HIV/AIDS, Conflict and Forced Migration
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I. Basic information

The HIV/AIDS pandemic is exacerbated by conditions of violence and instability, which increases the risk of exposure to the disease through large movements of people, widespread uncertainty over conditions, and reduced access to medical care… If unchecked, the HIV/AIDS pandemic may pose a risk to stability and security. (UN Security Council Resolution 1308, 17 July 2000)
Forced migration and HIV/AIDS are two of the crucial social issues facing the world today and can be seen as a ‘double emergency’ in some countries. Over twenty million people have died of AIDS-related illnesses over the past two decades, and there are an estimated thirty-eight million people living with HIV/AIDS around the world. There are also some seventeen million displaced persons globally. The association between HIV/AIDS and forced migration predictably appears particularly strong in sub-Saharan Africa with its large number of high intensity conflicts, its large and diverse population of displaced persons, and its overall HIV/AIDS prevalence rates estimated at somewhere between 7.5 per cent and 8.5 per cent (UNAIDS/WHO 2003). According to a paper presented to UNHCR, ‘within years, the mortality [from HIV/AIDS] is expected to double in the refugee camps. The ravages of the HIV epidemic in the camps in terms of social and medical consequences and its death toll outweigh those of any other single disease’ (UNHCR, 15 February 2001).

The links between HIV/AIDS, conflict and forced migration are at a relatively early stage of being explored and researched. Three key elements are central to the issue of forced migration and HIV/AIDS. Firstly, the correlation between conflict, forced migration, and the spread of HIV/AIDS. Secondly, the way in which forced migration can increase vulnerability to becoming infected with HIV/AIDS and its effects. Thirdly, the way in which HIV/AIDS could be a causal factor in humanitarian crisis and forced migration. After a brief definition of the key terms involved, these three issues are addressed in turn. This is followed by an overview and analysis of the key international legal instruments of relevance to the subject, and the guidelines that have been developed by the main actors involved. A summary of the main challenges that are faced when trying to tackle HIV/AIDS in situations of conflict and forced migration are then presented.

1.1 Definitions
The International Association for the Study of Forced Migration (IASFM) describes forced migration as ‘a general term that refers to the movement of refugees and internally displaced people (those displaced by conflicts) as well as people displaced by natural or environmental disasters, chemical or nuclear disasters, famine, or development projects’. The main causes of involuntary displacement are wars and armed conflicts, although natural disasters and development projects are also factors. According to the United Nations High Commissioner for Refugees (UNHCR), there are some fifty million uprooted people around the world, including both refugees and internally displaced persons (IDPs), of whom around 75 to 80 per cent are women and children.

The legal definition of a ‘refugee’ is a person residing outside his or her country of nationality, who is unable or unwilling to return because of a ‘well-founded fear of persecution on account of race, religion, nationality, membership in a political social group, or political opinion’ (Article 1 of the 1951 United Nations Convention Relating to the Status of Refugees). The most widely used definition of IDPs is one presented in a 1992 report of the Secretary-General of the United Nations (UN), which identifies them as ‘persons who have been forced to flee their homes suddenly or unexpectedly in large numbers, as a result of armed conflict, internal strife, systematic violations of human rights or natural or man-made disasters, and who are within the territory of their own country’.

Websites:
International Association for the Study of Forced Migration (IASFM) - http://www.iasfm.org/pages/1/index.htm
UNAIDS - http://www.unaids.org
UNHCR (legal documents): http://www.unhcr.ch/cgi-bin/txex/vtx/basics
II. Forced migration and the spread of HIV/AIDS
2.1 The biology of HIV/AIDS

There are a number of modes of infection for the human immunodeficiency virus (HIV). These are:

- unprotected sex
- mother-to-child-transmission (MTCT). This can be prenatally, at the time of delivery, or postnatally through breastfeeding
- use of infected blood or blood products
- intravenous drug use with contaminated needles
- other modes of transmission involving blood such as bleeding wounds.

Once the virus enters the body, the virus attacks a particular set of cells in the human immune systems known as CD4 cells. Ultimately the virus destroys immune cells quicker than they can be replaced and the number of CD4 cells falls. In a healthy person there are 1,200 CD4 cells per microlitre of blood. In an HIV infected person, the CD4 cell count falls below 200. At this point opportunistic infections begin to occur and the person is said to have acquired immunodeficiency syndrome (AIDS).

The period from HIV infection to illness and death is crucial for the analysis and planning of the epidemic’s social, economic, and political impact. It was generally believed that in the richer countries people would live on average for ten years before they began to fall ill with AIDS. Without treatment, the normal period from the onset of AIDS to death is thought to be twelve to twenty-four months. With the development of effective antiretroviral therapies, infected people can expect to live a meaningful life for a longer period of time.

The incubation period in the developing world was thought to be shorter - between six and eight years. This is based on the assumption that people in the developing world often have poorer nutrition, lower health status, and less access to health care. However, a number of studies have also found similar incubation periods to those in the developing world (Barnett and Whiteside 2002: 30-34). The evidence suggests that the period from the onset of AIDS symptoms to death is shorter in developing countries because of lower health status, poorer nutrition, less access to health care, and the higher prevalence of opportunistic diseases such as tuberculosis. In addition, the vast majority of people in the developing world do not have access to antiretroviral therapy which would prolong both the HIV incubation period and the time spent living with AIDS.

Responses to the disease include, firstly, prevention. This covers the provision of male and female condoms, treatment of sexually transmitted diseases (which facilitate HIV infection), the effective screening of blood products and sterilization of medical equipment, and provision of antiretroviral drugs such as Nevirapine to mothers and children during delivery to reduce mother-to-child transmission. In addition, microbicides are currently under development. These are chemical substances that could be used vaginally and which aim to kill the HIV/AIDS viruses upon entry to the body. Interventions to prevent exposure to HIV by altering risky behaviour - ‘Knowledge, Attitude and Practices and Behaviour’ (KAPB) interventions - are also a key element in HIV/AIDS prevention. However, the problem is that even if people have the knowledge, they may not have the incentive or the power to change
their behaviour. It is therefore critical to recognize the structural socio-economic and political factors that increase vulnerability to becoming infected with the disease. Please see below for more details on vulnerability.

The second response is providing treatment and care for people living with HIV/AIDS. This includes the use of antiretroviral drugs which delay the onset of full-blown AIDS and therefore allow people living with HIV to lead fulfilling and productive lives. Treatment also covers opportunistic infections arising from HIV/AIDS such as tuberculosis and pneumonia. The limited ability of developing countries to purchase antiretroviral drugs, medicines to treat opportunistic infections, and facilities to ensure their adequate provision has prevented the beneficial effects of these treatments experienced in wealthier countries. Organizations such as the Treatment Actions Campaign, Médecins Sans Frontières, ActionAid, and WHO/UNAIDS have all launched campaigns to increase access to essential HIV/AIDS drugs. The response of care includes medical, nutritional, and psychosocial support for people living with HIV/AIDS, including palliative care for those close to dying of HIV/AIDS. Care and support should also be extended to orphans, the elderly, and other vulnerable surviving family members. The third response is the search for a cure and vaccine. Neither has yet been developed.

Websites:
ActionAid (access to drugs) - http://www.actionaid.org.uk/index.asp?page_id=1195
Global Campaign for Microbicides - http://www.global-campaign.org/
HIV Insite (University of California) - http://hivinsite.ucsf.edu/InSite?page=KB
International Partnership for Microbicides - http://www.ipm-microbicides.org/
Médecins Sans Frontières (access to essential medicines campaign) - http://www.accessmed-msf.org/
UNAIDS (antiretroviral therapy) - http://www.unaids.org/EN/in+focus/topic+areas/antiretroviral+therapy.asp
UNAIDS (microbicides) - http://www.unaids.org/EN/in+focus/topic+areas/microbicides.asp
WHO (3 by 5 initiative) - http://www.who.int/3by5/en/
WHO (microbicides) - http://www.who.int/hiv/topics/microbicides/microbicides/en/
WHO (prevention) - http://www.who.int/hiv/topics/en/

2.2 Forced migration and the epidemiology of HIV/AIDS
Epidemiology is the study of the distribution, frequency, and determinants of health-related events in human populations. It is based on the premise that adverse health outcomes do not occur randomly within a population but rather occur in somewhat predictable patterns. It describes the social and geographical distribution and dynamics of disease, and highlights the social and economic influences that help determine the spread of health problems such as HIV/AIDS (Hennekens and Buring 1987; Lilienfield and Lilienfield 1980). It identifies determinants that make individuals, groups, or a society more or less vulnerable to epidemic spread, and vulnerable to the adverse consequences resulting from illness and death. Barnett and Whiteside (2002: 65) note how ‘pathways of infection are mapped on to social, cultural and economic relations between groups of human beings … We all share the same world, but unequally, so are differentially exposed to disease organisms.’

Prevalence is the most commonly used epidemiological measurement of HIV/AIDS and refers to the percentage of the population which exhibits HIV or AIDS at a particular point in time. There is an important difference between prevalence rates and mortality rates because of the long cycle of progression from HIV to AIDS (and the variation in the onset of AIDS to
death). For example, South Africa has a prevalence rate of around 20 per cent amongst the adult population, whilst the annual AIDS death rate (mortality rate) over the next decade is projected to be between 1.5 per cent and 4 per cent of the adult population (UNAIDS, ‘Report on the Global HIV/AIDS Epidemic’, July 2002 - http://www.unaids.org/EN/resources/publications/corporate+publications/report+on+the+global+hiv+aids+epidemic+2002+.asp).

