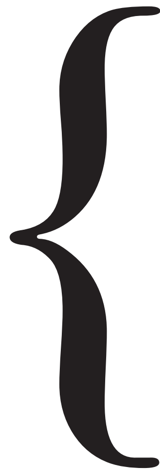
DISPLACED PERSONS



The forcible displacement of people through conflict or disaster is associated with increased food insecurity, the destruction of livelihoods and resulting poverty. Emergencies can disrupt care and treatment for people already living with HIV, and the negative impact of HIV on their health and livelihoods can increase the severity of the disasters they experience.

HIV in emergency situations is often addressed as a generic set of issues. However, available evidence suggests that different types of emergencies have different impacts on people living with HIV, which require tailored humanitarian responses and the integration of HIV-related concerns.

{ DISPLACED PERSONS

I am a displaced person. I face these issues.

WHY DISPLACED PERSONS ARE BEING LEFT BEHIND

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HIV burden

By the end of 2013, there were 51.2 million people forcibly displaced worldwide, the highest level on record according to the Office of the United Nations High Commissioner for Refugees (UNHCR). These included 16.7 million refugees, 33.3 million internally displaced persons and 1.2 million asylum seekers. Every four seconds, someone is forced to flee their home *(1)*.

In 2006, 1.8 million people living with HIV were also affected by conflict, disaster or displacement, representing 5.4% of the global total. Given that the numbers of displaced persons in 2013 increased by 24.2%, it is likely that the number of displaced persons living with HIV is also significantly higher.

In 10 countries, there was no consistent difference in the level of risky sexual behaviour between refugees and the host country population, as documented by behavioural surveillance surveys from 2004 to 2012.

In 17 studies from 13 countries, 87–99.5% of conflict-affected people adhered to antiretroviral therapy, which was similar to rates among non-affected groups.

The determinants of HIV among people affected by conflict are complex, and prevalences vary according to a number of interacting factors, the phases of disasters and contexts *(2,3)*.

THE TOP 4 REASONS

01
Restrictive laws, policies and practices

02
Limited access to quality health services

03
Stigma and discrimination

04
HIV services not prioritized in humanitarian responses

According to estimates in 2008, 1.8 million people living with HIV—5.4% of the global total—were affected by conflict, disaster or displacement in 2006. In the same year, an estimated 930 000 women and 150 000 children aged under 15 years living with HIV were affected by emergencies. Given that the number of displaced persons increased by 12.4 million—or by 24.2%—from 2006 to 2013, it is likely that the number of people living with HIV who are affected by conflict, disaster or displacement has also increased *(4).*

The 2013 levels of forced displacement were the highest since at least 1989, the first year for which comprehensive statistics on global forced displacement were published *(1).*

People living with HIV affected by emergencies by region (2006)

