

Refugees and HIV

Introduction:

Refugees do not necessarily display higher rates of HIV/AIDS infection than do non-refugee populations, but the trying conditions under which they live often leaves them susceptible to disease. The loss of family, property, food security, access to health care and education can lay a fertile breeding ground for the spread of HIV. Refugees can flee from conflict - but they can't always outrun disease.

Contrary to stereotypes that harshly identify them as 'disease carriers', refugees often migrate from conflict-scarred countries with relatively low HIV prevalence rates to more stable countries with higher prevalence rates. A refugee's chances of staying healthy while living in a host country can be boosted by easy access to health care, counselling, food aid and condoms. Many African governments and international NGOs have promised refugees full access to health services - but promises made on paper do not always translate into practice. The United Nations High Commissioner for Refugees (UNHCR) agrees that individual country plans might be insufficient to win the war against HIV under conditions where both people and disease so easily slip across borders.

The Numbers:

According to UNHCR estimates, 8.4 million people around the world were classified as refugees at the end of 2005, the lowest level since 1980. The dramatic reduction in refugee numbers in recent years is largely due to successful programmes of voluntary repatriation.

The total African refugee population at the end of 2005 was estimated at 2.5 million, or about one-third of the global total. Sudanese represent the largest refugee population: At least 693,300 people have fled the fighting in that country. Other large African refugees populations have come from the following nations: Burundi, 438,700; Democratic Republic of Congo, 430,600; Somalia, 394,800; Liberia, 231,100.

The Issues:

1. Who Is A Refugee? Who Is Not?

A person is only classified as a 'refugee' if he or she is escaping conflict or persecution in his or her own country and crosses an international border. Populations displaced by natural disasters, such as earthquakes and floods, or by economic hardship in their home country are not considered refugees. Instead, they are categorised as "populations of humanitarian concern". These people do not fall under the mandate of refugee-focussed organisations such as the UNHCR.

Internally displaced persons (IDPs) are sometimes confused with refugees. IDPs often face the same traumas as refugees - persecution, privation, displacement - but, crucially, they have remained in their home country and not crossed any international borders. By crossing an international border, refugees lose the theoretical protection offered by their home country, but acquire special rights. Lacking these rights, IDPs often suffer greater hardships than do refugees. Within their own countries, IDPs may lose all their basic human rights if their government is persecuting them or is at the point of collapse.

According to the International Displacement Monitoring Centre, Africa was home to about 12 million of the world's 23.5 million IDPs in 2006. The Democratic Republic of Congo Sudan and Uganda are Africa's worst affected countries.

2. What Happens To Refugees?

Refugees typically experience three distinct phases, known as the 'cycle of displacement':

1. The Emergency Phase. An emergency such as conflict or persecution causes refugees to flee their homes. This phase often deprives refugees of vital resources, such as shelter, food, health services and education.

2. The Post-Emergency Phase. Refugees have fled their country and settled in a host country, where they are supplied with the resources they lost during the emergency phase.
3. In the final phase, refugees will, depending on circumstances, choose or be directed into one of three options. They might repatriate to their home country, integrate and remain in their host country, or re-settle (sometimes seeking asylum) in a third country. According to UNAIDS, refugee populations remain in a host country for an average of 17 years.

3. What Factors Put Refugees at Risk to Acquiring HIV/AIDS?

Refugees know one condition better than most populations - instability. War destroys hospitals, schools, farms and houses, tears up communities and rips apart families. The breakdown of the social fabric usually quickens the spread of disease. In many countries, HIV infection rates are particularly high along truck routes or at border crossings, where the population is mobile and drug use is more widespread. Female refugees often find themselves at risk from sexual violence or are forced to trade sex simply to survive. Child refugees might be orphaned and uneducated, leaving them vulnerable to sexual predators.

Although conflict, displacement, food insecurity and poverty might leave them more susceptible to HIV, refugees do not always display higher rates of the infection. According to the UNHCR, a variety of complicated factors determine how seriously HIV affects refugees: Pre-conflict HIV rates among refugees, rates of surrounding communities in refugee camps, the level of interaction between refugees and host populations and exposure to violence will all determine the overall HIV rate in a given refugee population.