The mass movement of people is commonly understood to be a key factor in the geographic spread of communicable disease, including HIV/AIDS (Minas 2001; Smith 2002; UNAIDS February 2001; UNAIDS June 2000). Similarly, the negative impact of political violence upon health, and the influence of different typologies of conflict upon health, is increasingly well recognized (Murray et al., 2002; Richard et al. 1999; Noji 1997; Connolly and Heymann 2002; Levy and Sidel 1997).

However, it is virtually impossible to provide a standardized picture of morbidity and mortality in forced migrant populations. This is because of the wide variation in the availability and quality of health services in the conflict-afflicted and host countries, as well as in levels of wealth, epidemiological conditions, the type of settlement, and the prevalence and nature of the political violence. In addition, the epidemiological evidence on the link between HIV/AIDS and forced migration remains scarce and often subject to high levels of bias (Hynes et al. 2002; Salama and Dondero 2001; Spiegel et al. 2001b). This is largely due to the inherent difficulties associated with operating in a complex emergency situation. For example, the population movement means it is difficult to identify whether changes in prevalence rates are due to changes in risk factors, or fluctuating numbers of people (denominators). Many poor countries also lack reliable health registration systems, making it particularly difficult to get baseline demographic and health data, and denominators to determine the extent of HIV-related mortality and morbidity amongst displaced peoples. Refugees and internally displaced persons are also frequently not systematically included in HIV surveillance systems, and those forced migrants that are able to access these sites are not necessarily representative of the entire forced migrant population. For example, sentinel surveys to estimate HIV prevalence are also usually carried out in antenatal clinics and centres for treating sexually transmitted infections (STIs). In areas affected by conflict, these are most often not functioning. Such data collection is further impeded by insecurity, political involvement, restricted access to areas of conflict and sources of information, public fear and mistrust, lack of infrastructure, and lack of trained people to carry out the survey. HIV/AIDS may also be an underlying cause of mortality from diseases such as pneumonia and tuberculosis but is frequently not recorded as such. Lastly, displaced persons are very often left off the agenda of host governments. Even in more stable countries, such as Uganda and Thailand, which are often viewed as models of best practice in HIV surveillance and prevention, virtually no data exist about the HIV status of their large forced-migrant populations (Salama and Dondero 2001).

It was previously assumed that conflict itself increased HIV infection rates because of its impact upon health systems causing reduced capacity to screen blood/blood products, use of non-sterile medical equipment, reduced testing and treatment for HIV/AIDS and other sexually transmitted infections (STIs), and halting of HIV/AIDS prevention programmes. However, research at UNHCR has challenged this (Spiegel 2002; Spiegel and Qassim 2003; Spiegel and Nankoe 2004). The research has noted that the increased risk and vulnerability encountered during conflict does not inevitably mean increased exposure and infection to HIV/AIDS. The main factor that would appear to decrease HIV transmission in conflict situations is reduced population mobility due to destroyed infrastructure, trade, and conflict in surrounding areas. There is also evidence for decreased consensual sex due to trauma and
depression (Green 2003). Research by the Centres for Disease Control and Prevention (CDC) confirms such findings. Prevalence rates in Sierra Leone were 0.9 per cent and in Southern Sudan, 2.3 per cent. These were both lower than all surrounding countries, many of which have not been in conflict (Kaiser et al. 2002). Low HIV prevalence rates relative to surrounding countries have also been reported in Angola, which suffered from decades of civil war (De Jong and Spiegel 2003). As a result, HIV prevalence rates in some areas of conflict appear lower than in more stable neighbouring areas. The majority of refugees are therefore moving from conflict countries with lower HIV prevalence rates than those in which they seek refuge (Spiegel and Qassim 2003).

The danger is that as people are forced to leave conflict-affected areas, they are placed at increased risk as they move into areas of increased HIV/AIDS prevalence. Data indicates that amongst some refugee populations HIV/AIDS rates do increase. A resultant critical issue is the post-conflict period, as displaced people with potentially higher HIV/AIDS prevalence rates return to communities with lower rates. For example, prevalence rates among Rwandan returnees from Tanzania and Zaire was found to be 9 per cent, compared to prewar rates of 1 per cent in the rural areas from which 95 per cent of them came (Schrek 2000). Data from Angola also raises concerns about the risk of increased HIV rates in the general population following the return of refugees. The HIV prevalence rate in Angola is 1 to 4 per cent, whilst among Angolan refugees in neighbouring countries (Zambia and Namibia) it stands at 5 to 10 per cent, and among host communities in these neighbouring countries at 15 to 25 per cent (Spiegel and Qassim 2003). In Mozambique, sentinel surveys show that the HIV levels of high-risk populations were relatively low until the war ended, at which point the resumption of normal patterns of social mixing occurred alongside a marked rise in prevalence rates (UNAIDS/WHO, 2000b). Similar concerns are also expressed about Sierra Leone (ARC/CARE/IRC 2004: 24-5). The risk of rapidly increasing prevalence rates in post-conflict countries rises further as trade, transport, and population mobility all increase whilst health systems and HIV/AIDS prevention work remain limited. The importance of integrating HIV/AIDS programmes in post-conflict reconstruction efforts is therefore paramount.

The risk faced by displaced persons entering areas of higher prevalence rates are inextricably linked to other issues of vulnerability and these are discussed further in the following section.

Websites:
HIV Insite (University of California) - http://hivinsite.ucsf.edu/
WHO (peace-building) - http://www.who.int/disasters/bridge.cfm

2.3 Forced migration and increased vulnerability to HIV/AIDS
In addition to the risks of entering areas with higher HIV/AIDS prevalence rates, forced migration can increase vulnerability to becoming infected with HIV/AIDS and the effects of the disease. This includes exacerbating existing factors of vulnerability to becoming infected with HIV/AIDS such as poverty, poor access to health care, poor nutrition, lack of education, and political, economic, and social discrimination. The breakdown of social structures and
networks, lack of local language and knowledge of the new environment further increase vulnerability. Forced migrant populations are frequently politically and economically marginalized groups who may not have had equitable access to health programme resources and are unlikely to have a political voice. The prejudice and stigma associated with HIV/AIDS can also become particularly virulent when combined with stigma directed at displaced persons (Salama and Dondero 2001; Decosas 1995).

The main cause of HIV/AIDS infection is sexual transmission, and those caught up in and fleeing from complex emergencies tend to be more vulnerable to sexual transmission for a number of reasons. Firstly, increased sexual violence and rape. Combatants have frequently used rape as a weapon of war, with examples of systematic rape found from the conflicts in Mozambique, Rwanda, Liberia, Sierra Leone, Sri Lanka, Bosnia, Kosovo, and Sudan (Elliot 1999; Donovan 2002; Amnesty International 2004). Increases in HIV infections amongst the general population in Eastern Democratic Republic of Congo (DRC) (HIV prevalence between 15 and 24 per cent) have been attributed to massive sexual violence by paramilitary groups and foreign militaries, as well as the general breakdown in health services (Save the Children 2001). According to one UN official, rape by the military and civilians alike of refugee populations has become systematic in conflict-affected countries such as DRC, and despite the known risk of HIV, the authorities are doing little to control the epidemic (quoted in Smith 2002: 8). A survey among Burundian refugees in a Tanzanian camp identified that 26 per cent of women had experienced sexual violence since becoming a refugee (Holmes 2001). The cramped conditions and layout of refugee camps may also increase the vulnerability of women and young girls and boys to sexual abuse.

Secondly, increased use of sex as a commodity by women as a result of losing income caused by crisis and displacement. According to a 1999 WHO study in eastern and central Sudan, 27 per cent of single mothers surveyed had become sex workers to earn a living. Orphaned and unaccompanied children are particularly at risk in emergencies and often end up forced to trade sex for provisions, including to peace-keepers (Renaud 2001; Lawday and Webb 2002).

Thirdly, the breakdown of family, social, and/or cultural structures and consequent loss of norms that regulate sexual activity in stable conditions can also increase higher risk sexual activity and therefore vulnerability to HIV/AIDS. For example, there may be a desire to replace lost loved ones, either by having new children or by developing relationships with new partners. In the absence of formative social structures and the constraining influence of family and community, adolescents are also more likely to engage in risky behaviour such as alcohol or drug abuse, and increased sexual activity. In environments in which war is the norm and life-expectancy is low, there is an understandable lack of concern about HIV/AIDS when there are other, much more immediate threats such as violence, malnutrition, and more immediately debilitating diseases (Smith 2002: 8).

Fourthly, the sexual behaviour of armed forces, including peace-keeping units, can further spread HIV/AIDS (Smallman-Raynor and Cliff 1991; Hankins et al. 2002; Elbe 2003). The high-risk sexual behaviour associated with military forces and peace-keepers has resulted in prevalence rates being far higher among military personnel than the civilian population in both their countries of origin and those in which they are operating. In Cambodia surveys estimate the HIV prevalence rate for military personnel to be 8 per cent, while the rate among the Cambodian civilian population is 2.7 per cent (UNAIDS 2000a). According to one report, 32 per cent of peace-keepers in Sierra Leone originate from countries with HIV prevalence rates greater than 5 per cent (quoted in Elbe 2003: 40). A 2001 unpublished study in Sierra Leone conducted interviews with a sample of 202 United Nations’ peace-keepers and soldiers from the national army, and found that only 23 per cent of respondents could spontaneously
cite at least three routes of AIDS transmission; 38 per cent reported not being worried about AIDS; and only 39 per cent had used a condom during their last sexual activity (ARC 2001). The effect is that armed personnel and peace-keepers act as vectors of the disease to the civilian population they are mandated to protect. Little research appears to exist on the evidence of transmission of HIV/AIDS from armed forces and peace-keepers to displaced people specifically. However, given the close proximity between displaced persons and armed forces/peace-keepers, and high rates of voluntary, paid, and coerced sexual interaction between these groups, transmission rates could be hypothesized to be high.