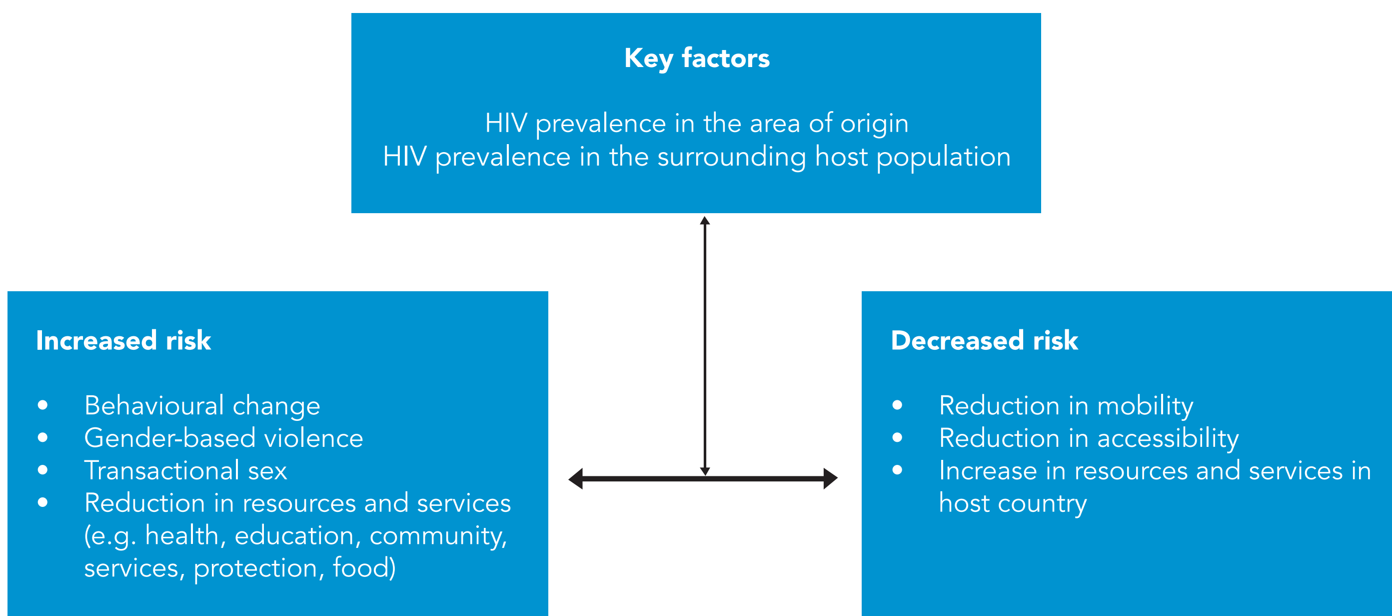
	Number	Percentage (%)
Sub-Saharan Africa	1 500 000	7
East Asia	38 000	5.2
Oceania	< 1 000	1.4
South and South-East Asia	90 000	2.3
Eastern Europe and central Asia	6 200	0.4
Western and central Europe	11 000	1.5
Middle East and North Africa	48 000	13.3
North America	8 200	0.6
Caribbean	< 1 000	0.2
Latin America	16 000	1
Global	1 800 000	5.4

Source: Lowicki-Zucca M, Spiegel PB, Kelly P B, Dehne KL, Walker N, Gyhs PD. Estimates of HIV burden in emergencies. Sex Transm Infect. 2008;84(Suppl 1):i42–i48. doi:10.1136/sti.2008.029843.

How HIV transmission is affected by emergencies is complicated and includes an interconnected mixture of exacerbating and diminishing vulnerability and risk factors that are context-specific.

Factors that increase a displaced person's vulnerability to HIV include a breakdown in social structures, a lack of income and basic needs, sexual violence and abuse, increased drug use and a lack of health infrastructure and education.

HIV risk factors in conflict zones and camps for displaced persons



Source: Spiegel PB. HIV/AIDS among conflict-affected and displaced populations: dispelling myths and taking action. Disasters. 2004;28(3):322–39.

However, there are also factors that may reduce the risk to HIV in such situations. These include reduced mobility and accessibility (e.g., destroyed infrastructure reducing travel to high-prevalence urban areas, displacement to remote locations and surviving in the bush) and, in the case of many displaced person camps, improved protection, health, education and social services.

The ultimate influence that these factors have is dependent on the HIV prevalence among the affected community prior to the conflict, the HIV prevalence among the surrounding community for those who have been displaced, exposure to violence during the conflict and flight from it and the level of interaction between the two communities. A study using data collected from 27 sites in 10 countries conducted among 24 219 people showed that there was no consistent difference in the level of risky sexual behaviour between refugees and the surrounding population, as documented by behavioural surveillance surveys from 2004 to 2012 *(5).*

Complicating these factors are the duration of the conflict and the length of time the displaced persons have resided in a particular camp. The former may keep people isolated and inaccessible for years, while the latter, depending upon the camp's location, may have the same result. Long-term post-emergency refugee camps generally provide better preventive and curative health services than do the surrounding local communities *(7).*

Restrictive laws, policies and practices

In the many states that restrict immigration by people living with HIV, refugees and asylum seekers may face significant additional burdens. Some countries harbour concerns that allowing HIV-positive asylum seekers to enter would result in large-scale immigration for treatment. These countries also fear that an influx of HIV-positive asylum seekers or refugees would pose a substantial public health threat, although this conclusion is contrary to evidence and has no moral, legal or public health basis.

