THE BRIDGE

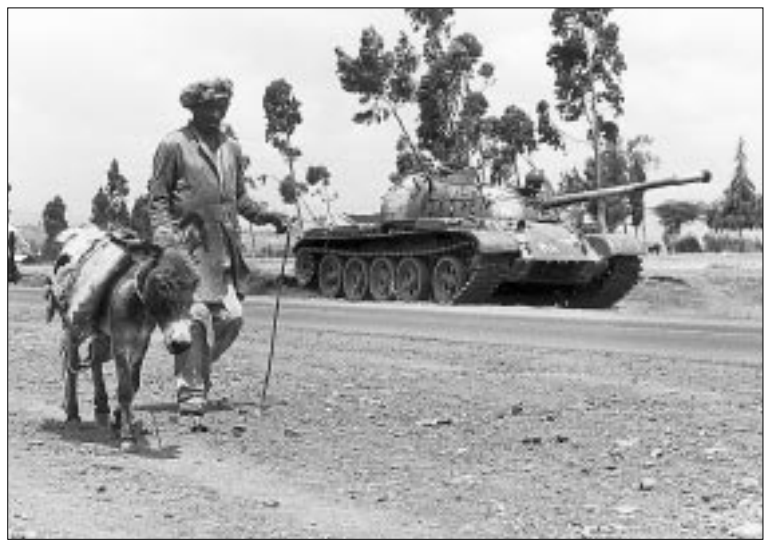
Migration and HIV

War, oppression, refugee camps fuel spread of HIV

From the war zones of Rwanda, Bosnia and Sierra Leone, to the stigmatised migrant communities of the industrialised North, there is a growing body of evidence linking war and forced migration to the spread of HIV.

A clear and dire warning emerges from interviews with panelists at the *12th World AIDS Conference*, some of them key members of Geneva's international community, and with other specialists in forced migration. They confirm that when basic health infrastructure disappears, or when health services are systematically denied to specific populations, a rise in HIV infection cannot be far behind.

NGO experts, in particular, argue that HIV prevention and counselling should remain a top priority, even in settings where other basic needs like food, water and shelter have become logistically difficult to provide. Some charge that UN agencies have balked at the idea of delivering HIV and STD services in refugee camps – not because it's impossible, but simply because it's too expensive.



Refugees fleeing war zones are vulnerable to HIV transmission and difficult to reach as community cohesion breaks down. WHO PHOTO BY L. GUBB

30,000 women raped

Manuel Carballo, coordinator of the International Centre for Migration and Health in Geneva, notes that complex emergencies are "totally disruptive" of individual, family and community life. The experience "disorganises and disperses families, breaks down much of the social cohesion that characterises stable societies, and increases the vulnerability of people."

In complex emergencies like the war in Bosnia, an obvious example is the use of widespread sexual violence. "If we look at Bosnia, Mozambique, Rwanda, Liberia, Sierra Leone, these are situations in which rape has been systematically used as a tool of war" Carballo continues.

Although data are not available for many conflicts, elevated rates of HIV infection followed the wars in Mozambique and Angola. Carballo said an estimated 30,000 to 40,000 women were raped during the war in Bosnia, and "we don't believe those figures are particularly unique or unusual."

During the acute phase of a complex emergency, "you get a population of girls and women who find themselves either on the road or in camps," Carballo explains. "In the camps, they're highly vulnerable to marauding groups, even including the people who are supposed to be guarding them." Women may also have to provide sex to buy additional security or food for themselves and their children.

The acute stage of a complex emergency may end fairly quickly, but Carballo says migrants' vulnerability to sexual exploitation doesn't end there. Even when refugees are integrated into receiving communities, "the economic structure of these communities is something too complex, difficult, or closed for refugees to fit into." As a result, "exposure to sexual abuse and exploitation becomes a much greater reality than it does in stable societies."

A number of responses to this situation have been put forward, from educating military troops on the sexual rights of women, to augmenting refugees' capacity to protect themselves.

Millicent Obaso of Nairobi, Kenya coordinates reproductive health services in refugee situations for the International Federation of the Red Cross (IFRC). She stresses the importance of meeting the immediate sexual health needs of refugees during the first six weeks of an emergency situation, when they are on the move from one country to another.

Maternal mortality matters

"Those needs were overlooked in the past, because the medical practitioners were more concerned with other diseases" like diarrhoea, malaria, and respiratory illnesses. Those are important too, she says, "but we also believe that maternal mortality is largely caused by reproductive health-related problems."

In relation to HIV/AIDS, Obaso says human behaviour is another concern. "We've learned that even those who are at war still have their sexual drives. The lawlessness and homelessness makes them feel that the consolation is probably in sex, and they need to be protected."

The IFRC supplies condoms to refugees in transit, and tries to deliver immediate assistance to women who are raped. In one successful pilot project, the organisation established a clinic on a riverboat between Congo and Rwanda. "Privacy is missing sometimes in that kind of setting," Obaso says. "But it's better than nothing. A woman who is about to die may have her life saved."

In more stable refugee situations, the IFRC may play a role in evaluating the sexual health services that are provided. "Very little is done in the area of HIV/AIDS, partly because it's expensive," Obaso explains. "Counselling takes a lot of time. And once you start it, you have to go the whole way. You can't just counsel someone, then not help them if they want to know their HIV status." And if they're infected, "you have a commitment to support them with that problem – not just through counselling, but with medical services."

Although the IFRC works with the UN High Commission on Refugees (UNHCR) to screen blood donations in some of the larger camps, Obaso says NGOs lack the resources to provide a full range of HIV/AIDS services. She suggests international agencies like UNHCR have also been reluctant to allocate funds for full-fledged HIV/AIDS programmes in refugee camps.

Mohamed Dualeh, UNHCR's senior public health officer, told The Bridge the agency has treated HIV/AIDS as a priority issue for the past five years, and works closely with UNAIDS to produce technical manuals and guidelines on AIDS in refugee camps and emergency settings. He says UN