The nature of settlement for displaced persons is also critical when addressing levels of vulnerability. Well-organized refugee camps may offer improved protection, nutrition, health services (including for HIV/AIDS prevention, treatment of opportunistic infections and care), education, and social services (Spiegel 2004b). The duration time in camps is also relevant, with long-term post-emergency refugee camps generally having better preventive and curative health services than the shorter term camps, and the surrounding local host population (Spiegel et al. 2002; Hynes et al. 2002). For example, research by UNHCR has found that there is a pattern of reduced HIV rates in camp populations. Using antenatal sentinel surveillance, HIV prevalence was measured among pregnant women in more than twenty camps housing around 800,000 refugees in Kenya, Rwanda, Sudan, and Tanzania. Results showed that the refugee populations in three of the four countries had significantly lower HIV prevalence rates than the surrounding host communities. In the fourth, the refugees and host community had comparable rates (Spiegel 2002). However, the results of these studies should not be used as an argument to ignore the needs of displaced persons. As Sam Guy from Marie Stopes International (MSI) and the Reproductive Health Response in Conflict Consortium (RHRC) notes, ‘the aim of any HIV/AIDS programme is to reduce transmission and if levels are low in these settings then we have the best possible reason to step-up prevention activities to ensure that they stay low. Not only is this good public health, it also makes sense in terms of reducing costs for treatment and care in the future’ (Guy 2004).

However, where camps are more open (where population movement is less restricted and interaction with the local community higher), the HIV/AIDS risk would also appear higher (Salama and Dondero 2001). In situations where refugees and IDPs are dispersed the risks of contracting HIV/AIDS appear much higher because the protective factors in camps is removed and people are generally placed in environments of higher HIV/AIDS prevalence (see previous section). Given that an estimated 60 to 75 per cent of Africa’s refugees may have never lived in camps, large numbers of displaced persons are therefore placed at increased risk of HIV/AIDS in their new surroundings.

Websites:
HIV Insite (University of California) - http://hivinsite.ucsf.edu/
2.4 Vulnerable groups

Between 75 and 80 per cent of displaced persons worldwide are women and children (http://www.unhcr.ch/cgi-bin/texis/vtx/statistics), and amongst groups of displaced persons, women and children appear at particular risk of contracting HIV/AIDS. In sub-Saharan Africa, women are at least 1.2 times more likely to be infected with HIV than men. Among young people aged 15 to 24, women were found to be two-and-a-half times as likely to be HIV infected as their male counterparts. Women are sexually active from an earlier age than men and infected on average six to ten years younger than men, and are biologically more vulnerable to contracting HIV (AIDS epidemic update, UNAIDS 2003a: 7). The lower social status of women also magnifies their vulnerability to being infected with HIV/AIDS, and vulnerability to its impact. The above mentioned risk of exploitation and abuse, including coercion into transactional sex for survival, is further increased in conflict situations. Many of the burdens of HIV/AIDS at the household level fall upon women, as they are the main producers of food and the main carers for children, the elderly, and the sick. The high levels of female mortality as a result of HIV/AIDS commonly result in increasing malnutrition amongst children and deterioration of household security and stability (World Bank 2000a).

Adolescents (aged 10 to 24) are at most risk of HIV infection, with 50 per cent of all new infections occurring amongst this age group (UNICEF, http://www.unicef.org/aids/index.html). Despite this there appear to be insufficient operational sexual health programmes targeting displaced adolescents (Women’s Commission 2000, see http://www.womenscommission.org/pdf/adol2.pdf). One study found that 30 per cent of adolescent girls aged 15 to 19 in Sierra Leone had not heard of AIDS (UNICEF 2000). Many children and young people orphaned by HIV/AIDS are frequently forced to become carers instead of being cared for. Those unable to care for themselves are less able to rely on an extended family or support network because of HIV/AIDS mortality and also the stigma associated with the disease. Such children and young people are particularly at risk of undertaking commercial sex, and of joining or being abducted by local militias who offer food, shelter, and identity. This abusive use of children as soldiers and the extreme actions they are led to commit puts this group at increased risk of contracting HIV (Lawday and Webb 2002: 5; UNICEF/USAID/UNAIDS 2002; Barnett and Whiteside 2002: 210).

Within the displaced populations, it appears that Internally Displaced Persons (IDPs) are at a greater degree of risk for several reasons. IDPs’ access to health care is often more limited, particularly as it may be offered by the government that caused their displacement in the first place. They are often far more difficult to access by humanitarian agencies and so less likely to receive health information and services, and generally suffer worse health outcomes than refugees or host populations as a result (WHO 2000; Salama et al. 2001; Lawday and Webb 2002: 14). Higher rates of integration into host communities may also increase HIV/AIDS transmission rates between the two groups. In a study of IDPs in Burundi, only one in twenty IDPs could identify condoms as a means of protection against HIV/AIDS (Wexler 2003: 11-13). A 1996 national HIV prevalence survey in Rwanda revealed an overall prevalence rate of 11 per cent, with the highest rates of 13.9 per cent found in IDPs (Mayaud 2001).

Similarly, knowledge on the situation for refugees not living in camps, such as urban refugees, is limited. However, it is expected that their vulnerability is higher than those living
in camps. Dispersed and urban refugees are often less documented and so receive less material support from UNHCR or other agencies, and rely upon host government services that may discriminate against them (Bruns and Spiegel 2003; Spiegel and Qassim 2003: 72-4). Evidence from urban refugees in South Africa suggests they are at considerably greater risk (Spiegel and Nankoe 2004).

Those who have directly suffered trauma of one sort or another are perceived as being at greater risk, and typically psycho-social programmes are used to help people cope with trauma, whether from conflict, epidemics or other distressing events. However, the notion of trauma and use of psycho-social programmes is heavily contested. It is criticized for being a Western concept that is not necessarily applicable to non-Western populations where people may have different understandings of such events and how to survive them. It is also criticized for depicting passive, vulnerable victims to events, whereas in fact most people are able to function and survive, developing coping mechanisms appropriate to their situations. (Ager 1997; Bracken et al. 1995; Richters 1998; Summerfield 1996, 1999; Wessells 1999). It is argued that a more effective way to support people who have experienced trauma is to develop on-going support structures from within a community and activities that promote a community’s well-being.

However, the degree to which people are able to cope in such circumstances and the notion of coping itself has also been questioned, particularly the ability to survive in the short term often at the expense of future well-being (Lawday and Webb 2002: 5; Harvey 2003: Barnett and Whiteside 2002: 325-7). Examples include the withdrawal of children from schools, women being forced to become sex workers, and the sale of household assets to provide additional family income and time for caring for vulnerable relatives.

Websites:
HIV Insite/University of California (sexual violence): http://hivinsite.ucsf.edu/InSite?page=kbr-08-01-09
International Committee of the Red Cross (ICRC) - Women and war - http://www.icrc.org/web/eng/siteeng0.nsf/iwpList2/Focus:Women_and_war
International Society for Traumatic Stress Studies - http://www.istss.org
Saving Women’s Lives - http://www.savingwomenslives.org/
UNAIDS (young people) - [http://www.unaids.org/Unaids/EN/In+focus/Topic+areas/Young+people.asp](http://www.unaids.org/Unaids/EN/In+focus/Topic+areas/Young+people.asp)

### III. The impact of HIV/AIDS on stability and security

Severe instability and state collapse is a multi-faceted phenomenon involving a number of interrelated processes. These can include damaged social institutions (such as the family, and the education and health systems), a volatile economy, poverty, high crime, the erosion of the government’s popular legitimacy, and control of the armed forces (Allen 1999; Elbe 2003; Barnett and Whiteside 2002: 4-98). High rates of HIV/AIDS may contribute to all of these processes, as recognized as early as 1990 when the CIA added AIDS incidence/prevalence to the list of variables to be considered when analysing state stability (Elbe 2003: 45).

Increased attention is now being paid to the strategic implications of HIV/AIDS, including its potential role as a causal factor in forced migration. Due to the fairly recent nature of the debate, complexity of the issue, and lack of information and reliable data, it is not possible to give a definitive picture of the strategic implications posed by HIV/AIDS. Opinions on the issue fluctuate between those who believe that the security risk posed by HIV/AIDS is dangerously underestimated and that HIV/AIDS could weaken states to the point of collapse (Singer 2002: 146; Schneider and Moodie, 2002), and those who believe that HIV/AIDS is a contributory factor to instability, but not the main cause (Elbe 2003: 9-10). Some of the key issues will now be addressed.

#### 3.1 Impact upon socio-economic and political stability

At the micro-economic level, HIV places great strain on agricultural output, food security, household earnings, and ability to cope due to adult morbidity and mortality from HIV/AIDS. It is estimated that infection of HIV by a family member results in a decline in household income by as much as 40 to 60 per cent (Lundberg et al. 2001). Women are particularly badly affected, as men tend to have more access to assets than women. HIV/AIDS also leads to a loss of knowledge and skills due to increased adult mortality, with particular impact on agricultural output and land use. This is accompanied by an increase in household expenditure (for medical care, drugs, transport, and funeral expenses) which thereby reduces the amount of income the household has available for other essential items. Access to credit is also increasingly restricted (Lundberg et al. 2001; De Waal 2003a: 1234-7; Barnett and Whiteside 2002: 222-41; Harvey 2003).