Some countries refuse to grant asylum or refugee status to people on the basis of their HIV-positive status who would otherwise qualify.

Some countries refuse to grant asylum or refugee status to people on the basis of their HIV-positive status, who would otherwise qualify. For those applicants who have credible fears of persecution in their home country, the strict application of national policies prohibiting entry for people living with HIV seems particularly inhumane. Under these circumstances, HIV-positive applicants may be prevented from obtaining asylum.

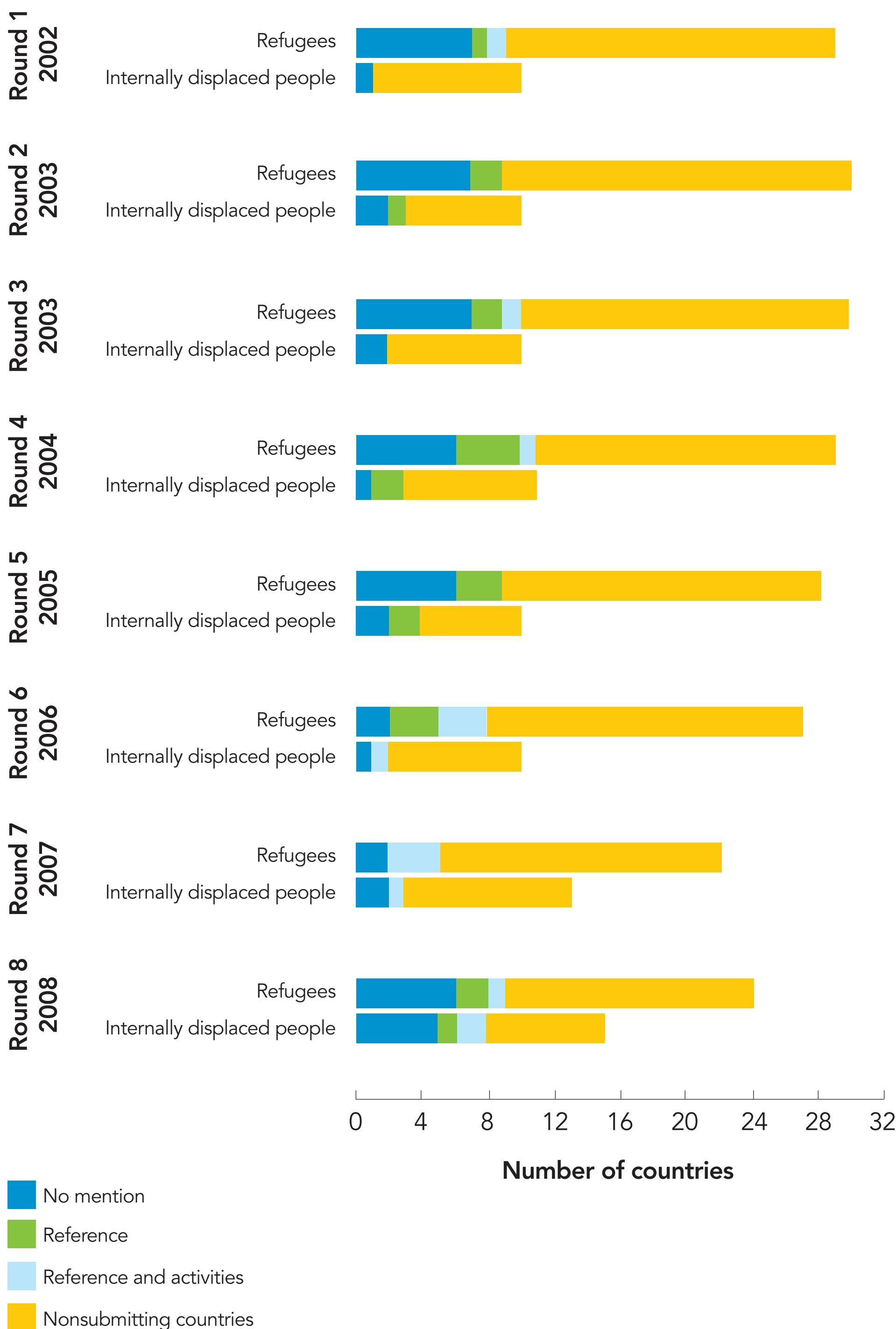
More likely, they may not even seek asylum, instead opting to live illegally in a country other than their country of origin. This can have significant adverse effects on their health, since undocumented migrants are less likely to seek health care or acknowledge that they are HIV-positive *(8).*