Ironically, refugees can also benefit from their status. Populations on the run will sometimes leave high-prevalence HIV zones for the relative safety of more isolated areas. Camps in host countries will often provide better health care, education and protection from violence than refugee populations enjoyed in their home communities.

4. Can Refugees Access HIV/AIDS Services?

The official answer is 'yes' - the more accurate answer is 'sometimes'. The issue of addressing refugees' reproductive health needs can be traced to 1994 with the publication of a report that brought the issue to the fore. (See Women's Commission for Refugee Women and Children. *Refugee Women and Reproductive Health Care: Reassessing Priorities*. New York: June 1994.) Until that time, governments and NGOs were often more occupied with providing the basics of survival and medical services that were considered 'life saving'. Today, HIV/AIDS education, counselling and - in some cases - even treatment is integral to the care provided to refugees.

But not all refugee populations are treated equally. Refugees fair about as well as host communities when it comes to HIV care and treatment: For better or worse, countries of asylum are ultimately responsible for the services refugees receive. A camp in Ethiopia hosting Eritrean refugees, for example, might provide little in the way of health care and lack even the resources to test for HIV. However, camps in Zambia hosting Angolan refugees provide good medical care, voluntary HIV testing and even a steady supply of condoms to ward off the spread of disease. Refugees in South Africa have legally enjoyed the same rights to health care as South African citizens, but a variety of reasons, including language barriers, fear and xenophobia, mean foreign populations don't always receive equal treatment.

Governments and NGOs must also be careful to safeguard refugees' basic human rights. For this reason, testing for HIV cannot be made mandatory - making it difficult to determine precise infection rates among refugee populations.

See: "ETHIOPIA: Eritrean refugees desperate for HIV services"

http://www.plusnews.org/AIDSReport.ASP?ReportID=6516&SelectRegion=Horn_of_Africa&SelectCountry=ETHIOPIA

See: "SOUTH AFRICA: Refugees fall through the cracks in free treatment"

http://www.plusnews.org/AIDSReport.ASP?ReportID=5906&SelectRegion=Southern_Africa&SelectCountry=SOUTH_AFRICA

See: "ANGOLA-ZAMBIA: Refugees return home armed with the knowledge of HIV/AIDS prevention"

<http://www.plusnews.org/aidsreport.asp?reportid=6528>

5. Can Refugees Access ARVs?

Regular, monitored ARV treatment is problematic enough among stable populations, but is even more difficult among refugees. ART (ARV treatment) is life-long, requiring patients to ingest a precise dosage of drugs daily for the rest of their lives. Patients taking ARVs also require counselling, follow-up checks with doctors or health-care workers and a regular supply of expensive drugs. With a disease like tuberculosis, refugees might complete a six-month or year-long treatment programme that wipes out the disease, leaving them free to return home. But what happens to an HIV-infected refugee being treated with ARVs who leaves a host country for home? Who can guarantee ARV drugs will continue to be provided? Who will guarantee health care services will be provided? For these reasons, refugees often go without ARV treatment.

South Africa, Zambia and, most recently, Namibia have all extended ARV access to their refugee populations, while other countries in the region provide access on an unofficial basis. Despite promises of ARV access to refugees, very few among even host populations are receiving the drugs. Many urban refugees in countries like South Africa live anonymous lives outside camps, making it almost impossible to find and identify them and start them on ARV treatment.

See: "BOTSWANA: No refuge from HIV/AIDS in Dukwi camp"
<http://www.plusnews.org/aidsreport.asp?reportid=6063>

See: "ZAMBIA: Getting street kids to stay on the straight and narrow"
<http://www.plusnews.org/aidsreport.asp?reportid=6512>

Key Websites and Documents

1. United Nations High Commissioner for Refugees (UNHCR) <http://www.unhcr.org>
2. International Organisation for Migration (IOM) <http://www.iom.int>
3. Human Rights Watch International: <http://www.hrw.org>
4. Study: Forced Migration and Transmission of HIV and Other Sexually Transmitted Infections: Policy and Programmatic Responses: <http://hivinsite.ucsf.edu/InSite?page=kb-08-01-08#S3X>
5. Study: HIV/AIDS Among Conflict-Affected and Displaced Populations: Dispelling Myths and Taking Action. <http://www.irinnews.org/aids/pdf/HIV-and-Conflict-Disasters-9-04.pdf>