The social impact of HIV/AIDS is profound. For example, in sub-Saharan Africa in 1999, 860,000 primary school children lost their teachers to AIDS, and Africa is expected to lose 10 per cent of its teachers to AIDS by 2005 (Harvey 2003: 16). The Zambian Ministry of Education reports that 2.2 per cent of teachers died of AIDS in 1996. This was more than the
number produced by all teacher training colleges. The death rate in Zambia is expected to triple by 2005 (Barnett and Whiteside 2002: 311).

The ability of governments to provide effective health services is severely affected as HIV/AIDS increases the strain on what are already extremely limited resources. HIV/AIDS also impacts upon economic growth and tax revenue and therefore the ability fund health care. Health staff are dying of AIDS whilst there is a shortage in replacement staff as the national labour pool reduces from sickness and death from the disease. In Malawi it is estimated that between 25 and 50 per cent of all health care workers may be dead from AIDS by 2005 (Foreman et al. 2000). In the mid-1990s it was estimated that 66 per cent of Rwanda’s health budget and over a quarter of Zimbabwe’s went on treatment for people with HIV/AIDS (Commons Select Committee on International Development, 29 March 2001). According to the US National Institute for Security (December 2000) the worst affected countries will devote more than half of their health budgets to tackling the disease.

Not only are countries having to cope with the direct costs of preventing and treating HIV/AIDS, they are also having to do so whilst macro-economic growth declines as HIV/AIDS mortality and morbidity hit the most economically productive demographic age groups. The disease reduces access to education, decimates the labour force, increases absenteeism, increases training costs, and reduces productivity. It also reduces savings, erodes the tax base, and reduces the size and wealth of markets. It may also increase uncertainty, and undermines confidence in the economy, and so could discourage private and foreign investment.

A number of macro-economic studies and predictive modelling exercises have been conducted to assess the impact of the disease upon national economies. A World Bank study (2000a) suggests that an adult prevalence rate of 10 per cent may reduce the growth of national income by up to a third. A macro-economic predictive modelling study of South Africa by Arndt and Lewis (2000) projected that by 2010 the economy would be 17 per cent smaller than it would have been without AIDS and the per capita income 8 per cent smaller. A World Health Organization report conservatively estimates that the economic value of the lives lost due to AIDS in sub-Saharan Africa is equivalent to 11 per cent of the region’s combined gross national product in 1999 (WHO 2001: 31-2). While these losses could be absorbed for a year or two, they pose larger problems when they occur cumulatively over a sustained period of time. A senior World Bank official cited HIV/AIDS as the single greatest threat to economic development in sub-Saharan Africa (quoted in Harvey 2003: l2). According to Alex De Waal (2003b: 1-23), Director of Justice Africa, HIV/AIDS has effectively thrown the process of political and economic development into reverse in a number of countries.

HIV/AIDS can also increase civil crime. The ability of police forces to conduct their work is reduced. In Zambia, AIDS is estimated to have caused 75 per cent of deaths in the police force between 1998 and 2000, whilst crime has reportedly risen as some people living with HIV/AIDS are apparently less concerned with the potential repercussions of criminal activity given their limited life expectancy (Elbe 2003: 49). As mentioned in the previous section, the high numbers of orphans as a result of AIDS has also increased risk of crime, and of orphans being abducted by criminal gangs or insurgent groups and becoming child soldiers (UNICEF/ USAID/UNAIDS 2002; Barnett and Whiteside 2002: 210). It is estimated that up to half of all combatants in Sierra Leone were in the age range of 8 to 14 years (Peters and Richards 2003).
The impact upon the disease at the governance level is less understood and requires more study, but it is assumed to erode the capacity to govern. Weak political leadership over HIV/AIDS would inevitably exacerbate the situation. Tensions could also emerge if one group felt itself disproportionately affected by HIV/AIDS and/or marginalized from care and treatment. For example, in Uganda in the mid-1990s the Defence Minister is alleged to have suggested that one of the most likely potential triggers for a coup was the perception among the military that the government was not doing enough to combat HIV/AIDS (Elbe 2003: 50). Ruling groups have in the past been willing to manipulate health and nutritional supplies to damage the support base of political opponents. According to one specialist, ‘the uneven distribution of essential HIV treatment based on social, ethnic, or political criteria could well put unmanageable pressures on social and political structures, threatening the stability of regimes throughout Southern Africa’ (Cheek 2001). The prominence of HIV/AIDS as a campaign electoral campaign issue is also increasingly likely, as apparent in the general election in Malawi in May 2004 (http://www.guardian.co.uk/international/story/0,,1220449,00.html).

This social and economic upheaval is generally taking place in political economies that were already fragile and weakened by a variety of other factors such as poverty, acute inequality, and weak governance. A report to the Select Committee on International Development at the British House of Commons (29 March 2001) noted that ‘evidence suggests that in societies facing economic crisis and a lack of clear political leadership the presence of HIV/AIDS with its associated stigma may cause instability’. It goes on to note that ‘there is thus a prima facie argument … that HIV/AIDS increases poverty, that there will be greater social insecurity and possibly conflict as a result of the HIV/AIDS epidemic’.

Websites:
HIV Insite/University of California (Political economy of HIV/AIDS) - http://hivinsite.ucsf.edu/InSite?page=kbr-08-01-10
UNAIDS (economics and development) - http://www.unaids.org/en/in+focus/topic+areas/economics+and+development.asp
UNAIDS (impact on agriculture and rural households) - http://www.unaids.org/en/in+focus/topic+areas/impact+on+agriculture+and+rural+households.asp
UNAIDS (non-school education) - http://www.unaids.org/EN/in+focus/topic+areas/education+--+outside+school-settings.asp
UNAIDS (school education) - http://www.unaids.org/EN/in+focus/topic+areas/schools.asp

3.2 Impact upon national and international security
From the limited data available, it appears that HIV/AIDS is having a serious impact upon armed forces around the world, with prevalence rates far exceeding those found in civilian populations both in their country of origin and in the surrounding civilian population in the area of deployment (Altman 2003; Heinecken 2001). UNAIDS studies indicate that military forces have infection rates between two and five times higher than the civilian population (UNAIDS 1998a: 2). According to the National Intelligence Council (2000), several armed forces in sub-Saharan Africa have HIV prevalence rates of around 10 to 20 per cent, with
some as high as 60 per cent. Rates in the Cambodian military range from 6 to 17 per cent, and in Haiti 1995 prevalence rates in the military were reported to be around 10 per cent. In 1996, 34 per cent of all deaths among active-duty military personnel in the Congo were estimated to be AIDS related. In Zambia and Namibia, AIDS-related illnesses now constitute the leading cause of death among the military and police forces. In Thailand, the military has designated HIV/AIDS a threat to national security (Elbe 2003: 23). Reasons for higher prevalence rates include mobility, frequent casual sexual relations (particularly with sex workers), peer pressure, and alcohol and drug use (Elbe 2003: 17). The issue of demobilization of combatants, their reintegration into civilian life, and the impact this may have on the spread of HIV/AIDS is also an area of concern (Carballo et al., October 2000).

Implicit within this is the effect that HIV/AIDS is having upon peace-keeping operations (Tripodi and Patel 2002). Many armed forces with high HIV prevalence rates also regularly contribute to international peace-keeping operations aimed at mitigating and containing the outbreak of armed conflicts. In addition, peacekeeping forces are at increased risk of becoming infected by being deployed in areas of high prevalence. This is particularly so in Africa where three-quarters of the police officers and soldiers under UN command are stationed (International Crisis Group 2004). According to senior officers in the French army’s health services, tours of duty overseas multiply the risk of HIV infection for French military personnel by a factor of five. Among Nigeria’s military forces returning from peace-keeping duties in Sierra Leone and Liberia, HIV infection rates were 11 per cent compared with the national adult rate of 5 per cent. (UNAIDS 1998a: 5). The effect is that peacekeepers act as vectors of HIV, spreading the virus among population in areas of deployment and back in their country of residence. As a result, HIV/AIDS has additional regional and international strategic ramifications by hindering international attempts to respond to conflict by threatening peace-keeping operations as countries become less able or willing to contribute personnel (Elbe 2003: 39). However, some military forces are responding to the threat in a progressive manner, such as prevention programmes being run by the Ugandan military (ICG 2004). The UN General Assembly has also recognized the problem and in September 2003 launched a global initiative on ‘Engaging Uniformed Services in the Fight against HIV/AIDS’ in partnership with UNAIDS, UN’s Department of Peace-keeping Operations (DPKO), and national governments (http://www.unaids.org/en/in+focus/topic+areas/uniformed+services.asp).

Elbe (2003: 23) notes that ‘the crucial question, therefore, is not whether HIV/AIDS is having an impact on the armed forces, but rather how, in the worst-affected countries, this impact will manifest itself, and with what overall strategic significance. These include impacting upon human and financial resources due to continual replacement and training of lost personnel, an inability to find sufficient numbers of new recruits, and damaged morale and cohesion, and civil-military relations.’

Peter Singer (2002: 146) believes that HIV/AIDS will weaken armed forces ‘to the point of failure or collapse’. The most common hypothesis is that such a reduced military capacity could increase a state’s vulnerability to external attack, or its vulnerability to internal rebel groups, because of the perception by the aggressors that the armed forces were no longer an effective threat. However, Stefan Elbe (2003: 36) notes that high prevalence rates amongst armed forces could conceivably have benign strategic benefits with a reduction in operation efficiency hampering expansionist military plans in bellicose countries.

Websites:
IV. International law, forced migration, and HIV/AIDS

Three interrelated branches of international law, which complement and reinforce each other, relate to HIV/AIDS, refugees, and IDPs. In each field, the body of law is primarily made up of treaties, which create binding obligations for the countries that have ratified them. International law is informed by authoritative interpretations of treaty provisions, international consensus documents, and the comments and recommendations of the bodies created by each treaty to monitor implementation. The three interrelated fields are outlined below.