In a number of countries, mandatory HIV testing of refugees and asylum seekers includes HIV testing without pre- or post-test counselling and a lack of privacy for refugees who undergo HIV tests. In some countries, this occurs even where national legislation clearly states that all HIV testing should be voluntary, conducted with informed consent and combined with counselling and strict confidentiality *(9).*

Even in countries where displaced persons who are living with HIV are permitted to stay, their access to treatment is not guaranteed. Some host countries fail to recognize that HIV programmes for displaced persons are not only a human rights issue, but a public health priority for affected populations and host populations alike.

An analysis of national HIV strategic plans and grants awarded by the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund) in rounds 1–8 in sub-Saharan Africa shows that there are gaps in service planning and provision for displaced persons *(10).* A majority of countries (57%) did not mention internally displaced persons, and only 48% accounted for refugees in their HIV national strategic plans. A minority (21–29%) of plans included activities for refugees and internally displaced persons. Between 61% and 83% of countries with ≥10 000 refugees and internally displaced persons did not include these groups in their approved proposals.

Number of African countries with >10 000 displaced people including refugees and/or internally displaced people in accepted Global Fund proposals with an HIV component (Rounds 1–8; 2002–2008)



Source: Spiegel PB, Hering H, Paik E, Schilperoord M. Conflict-affected displaced people need to benefit more from HIV and malaria national strategic plans and Global Fund grants. Confl Health 2010;4:2.

Limited access to quality health services

For people who are forced to leave their home, life is focused on survival and meeting the most basic needs of safety, shelter, food and water. Displaced persons find themselves in different types of living situations. By the end of 2013, 58% of refugees globally were living in non-camp settings in urban areas. Among those who were living in camps, 93% of them resided in rural areas, most in sub-Saharan Africa and Asia *(1).*

The health of people living with HIV is vulnerable during violent conflicts, and HIV programmes should have appropriate contingency plans wherever political instability may occur.

Within conflict-affected settings, there can be unique challenges to providing, accessing and adhering to treatment. Access to HIV-related services may be limited by logistical challenges on the ground, which pose risks for the discontinuation of HIV and tuberculosis treatment, putting lives at risk and contributing to resistance. The provision of condoms is key to preventing the transmission of HIV. Pregnant women and breastfeeding mothers also need services to prevent vertical transmission.

HIV-related services in conflict settings are neglected for various reasons, including poor health infrastructure and resources and a lack of giving priority to HIV-related health needs given the limited resources and competing medical priorities. There may be fears related to the complexity of providing antiretroviral therapy and a lack of relevant guidelines. The unstable nature of the situation leads to concerns about interrupting treatment, which may lead to antiretroviral resistance and a belief that, unless the provision of treatment can be maintained for the person's life, then it should not be initiated at all. Nevertheless, it has been demonstrated that treatment for HIV in conflict zones is both feasible and effective, and guidelines related to the process have been produced *(11)*. An analysis of 17 studies in 13 countries showed that 87–99.5% of people affected by conflicts adhered to treatment, which was similar to adherence rates among non-affected groups *(6).*

Antiretroviral therapy disruption should be anticipated in emergencies. As treatment access increases, ever-larger numbers of people living with HIV in currently stable areas are at risk of treatment disruption should conflicts affect their health services or force their migration. Effective supply chain management systems are fundamental to the stocking of antiretroviral medicines.

Treatment interruption during the 2008 post-election violence period (30 December 2007 to 28 February 2008) in Kenya was measured among adults attending an antiretroviral therapy clinic in Nairobi and compared with the same time period one year earlier *(12)*. Despite clinical services remaining open, more clients (16.1%) experienced treatment interruption during the violence than during the comparison period (10.2%). Clients listed fear, a lack of transportation and violence as contributing to the treatment interruption.

