additional funding to implement cross-border activities.

### **Combining humanitarian and development funding**

In 2001, the Zambian Government launched a US\$ 25 million initiative for reducing poverty, and improving peace and stability for Angolan refugees and host communities living in western Zambia. HIV-related services were later incorporated under the initiative. Resources to fund the initiative were mobilized from both development and humanitarian funding streams. Humanitarian aid is relatively accessible and has minimal restrictions, although funds need to be used within one year. It can assist in meeting immediate HIV-related needs, in combination with development funds for longer term HIV-related programmes.<sup>16</sup>

<sup>7</sup> See for example the 20th Activity Report of African Commission on Human and Peoples' Rights, 2006. [www.achpr.org](http://www.achpr.org)

<sup>8</sup> For example, a survey among Burundians in a Tanzanian camp revealed that 26% of women had endured sexual violence since becoming a refugee. Cited in Holmes W (2001). Health and Human rights. HIV and Human rights in refugee settings, *The Lancet*, 358:144–146.

<sup>9</sup> Hankins C et al. (2002). Transmission and prevention of HIV and sexually transmitted infections in war settings: implications for current and future armed conflict, *AIDS*, 16: 2245–2252.

<sup>10</sup> Op cit 5. Hynes M et al. (2002). Reproductive health indicators and outcomes among refugee and internally displaced persons in post emergency phase camps. *JAMA*, 288 (5): 595–603.

<sup>11</sup> Op cit 3. See also UNHCR (2006). The state of the world's refugees: Human displacement in the new millennium.

<sup>12</sup> UNHCR (2004). Protracted Refugee Situations, Standing Committee 30th meeting. EC/54/SC/CRP.14.

<sup>13</sup> In 2004, 28 countries in Africa hosted a population of more than 10 000 refugees. UNHCR reviewed 25 (89%) of these countries' National Strategic Plans and found 17 (68%) included refugees issues, while 8 (32%) did not; 11 (44%) described specific activities for refugees and 14 (56%) did not.

## Policy position

In 2001, all United Nations Member States signed the *Declaration of Commitment on HIV/AIDS*, recognizing that refugees are at increased risk of exposure to HIV infection and committed themselves to incorporating HIV into programmes that respond to emergencies. The Declaration also called upon United Nations agencies, regional, international and nongovernmental organizations to factor HIV into their assistance to countries affected by conflict and humanitarian crises. In 2006, Member States reaffirmed these promises in the *Political Declaration on HIV/AIDS* and committed to set ambitious national targets towards universal access to comprehensive prevention, treatment, care and support by 2010.

The realization of human rights is central to reducing vulnerability to HIV infection and addressing the effects of HIV. Host countries have specific obligations under international refugee and human rights laws. Over 140 countries are party to the 1951 *Convention relating to the Status of Refugees*, committing State parties to providing refugees with the same “public relief and assistance” as their nationals, including medical care. International human rights law provides the framework for a rights-based approach to responding to HIV.<sup>17</sup> The key human rights relevant to responding to HIV are: the right to health; the right to equality and non-discrimination; the right to privacy; the right to liberty and security of the person; the right to information; the right of participation; the right to work; and the right to education.<sup>18</sup> These rights apply equally to refugees as to host countries’ own citizens and are central to informing how host governments address the underlying causes of vulnerability to HIV and meet the HIV-related needs of refugees and host communities.<sup>19</sup>

UNAIDS and UNHCR recommend the following:

## Actions for governments:

- Incorporate refugees into HIV policies, strategic plans and programmes<sup>20</sup> for host communities and ensure appropriate access to comprehensive HIV prevention, treatment, care and support.
- Ensure that policies and programmes are designed, implemented, monitored and evaluated with the participation of refugees.<sup>21</sup>
- Ensure that laws, policies and programmes respect, protect and fulfil the rights of all refugees and that there is:
  - no discrimination towards refugees;
  - no discrimination on the basis of HIV status in asylum procedures;
  - protection from expulsion and forced return (or *refoulement*) and restrictions on freedom of movement on the basis of HIV status;
  - protection of women and children from sexual or physical violence and exploitation, paying special attention to separated or unaccompanied children and orphans;
  - access for children to the national education systems; and
  - access to and freedom of choice in work, with just and favourable conditions.
- Ensure policies and programmes are informed by evidence and
  - include refugees in the national serological and behavioural surveillance system, and focus on interactions within and between refugees and host communities; and
  - undertake, support and/or fund operational research that improves understanding of the impact of HIV among refugees and host communities and the effectiveness of policies and programmes in meeting their needs.
- Develop and sustain subregional initiatives to ensure continuity in HIV services across national borders utilizing regional inter-governmental platforms as appropriate.
- Promote, disseminate, and implement the Inter-Agency Standing Committee’s *Guidelines for HIV/AIDS interventions in emergency settings*<sup>22</sup>.

<sup>14</sup> For detailed examination of this and other best practice examples see UNAIDS/UNHCR (2005). *Strategies to support the HIV-related needs of refugees and host populations*. Geneva.