4.1 International human rights law

A human rights framework provides a useful basis for understanding and addressing the vulnerability of refugees to HIV/AIDS. It helps address societal and contextual factors that determine vulnerability, and to analyse how approaches to tackling HIV/AIDS may protect and possibly violate human rights (Mann 1999; Holmes 2001; McLellen 2001; Marin et al. 2003). This includes respecting people’s right to health and essential medicines (such as antiretrovirals), non-discrimination, confidentiality, privacy, information, freedom of movement self-determination, and protection from violence. UNHCR, UNAIDS, and a number of NGOs have all integrated a human rights framework into their policies, guidelines, and activities (see ‘International Guidelines’ section below for links to guidelines).

International human rights law relating to health and HIV/AIDS includes Article 25(1) of the Universal Declaration of Human Rights (UDHR), the 1966 International Covenant on Economic, Social, and Cultural Rights (ICESCR), and its partner covenant, the International Covenant on Civil and Political Rights (ICCPR). Of most relevance is Article 12 of the ICESCR, which recognizes ‘the right of everyone to enjoy the highest attainable standard of physical and mental health’. In the refugee context, the ICESCR states that everyone has rights with regard to health, without mention of citizenship or legal residency. The principle of non-discrimination is also fundamental to human rights law and is of particular significance to both displaced people and those living with HIV/AIDS who frequently suffer from high levels of stigma and discrimination. This is reflected in Article 1 of the UDHR, the Preamble to the UN Charter, and Article 2(2) which states that these rights apply without discrimination of any kind as to ‘race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status’. The UN Sub-Commission on the Prevention of Discrimination and the Protection of Minorities has considered that ‘other status’ in the non-discrimination context should include health status (UN doc. E/CN/.4/Sub.2/1994/L.42). See http://www.unhchr.ch/html/intlinst.htm for the specific international human rights instruments.

The United Nations Committee on Economic, Social, and Cultural Rights, the treaty body composed of experts to monitor implementation of the ICESCR provisions, provided further details in 2000 on Article 12 through ‘General Comment 14’, which makes explicit reference to HIV/AIDS.
Further substantive and procedural support is provided by regional mechanisms such as the European Social Charter (Articles I and II); the European Convention on Human Rights and its five protocols (Article I); the African Charter on Human and Peoples’ Rights (Article 16); the American Convention on Human Rights (Article 4); and the American Declaration on the Rights and Duties of Man (Article XI).

International human rights conventions, such as the 1979 Convention on the Elimination of All Forms of Discrimination against Women (CEDAW, http://www.un.org/womenwatch/daw/cedaw/), are also of relevance (Articles 10, 12, 14, and 16). The CEDAW Committee, which is a treaty body, issued a General Recommendation in 1999 on Article 12 of the Women’s Convention, which states outright that access to health care includes reproductive health care for all women and girls, ‘even if they are not legally resident in the country’. The Committee noted that special attention should be given to the health needs and rights of refugee and internally displaced women. The Convention on the Rights of the Child (1989) has also been used to try to meet the needs of children impacted upon by conflict and the HIV/AIDS epidemic (http://www.unhchr.ch/html/menu3/b/k2crc.htm).

A number of international conferences have used a human rights approach to advance reproductive health and the fight against HIV/AIDS. Most notably, the 1994 International Conference on Population and Development (ICPD) helped develop a broader, more expansive human rights based approach to reproductive health. This included HIV/AIDS and reproductive health in conflict situations, noting that ‘reproductive health care should be available in all situations and be based on the needs and expressed demands of refugees, particularly women, with full respect for the various religious and ethical values and cultural backgrounds of the refugees while also confirming with universally recognized international human rights’ (http://www.unfpa.org/icpd/). While such international consensus documents do not create binding obligations, they are agreed to by governments and thus reflect political will. They are also widely used by NGOs as advocacy tools and by treaty-monitoring bodies as standards for evaluating how states are meeting their treaty obligations.

While international human rights law provides a solid legal basis for health rights, it is subject to a number of weaknesses which have limited its impact (Girard and Waldman 2000). Its enforcement mechanisms are notoriously weak, and in the case of ICESCR, are limited to reporting by countries to the treaty body. Treaties generally also do not create legal obligations for non-state actors such as insurgent groups, who might control territories where many refugees or IDPs find themselves. Additionally, certain human rights can be suspended in times of war or in serious national emergencies, precisely at the time when refugees and IDPs are most likely to need this protection. Furthermore, human rights conventions do not deal explicitly with internally displaced populations or forced relocations, do not provide for a right of access by humanitarian organizations, and are not binding on rebel forces. Also, in practice, refugees often remain on the periphery of effective protection. Non-nationals, simply because of their lack of citizenship, are perceived to stand outside the community, and on that basis may be denied their entitlements under international human rights law. Finally, even when dealing with their own citizens, particularly IDPs, many states are unwilling or unable to observe binding obligations included in the human rights treaties they have ratified (Goodwin-Gill 1996: 55).
The human rights approach has also been criticized in a number of ways. Firstly, on the grounds that the emphasis upon individual rights fails to acknowledge the fundamental nature of contagious disease which requires a communal, public health effort. Secondly, that the individuality of the human rights approach has meant that the structural questions of distribution of resources and power have been marginalized and that a social justice framework would be more appropriate (De Cock et al. 2002). Whilst the use of human rights discourse and law by agencies promoting HIV/AIDS care can be used as a lever to improve government responsiveness, it also runs the risk of antagonizing the government against such agencies, and may prompt accusations of impartiality against agencies on the part of governments (Rieff 2002; Fox 2001; White and Cliffe 2000; Slim 1997b).

Websites:
Amnesty International - http://www.amnesty.org/
Amnesty International (Stop Violence Against Women campaign) - http://web.amnesty.org/actorwomen/index-eng
Center for Reproductive Rights - http://www.crlp.org/
HIV Insite/University of California (human rights and HIV/AIDS) - http://hivinsite.ucsf.edu/InSite?page=kb-08-01-07
UNHCHR - http://www.unhchr.ch

4.2 International refugee law and humanitarian law
The UNHCR 1951 Refugee Convention and related Protocol of 1967 (see http://www.unhcr.ch/cgi-bin/texts/vtx/basics) address the specific rights of refugees. The Convention requires signatory countries to treat refugees lawfully staying in their territory the same as they treat their own nationals, with respect to social security schemes including health (Article 24).

IDPs are also not covered by the Refugee Convention. To address this shortfall, non-binding legal principles on internal displacement have now been developed and disseminated. These draw on analogous refugee law and existing humanitarian and human rights law (Deng 1999) and include the right to health care. However, responsibility for the protection and provision of basic services to IDPs still rests with national governments, many of which may be unwilling to prioritize the delivery of services to IDPs, or may lack the technical capacity to
coordinate or monitor the programmes of international humanitarian organizations during emergencies.

Humanitarian law provides an important complement to human rights and refugee law regarding the provision of health services in times of armed conflict. It partially addresses internally displaced populations, forced relocations, and the right of access by humanitarian organizations. It is set forth in the 1949 Geneva Conventions and their two 1977 Additional Protocols (see http://www.icrc.org/Web/Eng/siteeng0.nsf/htmlall/party_gc). These apply to non-combatants such as refugees and IDPs in situations of international armed conflict and in certain situations of internal armed conflict. The basic principles include the obligation for all parties to collect and care for the sick and the wounded, as well as the obligation to respect and protect hospitals, ambulances, and medical personnel, and to provide protection against rape and indecent assault.

However, humanitarian law does not cover all armed conflict situations, with internal conflicts being particularly problematic, and the difficulty in enforcing international law is often exacerbated in cases of civil war. Although IDPs are guaranteed certain basic rights under the Geneva Conventions, ensuring these rights are secured is often the responsibility of authorities that were responsible for their displacement in the first place. The IDPs can also not invoke the same legal protections as refugees. As a result, access by IDPs to health care is often very limited, particularly as often no specific international humanitarian agency is responsible for providing them with protection and humanitarian assistance. Although a representative of the UN Secretary-General on Internally Displaced People was appointed in 1992 and Guiding Principles on Internal Displacement were introduced in 1998, these are not legally binding.

Websites:
International Committee of the Red Cross (Geneva Convention and additional protocols) - http://www.icrc.org/Web/Eng/siteeng0.nsf/htmlall/party_gc
UNHCR - http://www.unhcr.ch

V. International guidelines and resources to tackle HIV/AIDS in conflict situations
The most recent and comprehensive guidelines available are the updated 2003 ‘Guidelines for HIV Interventions in Emergency Settings’ produced by the Inter Agency Standing Committee, which is a consortium of UN agencies, the Red Cross, and governmental and non-governmental agencies (http://www.humanitarianinfo.org/iasc/publications.asp). The guidelines provide a list of recommended multi-sectoral activities to be conducted in three phases (emergency preparedness; during an emergency; and the stabilized phase).

UNAIDS, the joint UN programme on HIV/AIDS, is the key UN body concerned with HIV/AIDS, and coordinates the HIV/AIDS-related activities of other UN agencies such as WHO, UNICEF, UNHCR, UNDP, and UNFPA. The UNAIDS website (http://www.unaids.org/en/default.asp) is the key source for excellent information on HIV/AIDS, including for forced migration. They have produced a wide-range of useful guidelines, fact sheets, and other documents on subjects relating to HIV/AIDS and forced migration. These can found at http://www.unaids.org/en/in+focus/topic+areas.asp.
UNHCR have a number of useful HIV/AIDS guidelines, reports, and materials which can be best accessed through http://www.unhcr.ch/cgi-bin/texis/vtx/home?page=PROTECT&id=401915744.