As this study demonstrates, the health of people living with HIV is vulnerable during violent conflicts, and HIV programmes should have appropriate contingency plans wherever political instability may occur. Innovative service delivery models may help to address this *(12).*

In emergencies, reduced access to basic foods, health services and water and sanitation are common. These factors present particular problems for people living with HIV who have specific nutritional needs and have increased energy requirements. Thus, access to food is particularly vital for them *(13).*

Children below 18 years constituted 50% of the refugee population in 2013 *(1).* Concerns remain that the specific needs of displaced children living with HIV may be not met due to the limited availability of HIV-related paediatric services in settings with poor infrastructure and extremely weak health systems in the host areas. Similar to adults, children, when provided with access to treatment even in armed conflict zones, are likely to adhere to treatment, as demonstrated in previous studies *(14).*

Stigma and discrimination

Stigma and discrimination weaken the ability of individuals and communities to protect themselves from HIV and to remain healthy when they are HIV-positive. This is more pronounced for displaced persons.

Displaced persons, in general, have long been falsely blamed for spreading HIV among host populations.

Displaced persons, in general, have long been falsely blamed for spreading HIV among host populations. In the largest study of paired sites of refugees in protracted refugee camps and settlements and surrounding populations, the data showed no consistent difference in the level of risky sexual behaviour, such as multiple sexual partners, premarital sex and early sexual debut, as well as the prevalence of HIV testing and comprehensive knowledge of HIV among the two populations *(5).*

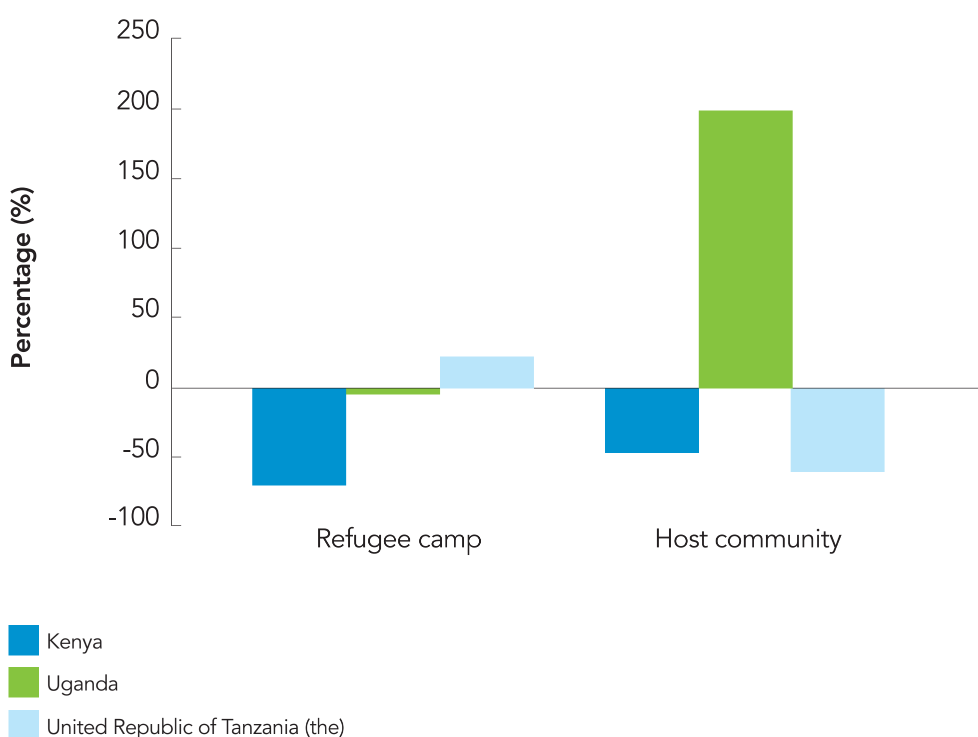
Studies focusing on Guinea, the Sudan and Uganda found that media reporting was incomplete, misleading or incorrect. Given the unique characteristics of the HIV epidemic and conflict-affected and displaced persons, the media have a special obligation to report in a balanced and nondiscriminatory manner, which may go beyond the accepted standards of journalism. The media may wish to have HIV data and their interpretations reviewed by technical experts before going to press. Specific training for reporters and editors regarding ethical issues and basic epidemiological methods may help them to better understand the complexity of the situation and to report more accurately *(15).*