<sup>15</sup> The Great Lakes Initiative on AIDS (GLIA) was funded by a US\$ 20 million grant from the World Bank and involves UN organizations, bilateral and multilateral donors, nongovernmental organizations and the private sector, working together with the six countries involved. GLIA encompasses strategies to address the needs of various mobile populations that may cross borders, including migrants and IDPs, as well as refugees.

<sup>16</sup> Such an approach is consistent with efforts to improve harmonization of international AIDS funding and ensure effective and efficient use of all available resources in the response to HIV. See the “Three Ones” and the Global Task Team recommendations, [www.unaids.org/en/Coordination/Initiatives/](http://www.unaids.org/en/Coordination/Initiatives/)

<sup>17</sup> International Guidelines on HIV and Human Rights, 2006 Consolidated version, Office of the United Nations High Commissioner for Human Rights (OHCHR) and UNAIDS, 2006. [www.ohchr.org/english/issues/hiv/guidelines.htm](http://www.ohchr.org/english/issues/hiv/guidelines.htm)

<sup>18</sup> International Covenant on Economic, Social and Cultural Rights 1966, article 2, 6, 12, 13; 15; Convention on the Rights of the Child 1989, article 1, 2, 13, 15, 16, 17, 23, 24, 28; Universal Declaration of Human Rights 1948, article 1, 7, 19, 23; International Covenant on Civil and Political Rights 1966, article 7, 9, 17, 19.2, 26; Convention on the Elimination of All Forms of Discrimination Against Women 1979, article 7, 8, 10, 13, 14, 16; ILO Declaration of Fundamental Principles and Rights at Work, 1998.

<sup>19</sup> UNHCR (2006). *Note on HIV/AIDS and Protection of Refugees, IDPs and Other Persons of Concern*. UNHCR 2006. This document provides detailed guidance about how refugee and human rights law applies when addressing the HIV-related needs of refugees. [www.unhcr.org](http://www.unhcr.org)

<sup>20</sup> All available funding sources including humanitarian aid should be pursued to effectively integrate refugees within national HIV policies and programmes.

<sup>21</sup> This also applies to nongovernmental organizations and other organizations who provide programmes for refugees.

<sup>22</sup> [www.humanitarianinfo.org/iasc](http://www.humanitarianinfo.org/iasc)

## Actions for civil society:

- Strengthen the capacity of refugee community leaders and organizations, including those of people living with HIV, to advocate for their rights.
- Increase communication and cooperation between refugee and host communities and their representatives, including community leaders, women's groups and student groups.
- Challenge stigma and discrimination against refugees and advocate necessary legal and policy reforms to ensure that their human rights are respected and fulfilled.
- Increase networking and information exchange between refugee groups and organizations working on behalf of refugees and between refugees and policy makers.

## Actions for international partners:

- Advocate and support governments to meet their international obligations under refugee and human rights law and implement strategies that reflect best practices in responding to the HIV-related needs of refugees and host communities.
- Encourage governments to consider the needs of refugees in preparing funding proposals, provide resources for incorporating these needs into national HIV and health policies and programmes, and ensure that funding conditions do not prevent funds from being simultaneously used for refugees and host communities.
- Support governments in norm setting and identifying packages of services for refugees and in developing effective systems for data collection and analysis, and using data to inform policies and programmes.

## Policy-makers' voices:

*Dr David Apuuli, Director General of the Ugandan AIDS Commission*

Uganda currently hosts about 260 000 refugees, the majority of whom are from the Democratic Republic of the Congo, Rwanda and the Sudan. The Ugandan Government's approach has been one of integration, recognizing our responsibilities to refugees in our country. Under the Government's Self-Reliance Strategy, refugees have been provided with land, and live in settlements together with our citizens.

Since 2004, the Government has worked in partnership with UNHCR to ensure access to local services, food security and improve income generating opportunities for refugees and local communities alike. This approach has provided a strong foundation for responding to HIV among both refugees and local communities. It has ensured access to additional funding to strengthen the capacity of local health services to address HIV related needs of both refugees and local communities.

HIV has no borders, so we must respond to HIV not only within our own country, but also together with our neighbours. A critical part of the work of The Great Lakes Initiative on AIDS is to enable participating countries to develop consistent and coordinated approaches so that we can respond effectively.

*Dr Kamran Lankarani, Minister of Health and Medical Education, Islamic Republic of Iran*

It is estimated that today about 2 million refugees are living in Iran. They are mostly from Afghanistan—the large majority of them are women and children. The Government of Iran has always made, and will continue to make available, all health interventions including HIV prevention, treatment and care for our refugee populations without discrimination against them.

So far, all HIV prevention and care programmes including methadone maintenance therapy and other harm reduction measures, have been provided free of charge to all refugees living in Iran. The Government is also providing them with antiretroviral medicines, based on national care and treatment protocols.

The country's HIV policy, developed recently with the participation of all stakeholders, devotes a chapter to HIV prevention among refugees and migrant populations.

In order to respect the dignity of the individual and uphold human rights, which in our constitution includes the right to health, and considering also that refugees are integrated within our host populations, Iran is committed to maintaining and promoting the health of its refugees.