The International Federation of Red Cross and Red Crescent societies also provide some information on HIV/AIDS services (http://www.ifrc.org/what/health/hivaids/index.asp) and are in the process of developing best practice guidelines for NGOs providing HIV/AIDS services in humanitarian crisis situations (see http://www.ifrc.org/what/health/hivaids/code/).

The leading set of guidelines on reproductive health for displaced persons is the ‘Interagency Field Manual for Reproductive Health in Refugee Situations’ (see http://www.unfpa.org/emergencies/manual/) produced by a consortium of UN agencies and NGOs. This includes details on the provision of a Minimum Initial Service Package (MISP) for reproductive health in refugee situations. WHO have also produced ‘Reproductive Health during Conflict and Displacement’, which complements the Interagency Field Manual and focuses particularly on the vulnerability of women and young people to sexual violence (http://www.who.int/reproductive-health/publications/RHR_00_13_RH_conflict_and_displacement/). NGO guidelines include ones developed by IRC, Médecins Sans Frontières, and the Women’s Commission. Please see below for web links.

A number of ethical codes of conduct for agencies providing humanitarian relief have also been developed since the early 1990s. These include the ‘Code of Conduct’ produced by the Red Cross movement and a number of NGOs, which seeks to safeguard high standards of behaviour by humanitarian agencies and to maintain the independence and effectiveness of disaster relief (http://www.ifrc.org/what/values/). A second code of conduct was developed in the form of the Sphere project to try to improve accountability among aid agencies (http://www.sphereproject.org). Its first objective is to assist the international humanitarian community in developing a common framework for humanitarian action. Known as the ‘Humanitarian Charter’, the framework is based on key principles in international human rights and humanitarian law, and on the Red Cross/Red Crescent Code of Conduct. The second objective of the Sphere project is to outline minimum technical standards for humanitarian interventions (Griekspoor and Collins 2001).

Please see the ‘Other Resources’ section for links to other resources on the web.

Guidelines on the web:
International Humanitarian Forum on War and Accountability - http://www.icrc.org/web/eng/siteeng0.nsf/iwpList2/Focus:Accountability
Médecins Sans Frontières (various) - http://www.msf.org/source/refbooks/index.htm
VI. Challenges
6.1 Increasing resources and commitment
The global response to HIV/AIDS generally has expanded significantly in the past few years. However these developments do not match the epidemic’s scale or pace. There is an urgent need to boost prevention programmes, and antiretroviral treatment coverage remains dismal in sub-Saharan Africa overall (UNAIDS/WHO 2003a: 4). Assistance for displaced people and in conflict situations is particularly scant (Lubbers 2003; Smith 2002; Lawday and Webb 2002; ICG April 2004; De Cock et al. 2002).

According to a report commissioned by Save the Children, the ‘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 HIV/AIDS’ (Lawday and Webb 2002: 1).

The Global Fund for AIDS, Tuberculosis, and Malaria (GFATM, http://www.theglobalfund.org/en/) represents the largest multi-lateral funding agency for HIV/AIDS. However it has been criticized for failing to take into account the needs of displaced persons (Spiegel 2004b). For example, in the first round of disbursements by GFATM in early 2002, conflict-affected countries were largely bypassed, with only Burundi, Rwanda, and Cambodia receiving funds for HIV/AIDS prevention and care work. In a study of funded projects up to the third GFATM funding round, of twenty-nine countries with refugee populations of more than 10,000 in Africa, twenty-three had approved proposals with an HIV/AIDS component for the GFATM. However, only five included refugees in their proposals and of those five only three gave specific details of activities with refugees (Spiegel and Nankoe 2004). For example, Uganda and Thailand, widely viewed models of best practice, both failed to include displaced persons in GFATM-approved projects worth over $157,000,000 despite having 236,041 and 121,715 displaced persons respectively (Please see below for links for funding provided by GFATM to specific countries, and for numbers of displaced persons.) Funding by the World Bank’s Multi Country AIDS
Programme fares a little better (for map, see http://www.worldbank.org/afr/aids/map.htm). Of the twenty-nine countries with refugee populations of more than 10,000 in Africa, sixteen were funded, but only eight gave specific details of activities with refugees (Spiegel 2004b). Ruud Lubbers, the UN High Commissioner for Refugees, noted that ‘not only are refugees accused of spreading HIV and other diseases, but they are often excluded from multi-million dollar HIV/AIDS programmes … The development of integrated HIV/AIDS strategies would be given an enormous boost if donor governments would loosen current restrictions on funding so money can be used more flexibly to provide HIV/AIDS programmes to both refugees and local communities’ (Lubbers 2003b).

The US administration’s ‘President’s Emergency Plan for AIDS Relief’ (PEPFAR, http://www.state.gov/s/gac/rl/or/c11652.htm), which as of July 2004 had pledged $15 billion over five years to fight HIV/AIDS, has also failed to take into account the needs of displaced peoples, and has incurred the anger of many within the HIV/AIDS community because of its faith-based policies, particularly the prioritization of abstinence over condoms to prevent HIV/AIDS. At the time of the XV International AIDS Conference in Bangkok in July 2004, Dr Peter Piot, Executive Director of UNAIDS, declared that ‘we know condoms save lives. We are not in the business of morality. Condom promotion should be part of education about sexuality for young people.’ Poul Nielsen, the EU’s Commissioner for Development and Humanitarian Aid, criticized US administration for ‘preaching one line only and denying people’s rights by trying to push them into abstinence. It will weaken the battle against Aids, and the unfortunate reality is that it will directly endanger the lives of millions of women’ (http://observer.guardian.co.uk/international/story/0,,1258589,00.html).

Despite increasing concern over potentially rapid increases in HIV/AIDS prevalence in post-conflict situations, there remains a weakness in factoring in AIDS into conflict resolution activities. Peter Piot stated to the UN Security Council on 17 November 2003 that ‘I do note with some regret, however, that the Security Council has not taken the opportunity to expressly address AIDS in a number of recent resolutions establishing and extending UN missions, especially given that some of these missions are operating in regions which already have major HIV epidemics’ (quoted in Elbe 2003:67). Analysts must take more seriously the growing burden of widespread illnesses such as HIV/AIDS when surveying the contemporary strategic landscape and the implications this may have for forced migration (Elbe 2003: 67).

Websites:
Global Fund to fight AIDS, Malaria and Tuberculosis (GFATM) - http://www.theglobalfund.org/en/
HIV Insite (University of California) - http://hivinsite.ucsf.edu/InSite?page=Policy
President’s Emergency Plan for AIDS Relief (PEPFAR) - http://www.state.gov/s/gac/rl/or/c11652.htm)
WHO (3X5 initiative) - http://www.who.int/3by5/en/
6.2 Increasing support of host governments

The capacity of governments to respond to the overall HIV/AIDS crisis is clearly limited, with many countries struggling to provide adequate services to their own populations, particularly in post-conflict situations. The need to support host governments and encourage strong leadership in their HIV/AIDS programmes is paramount (DFID 2004: 24-30, http://www.dfid.gov.uk/Pubs/files/HIVAIDStakingaction.pdf). A study by Kennedy et al. revealed that despite the high risk of rapidly rising HIV/AIDS prevalence rates, Liberia ‘is in a stage of vague awareness … regarding HIV/AIDS-related activities … there is a critical need to acquire adequate resources and build capacity to implement effective HIV/AIDS-related programming services’ (Kennedy et al. 2004: 169-80).

It also appears that many host countries often do not view refugee health programmes as within the scope of their national aids control programmes, relying instead upon UNHCR to look after the welfare of these populations (Salama and Dondero 2001: 15 (suppl. 3), S8). In a UNHCR study of twenty-two African countries with over 10,000 refugees, only fourteen HIV/AIDS National Strategic Plans mention refugees, and only ten have any specific activities aimed at refugees (Spiegel 2004b: p.713). Spiegel (Spiegel and Nankoe 2004: 23) notes that ‘Refugees have been systematically excluded from many host countries. HIV/AIDS National Strategic Plans … improving HIV/AIDS interventions for refugees in an integrated manner with the surrounding host population will invariably improve services for both communities.’ Rudd Lubbers, the High Commissioner for Refugees noted that ‘host countries should stop excluding refugees from their AIDS programmes. It is highly discriminatory and totally counter-productive … these individuals have been neglected for too long’ (Lubbers 2004).

Thailand, Uganda, and Senegal have all developed relatively successful HIV surveillance and prevention systems and yet virtually no specific data exist about the HIV status of their large forced migrant populations (Salama and Dondero 2001: S4-S12). The danger is that as a result, their needs will be largely ignored. De Waal (2003: 1-23) also notes that regional government initiatives such as the ‘New Partnership for Africa’s Development’ (NEPAD) ‘include scant reference to HIV/AIDS as a public health problem and none at all to its development impact - or the impact upon conflict and security’.

The failure of governments to incorporate displaced persons into their national AIDS activities and surveillance systems has implications for HIV/AIDS funding for displaced persons - particularly where governments take the main management role. In a study by Brugha et al. (2004: 95-100) of experiences to date with the GFATM, one representative in Tanzania noted that ‘there is an imbalance of power in favour of [government], which is talking only on behalf of government …’. The result is that agencies representing displaced persons are marginalized from the main sources of AIDS funding. In Tanzania, there are no specific activities mentioned for displaced persons in any of the three accepted GFATM projects which total over US$109,707,298 in approved funds. This is despite the fact that Tanzania has an estimated 649,940 displaced persons within its borders. Please see below for links for funding provided by GFATM to specific countries, and for numbers of displaced persons.