In addition, power imbalances that make girls and women disproportionately vulnerable to HIV become even more pronounced during conflicts and displacement. There may be increased pressure to engage in sex work. HIV risk among sex workers and their clients may be increased due to lower condom use and increased violence. Sex workers are highly

stigmatized in the community and often may not access HIV prevention and response services, thus increasing their risk of acquiring and transmitting HIV. Gay men and other men who have sex with men, male sex workers and people who inject drugs also face high levels of stigma and often do not have access to HIV prevention and treatment services *(13)*.

In an analysis of baseline and end-of-project behavioural surveillance surveys in 2010 in Kenya, Uganda and the United Republic of Tanzania, accepting attitudes towards people living with HIV decreased in five of seven sites over a five-year period. The decrease ranged from a drop of 4.4% in a camp in Uganda to 75.5% in the town of Lukole, a host area in the United Republic of Tanzania *(16)*.

Direction and magnitude of change in accepting attitudes towards people living with HIV among people aged 15–49



Source: Office of the United Nations High Commissioner for Refugees, The World Bank. Changing regional trends in HIV-related behaviours in refugee camps and surrounding communities. Kenya, United Republic of Tanzania (the), and Uganda. Geneva: Office of the United Nations High Commissioner for Refugees; 2011.

HIV services not prioritized in humanitarian responses

The different stages of emergencies have funding needs that require support at strategic points in time. Donor agencies generally maintain a scope of funding and focus on specific fields or interests.

Donors and humanitarian actors do not adequately prioritize HIV in emergency responses. This is largely because HIV is generally subsumed under other health concerns or is considered a development issue. This oversight must change in order to address HIV within the continuum of the cycle of displacement *(17)*.

Donors and humanitarian actors do not adequately prioritize HIV in emergency responses, since HIV is generally subsumed under other health concerns or considered a development issue.

The Horn of Africa experienced two consecutive seasons of poor rainfall in 2011, resulting in one of the driest periods since 1995. The United Nations declared a famine in Somalia. Approximately 12.4 million people were affected in Djibouti, Ethiopia, Kenya and Somalia. In the appeal documents detailing the humanitarian requirements for the Horn of Africa, HIV was referred to in only three insignificant places, with no reference to data on the magnitude of the problem nor mention of existing gaps in HIV-related services responding to the crisis.

An analysis of the drought-related humanitarian appeals revealed that no HIV-specific projects were included as a part of country appeals despite both Ethiopia and Kenya being high-burden HIV countries and Djibouti experiencing a concentrated epidemic.

Failure to articulate HIV needs in humanitarian instruments is a lost advocacy and resource mobilization opportunity. Despite global advocacy by UNAIDS and other actors on the need to systematically address HIV-related needs during emergencies, the focus of traditional humanitarian actors during a crisis is on outbreak-prone diseases and malnutrition. In future, stronger regional-level coordination and advocacy efforts need to occur *(18)*.

Humanitarian requirements for the Horn of Africa drought, 2011

	Djibouti	Ethiopia	Kenya	Somalia
Total funding requirement (US$)	1 062 510 067	644 568 098	740 700 000	1 062 510 067
Health and nutrition funding requirement (US$)	7 672 500	31 360 739	16 696 699	80 078 772
Funding requirement for HIV-specific projects (US$)	0	0	0	88 000 Female genital mutilation-HIV link under protection

Source: Doraiswamy S, Cornier N, Omondi M, Spiegel P. HIV in the Horn of Africa crisis: what can we learn? Review of humanitarian instruments. In: XIXth International AIDS Conference, abstract no. WEPE594. Washington, DC; 22–27 July 2012.

CLOSING THE GAP

Increasing numbers of people are being displaced to low-income countries that have fewer resources to dedicate to the complex needs of this vulnerable population, including their HIV-related needs. In 2013, developing countries hosted 86% of the world's refugees compared to 70% 10 years ago; the least-developed countries provided asylum to 2.8 million refugees by the end of the year *(1)*.

As the number of people being affected by displacement continues to grow, the need for services to address the HIV prevention and treatment needs of displaced persons affected by or vulnerable to HIV are key.

An HIV-positive serostatus should not adversely affect a person's right to seek asylum, to access protection or to avail oneself of a durable solution.

All mandatory HIV testing—which has no public health justification—of displaced persons, including asylum seekers and refugees, must end.

Appropriate measures need to be taken to ensure that women and children are protected from sexual and physical violence and exploitation.

The right to health includes access not only to antiretroviral therapy but also to HIV-related educational materials. Therefore, governments and humanitarian actors should ensure the widespread dissemination of HIV-related information to displaced persons, particularly with regard to prevention, treatment and care, as well as information related to sexual and reproductive health.

Treatment must be made available to all eligible displaced persons. The right to health, including the principle of access to essential medicines, articulates the rationale for providing access to life-saving interventions for people living with HIV, regardless of their personal circumstance. The Convention Relating to the Status of Refugees enshrines the principle of equity, whereby host countries should provide refugees with a similar standard of medical care to that which is routinely available to its citizens. Since antiretroviral therapy can help prevent the onward transmission of HIV to sexual partners, it is in the self-interest of governments which host displaced persons to support programmes that serve all populations within their borders to the highest possible standard *(19)*.

Programmes which are based on a situation analysis and designed to address stigma and discrimination directed at displaced persons living with HIV are needed. Furthermore, programmes should target the key drivers of stigma and discrimination at all levels. They should also be based on clear, specific objectives or results, including specific attitudinal and behavioural objectives related to stigmatizing groups, stigmatized groups and changes in the structural drivers and facilitators of stigma and discrimination *(20)*.

HOW TO CLOSE THE GAP

01

Reform punitive laws and policies

02

Ensure access to treatment

03

Address stigma and discrimination

04

Integrate HIV into national disaster preparedness and response plans

It is vital that HIV services be integrated into humanitarian response design and implementation. Ensuring and sustaining access to HIV prevention, treatment and care services need to be priorities.

At a minimum, HIV-related services should initially be restored in an emergency setting to include *(21)*:

- Identifying a single agency to lead HIV coordination efforts.
- Protecting all people living with HIV against human rights violations.
- Maintaining the provision of antiretroviral therapy for HIV and treatment for tuberculosis, sexually transmitted infections and opportunistic infections, including for specific services for pregnant women.
- Ensuring that information on HIV prevention and access to prevention and reproductive health commodities are available and providing post-exposure prophylaxis for survivors of sexual violence and anyone experiencing occupational exposure to HIV should be provided.
- Sustaining community-level home-based care and support for adults and children living with HIV.
- Supporting mechanisms to prevent, protect and respond to gender-based violence.
- Ensuring that appropriate care and nutrition is available for all adults and children living with HIV.

Avoiding the establishment of vertical systems to address HIV among displaced persons is important. Instead, their needs should be integrated into existing HIV responses and health programmes. It is also important, where and as much as possible, to ensure that HIV programmes are developed in consultation with these affected populations.

In the first instance, services should be provided through existing national structures during emergencies when the capacity exists. If the capacity of public health institutions is fully stretched, the second option is to work through international or national nongovernmental organizations based on the available capacity.

As soon as the minimum level of activities are in place and the emergency has stabilized, the primary goal should focus on developing an integrated response that ensures people who have been displaced by conflicts or disasters have equal access to HIV-related services at a level similar to that of the surrounding national population.

The goal is to develop an integrated response ensuring that people who have been displaced by conflicts or disasters have equal access to HIV-related services at a level similar to that of the surrounding national population.

UNAIDS / JC2656 (English original, July 2014, updated September 2014)

ISBN 978-92-9253-062-4

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Printed on FSC-certified paper

20 Avenue Appia
CH-1211 Geneva 27
Switzerland

+41 22 791 3666
distribution@unaids.org

unaids.org