Governments also need to work hard to change the atmosphere of discrimination against both displaced peoples and those with HIV/AIDS, and to reduce social and economic vulnerability by promotion inclusion and participation. They must also ensure that HIV/AIDS testing is voluntary, and that HIV/AIDS status will not affect the legal status of refugee and its
associated benefits. Without such assurance, displaced persons will inevitably avoid government services.

Websites:

6.3 Towards a more comprehensive provision of services
The difficulties faced by staff of humanitarian agencies in such complex emergency situations are considerable, and concerns exist as to whether work on HIV is beyond their organizational remit, and whether the particular skills required by emergency programming are suited to addressing HIV-related issues. Lawday and Webb, of Save the Children, note that ‘humanitarian efforts to tackle HIV/AIDS have concentrated on preparing guidelines that field staff have often lacked the capacity and confidence to implement’ (Lawday and Webb 2002: 2). Staff are also hampered by the lack of data and information on effective HIV interventions in emergency settings. The attitudes of local authorities have had a detrimental effect upon agencies’ abilities to provide such services (Smith 2002: 23).

HIV/AIDS services to displaced persons appear to be caught in the debate between humanitarianism and development, with some humanitarian agencies seeing it as the work of specialist development and HIV/AIDS practitioners, whilst development and HIV/AIDS practitioners commonly see any services for displaced persons as purely humanitarian. Despite the links between emergencies and HIV vulnerability, agencies’ humanitarian emergency operations have tended to focus on meeting basic needs, providing shelter and food, and treating infectious diseases such as measles, cholera, and dysentery (Smith 2002). Whilst some emergency health interventions may address immediate, biomedical aspects of HIV/AIDS vulnerability and transmission, by their very nature they generally fail to address the underlying social and economic issues related to HIV and displacement that a longer-term development approach would be more suited for.

In addition, the context of conflict situations has changed over the past decade - camp scenarios are no longer the norm since populations are often dispersed among local communities. In many conflict situations, ongoing war has led to ‘chronic emergencies’ affecting entire countries and with long rehabilitation phases such as have occurred in Afghanistan, Angola, Somalia, and the DRC. In such situations longer term HIV/AIDS work is essential as the increased risk and prevalence of the disease presents major threats to the long-term health of these populations.

The result appears to be that some agencies are failing adequately to provide HIV/AIDS services. A September 2000 study by the Women’s Commission for Refugee Women and Children indicated that of the eighty agencies surveyed, only eight had a reproductive health policy or guidelines. Among US-based international NGOs included in the study, only 22 per cent were addressing HIV/AIDS programming (Women’s Commission 2000b). In a survey of refugee settings worldwide, UNHCR found that Voluntary Counselling and Testing (VCT) is not available in most programmes (UNHCR, HIV/AIDS and Refugees: UNHCR’s Strategic Plan 2002-2004, Geneva, 2004). Similarly, STI services are still neglected, despite their relative simplicity and strong evidence for effectiveness in
reducing HIV/AIDS transmission in refugee settings (Mayaud 2003; Mayaud et al. 2001: 121-4). Mother-to-child transmission (MTCT) prevention programmes also do not seem to be universally applied, despite evidence suggesting that MTCT can be higher during complex humanitarian emergencies (Khaw 2000). A 1999 study by MERLIN revealed that out of thirteen HIV/AIDS programmes for displaced people, only three provided home-based care for terminally ill people and only one included income-generating activities to support orphans (Young 1999a). UNICEF have also reported failures in developing programmes for young people (UNICEF 2000; UNICEF/USAID/UNAIDS 2002). A report by Save the Children notes that ‘humanitarian agencies operation in most conflict settings are 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 peoples with access to HIV prevention and treatment services’ (Lawday and Webb 2002: 1). The active participation of displaced people, particularly vulnerable groups, in supporting programme activities would also appear to be paramount.

However, some agencies have managed to overcome these challenges and are providing a more comprehensive range of reproductive health and HIV/AIDS services. Agencies such as ARC, IRC, and UNHCR are conducting surveillance, VCT and prevention of MTCT activities in their respective programmes with displaced and conflict-affected populations in Kenya, Uganda, Tanzania, and Sierra Leone. The benefits of providing services in refugee camps were highlighted by results from the study by Kabagabo et al. (1999) of HIV serosurvey. This revealed an overall HIV prevalence of 11.1 per cent compared to people who had been displaced in camps outside the country (10.5 per cent) with the lowest rates among returning long-term exiles (9.7 per cent). It appeared that rates were lowest amongst those returning from camps in Tanzania (compared to Zaire or Burundi), where HIV/AIDS prevention and STI interventions had been greater (Mayaud 2001: 121-4). Results from an HIV/AIDS prevention project run by ARC also indicate the benefits of implementing such activities in post-conflict settings (ARC/RHRC 2003, see http://www.rhrc.org/pdf/ARCSLPostInterventionSurvey.pdf). To ensure such progress becomes more widespread, ‘there is a need to increase advocacy efforts aimed at humanitarian agencies to encourage their support of HIV/AIDS programming’ (Purdin et al., 2001). In addition, governments and donors need to support agencies in the scaling up of HIV/AIDS services.

It is critical to ensure that such work is integrated and coordinated with HIV/AIDS programmes by local health authorities for the host population. If longer-term support is going to be provided by agencies, it inevitably requires the consent and support of the host government. It is crucial that the needs of the previously under-served minority groups are recognized and that more equitable and appropriate access to health services is ensured, in order to avoid a continuance of problems (that may have led to the conflict or displacement itself).

Care and treatment
There is considerable debate over the provision of antiretroviral treatment for HIV/AIDS for displaced persons, with concerns raised over costs, and the ability to maintain provision and access for treatment due to population movement and return. There is also the possibility of reduced treatment efficacy if drug-resistance rises as a result of non-compliance. This is particularly pertinent as displaced persons may repatriate to areas where ARV treatment is not available. The potential effects of increasing drug resistance could have quite serious public health implications. UNHCR are currently developing a strategy to address this issue.
There is also concern that the increasing focus on treatment will undermine prevention, and lead to a remedicalization of HIV/AIDS, and so distract from attempts to recognize and address the social and economic determinants of the disease (Barnett and Whiteside 2002: 364). There is debate regarding the treatment of tuberculosis (which as an opportunistic infection accounts for over a third of AIDS deaths worldwide) for displaced persons due to concerns over treatment continuity and drug-resistance arising from halted treatment regimes.

However, others question the ethics of denying treatment to displaced persons whilst settled populations are increasingly provided with it. The declaration by the Ugandan government to provide free antiretrovirals could prove a test case with regard to the large numbers of refugees and IDPs residing there. Examples already exist of the provision of antiretrovirals in conflict areas by humanitarian agencies, with MSF (Holland) providing antiretrovirals in the DRC. The apparent scaling up of antiretroviral treatment generally, as a result of initiatives such as WHO’s 3X5, the Global Fund for AIDS, Tuberculosis, and Malaria (GFATM), and the (US) ‘President’s Emergency Plan for AIDS Relief’ (PEPFAR), would suggest that it is likely that an increasing number of displaced persons will be receiving treatment prior to displacement. Humanitarian agencies and host governments may therefore be required to provide for the continuation of such people’s treatment.

Websites:
HIV Insite (University of California) - http://hivinsite.ucsf.edu/InSite?page=KB
Médecins Sans Frontières (access to essential medicines campaign) - http://www.accessmed-msf.org/
President’s Emergency Plan for AIDS Relief (PEPFAR) - http://www.state.gov/s/gac/rl/or/c11652.htm
UNAIDS (antiretroviral therapy) - http://www.unaids.org/EN/in+focus/topic+areas/antiretroviral+therapy.asp
WHO (3X5 initiative) - http://www.who.int/3by5/en/#

Protection
Fundamental to protecting the human rights of people living with HIV/AIDS are the issues of stigma and discrimination. HIV/AIDS-related stigma can be described as a ‘process of devaluation’ of people either living with or associated with HIV/AIDS (UNAIDS 2003b). This often stems from the underlying stigmatization of sex and intravenous drug use - two of the primary routes of HIV infection. HIV/AIDS-related stigma builds upon, and reinforces, existing prejudices. It also plays into, and strengthens, existing social inequalities - especially those of gender, sexuality, and race. The risk is that where stigma exists people may prefer to ignore their real or possible HIV status. This can increase the risk of faster disease progression for themselves as well as the risk of spreading HIV to others.

Discrimination follows stigma and is the unfair and unjust treatment of an individual based on his or her real or perceived HIV status. Discrimination occurs when a distinction is made against a person that results in their being treated unfairly and unjustly on the basis of their belonging, or being perceived to belong, to a particular group. When applied to displaced persons, both stigma and discrimination can become particularly pronounced in both the new area of settlement and upon return to the area of origin. It can occur at the social and economic level with reduced access to health and education services, and employment opportunities. It can also occur at the political level, with governments applying or threatening to apply compulsory HIV/AIDS testing, and resultant refusal of entry or repatriation dependent on the test result. Such policies breach fundamental human rights as
well as leading displaced persons to avoid the authorities, including health services, for fear of repatriation. This risks faster disease progression for people living with HIV/AIDS and increasing the spread of HIV/AIDS to others (All Party Parliamentary Committee on HIV/AIDS 2003).

Concerns exist that the immediate, biomedical aspects of HIV/AIDS still dominate, and that insufficient emphasis is being placed on protection issues and vulnerability of women at risk from gender-based violence and rape, and orphans and children separated from their parents during conflict and displacement (Smith 2002; Ward and Brewer 2004). Whilst there is increasing recognition of protection issues in HIV/AIDS policies and guidelines for displaced persons, it would appear that much remains to be done (Beatty et al. 2004; Ward and Brewer 2004; Ward 2002).

Websites:
HIV Insite/University of California (sexual violence) - http://hivinsite.ucsf.edu/InSite?page=kbr-08-01-09
Reproductive Health Response in Conflict Consortium (RHRC) - http://www.rhrc.org

Surveillance, research, and evaluation
Despite the difficulties of conducting HIV/AIDS surveillance (see section 2.2), methodologies do exist for use in both an acute emergency phase and the post-emergency phase. This should ideally include both biological (or serological) surveillance which looks at biologically recorded rates of HIV/AIDS and HIV/AIDS-related diseases such as STIs, tuberculosis and other opportunistic infections, and also behavioural trends (behavioural surveillance). Examples of effective surveillance include programmes by ARC in Sierra Leone and UNHCR in Rwandan refugee camps in Tanzania. Surveillance methodologies can also be found at UNAIDS, including guidelines for resource-constrained settings (please see below for web links). However, there remains a dearth of HIV/AIDS behavioural and biological data in situations of forced migration. Refugees and IDPs frequently remain excluded from national HIV surveillance systems, and those forced migrants that are able to access these sites are not necessarily representative of the entire forced migrant population (Salama and Dondono 2001: S4-S12; Spiegel 2004b: 11). IDPs and urban refugees not living
in camps are particularly poorly documented and so often excluded from governmental and non-governmental assistance programmes (Spiegel 2004b: 713). Such data, especially serial data to establish trends, are essential in directing, monitoring, and evaluating HIV/AIDS programmes. Such data will also improve the current, limited understanding of how conflict and displacement affect the spread of HIV/AIDS.

There is a need for a better evidence base on HIV/AIDS interventions for displaced persons, with NGO staff expressing frustration at the lack of evaluation and information on effective HIV interventions in emergency settings (Smith 2002: 23). Potential areas of investigation include:

- methods to improve integration of HIV/AIDS programmes among displaced and non-displaced populations
- policies and programmes to reduce HIV/AIDS stigma and discrimination towards displaced populations from local communities/governments
- findings on the provision of antiretroviral treatment to displaced persons
- interactions between armed groups, conflict-affected populations and surrounding communities
- cost-effectiveness analysis of HIV/AIDS interventions among displaced persons
- the impact of HIV/AIDS on people’s desire to return to their home area.

Informed consent in combination with the active participation of community members in the design and implementation of surveillance systems are critically important safeguards in reducing prejudice and stigma against those with HIV/AIDS (Salama and Dondero 2001: S11). The limited levels of power and control of refugees and IDPs when participating in medical research means that ethical research standards need to be strongly respected.

Websites:
HIV Insite/University of California - http://hivinsite.ucsf.edu/InSite?page=kbr-08-01-03
London School of Hygiene and Tropical Medicine: ‘Evidence-based Humanitarian Aid’ - http://www.lshtm.ac.uk
UNAIDS (evaluation) - http://www.unaids.org/EN/in+focus/topic+areas/evaluation.asp
UNAIDS (surveillance and reporting) - http://www.unaids.org/EN/in+focus/topic+areas/surveillance+and+reporting.asp

VII. Conclusion
In June 2001 the UN General Assembly’s Declaration of Commitment on HIV/AIDS stated that ‘populations destabilised by armed conflict … including refugees, internally displaced persons, and in particular women and children, are at increased risk of exposure to HIV infection’. It 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’. The extent to which this has taken
place is questionable. As Susan Purdin (Purdin et al. 2001) notes, ‘many - though by no means all – multi-lateral, national, and nongovernmental bodies have issued policy statements that recognise the importance of reproductive health services, and HIV/AIDS prevention and care services in particular, for refugees. The policies, however, are too often stronger on paper than in practice.’

There are strong humanitarian, epidemiological, and strategic reasons for increasing efforts to prevent HIV/AIDS spreading amongst displaced persons, and providing medicines to those living with HIV/AIDS. Managing the crisis is not beyond hope. If sufficient resources and commitment are made available, prevalence and mortality rates could be reduced. Above all, what is required is an understanding of the needs of displaced persons and an active response to those needs. As Ruud Lubbers (2003a), the United Nations High Commissioner for Refugees, notes, ‘refugees should neither be blamed for the HIV/AIDS pandemic and nor should they be ignored’.

VIII. Other resources
8.1 Journals, databases, and media/news sources
Journals
AIDS (the official journal of the international AIDS Society) - http://www.aidsonline.com/pt/re/aids/home.htm;jsessionid=BCEYrMBLJj3xKp1nMDi9Nj6V6RVFxO5X6pCF0R0NobWjee8KiX2!-1476597349!-949856031!9001!-1


AIDS Care - http://www.tandf.co.uk/journals/titles/09540121.asp


AIDS Patient Care and STDs - http://www.liebertpub.com/APC/default1.asp


British Medical Journal - http://bmj.bmjjournals.com/


Lancet - http://www.thelancet.com

Reproductive Health Matters - [http://www.elsevier.com/wps/find/journaldescription.cws_home/622668/description#description]

Databases
African Journals Online - [http://www.inasp.org.uk/ajol/]
Eldis (HIV/AIDS) - [http://www.eldis.org/hiv/aids/index.htm]
Popline - [http://db.jhuccp.org/popinform/basic.html]
Web of Knowledge - [http://wok.mimas.ac.uk/]

Media/news sources
Africa Daily (News) - [http://www.africadaily.com/]
AIDS Channel - [http://www.aidschannel.org/]
AIDS Science (JAMA) - [http://aidscience.com/]
Aegis - [http://www.aegis.com/]
All Africa - [http://allafrica.com/aids/]
British Broadcasting Corporation - [http://news.bbc.co.uk/1/hi/health/background_briefings/aids/default.stm]
HIVinsite (news service) - [http://hivinsite.ucsf.edu/InSite?page=nw-00-00]
HealthNet - [http://www.healthnet.org/]
Guardian (HIV/AIDS) - [http://www.guardian.co.uk/aids/0,7368,405525,00.html]

8.2 Academic and research institutes
Centres for Disease Control and Prevention (AIDS) - [http://www.cdc.gov/hiv/dhap.htm]
Columbia University Mailman School of Public Health - [http://www.mailman.hs.columbia.edu/index.html]
François-Xavier Bagnoud Center for Health and Human Rights (Harvard University) - [http://www.hsph.harvard.edu/xfbcenter/]
Harvard University School of Public Health - [http://www.hsph.harvard.edu/]
HIV Insite (University of California) - [http://hivinsite.ucsf.edu/]
International Centre for Migration and Health - [http://www.icmh.ch/]
Johns Hopkins University Bloomberg School of Public Health - http://www.jhsph.edu/
London School of Hygiene and Tropical Medicine - http://www.lshtm.ac.uk
Overseas Development Institute - http://www.odi.org.uk
Oxford University Refugee Studies Centre - http://www.rsc.ox.ac.uk
University of California (Centre for AIDS Prevention Studies) - http://www.caps.ucsf.edu/
University of Kwazulu-Natal - http://www.nu.ac.za/
York University (Canada) Centre for Refugee Studies - http://www.yorku.ca/crs/

8.3 Governmental, inter-governmental, and multi-lateral institutions
Centers for Disease Control and Prevention (CDC) - http://www.cdc.gov
Department for International Development (UK) - http://www.dfid.gov.uk
International Committee of the Red Cross (ICRC) - http://www.icrc.org
International Federation of Red Cross and Red Crescent Societies - http://www.ifrc.org
International Organization for Migration - http://www.iom.int/
Sphere project - http://www.sphereproject.org
USAID (Synergy Project) - http://www.synergyaids.org/summaries.asp
World Food Programme (WFP) - http://www.wfp.org
World Health Organization (WHO) - [http://www.who.int](http://www.who.int)

8.4 Non-governmental organizations
Action Aid - [http://www.actionaid.org.uk](http://www.actionaid.org.uk)


Amnesty International - [http://www.amnesty.org](http://www.amnesty.org)

Bill and Melinda Gates Foundation - [http://www.gatesfoundation.org/default.htm](http://www.gatesfoundation.org/default.htm)

CARE (International) - [http://www.care.org](http://www.care.org)


Engender Health - [http://www.engenderhealth.org/](http://www.engenderhealth.org/)


International AIDS Society (XV International AIDS Conference, Bangkok) - [http://www.ias.se/bangkok/start.aspx](http://www.ias.se/bangkok/start.aspx)

International Centre for Migration and Health - [http://www.icmh.ch/](http://www.icmh.ch/)


International Family Planning Perspectives - [http://www.agi-usa.org/journals/toc/ifpp2701toc.html](http://www.agi-usa.org/journals/toc/ifpp2701toc.html)


International Rescue Committee - [http://www.theirc.org/](http://www.theirc.org/)


Medact - [http://www.medact.org/tbx/pages/section.cfm?index_id=3](http://www.medact.org/tbx/pages/section.cfm?index_id=3)

Norwegian Refugee Council - [http://www.nrc.no/engindex.htm](http://www.nrc.no/engindex.htm)

OXFAM (International) - [http://www.oxfam.org/eng/](http://www.oxfam.org/eng/)

ReliefWeb - [http://www.reliefweb.int/w/rwb.nsf](http://www.reliefweb.int/w/rwb.nsf)


**IX. Bibliography**


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Hennekens, C. and Buring, J.E., Epidemiology in Medicine, Philadelphia: Lippincott Williams and Wilkins, 1987.


