

HIV and humanitarian responses

Briefing Paper



This briefing paper discusses the interaction between humanitarian situations and HIV. It aims to show the links between emergencies and both the transmission of HIV and the impacts of AIDS. It provides a range of resources and further reading designed for NGOs to ensure that humanitarian responses can take a HIV-aware approach. Regardless of the HIV prevalence in a country, an emergency (whether a natural disaster or conflict) creates or exacerbates conditions which have the potential to increase HIV transmission. Without recognising the interaction between vulnerability and HIV, humanitarian responses may inadvertently contribute to people's susceptibility to infection, or exacerbate the impacts of AIDS. The impacts of HIV and AIDS, particularly in areas of high prevalence, may in turn undermine a humanitarian response. Responses need to ensure that they both *remain relevant* and *do no harm*.

The interaction between HIV and humanitarian contexts

This section discusses aspects of society which can protect people directly and indirectly from HIV infection and mitigate the impact of AIDS. A humanitarian situation can reduce some protective factors, such as regular secure social structures, or increase risk factors, such as military presence: these changes all have implications for both HIV transmission and humanitarian responses themselves.

Social structures and the movement of people

The physical and psychological social structures that would usually provide security and safety can quickly break down as families move location or become separated and communities fracture. Conventional networks and coping mechanisms for support deteriorate or disappear altogether. People can rely less on family and friends for support due to pressure over resources and shared needs throughout the community. Humanitarian crises can consequently result in a significant increase in women-headed households, in single women and unaccompanied children all of whom have heightened physical and sexual vulnerabilities.

The movement and displacement of people increases social and individual vulnerability; often leaving people entirely without the protection of friends, family, community structures and legal recourse. This also has consequences for host communities who can resent the arrival of displaced people, whether because of ethnic, cultural or economic issues. Host communities may find themselves forced to share already stretched resources and may see displaced people benefiting disproportionately from relief responses.

Health and psychosocial well-being

In the most extreme cases, clinics and hospitals simply stop operating due to the destruction of buildings and infrastructure, and ongoing conflicts. In other situations, they may find themselves overwhelmed by admissions for serious injuries or disease, for example, as a result of a cholera outbreak because of a lack of clean water. Services that can continue may experience severe interruptions to medical supplies and power. In a crisis, emergency medical interventions usually take priority over sexual and reproductive health, and consequently displace access to contraceptives, STI prevention services and AIDS-related care. The availability of drugs for care of chronic illnesses declines, impacting

on the maintenance of the health of both those living with HIV and of their carers. In addition to the physical health of the population, any humanitarian crisis often impacts considerably on the psychosocial well-being of individuals and reduces their ability to cope.

Economic patterns and livelihoods

The disruption of an emergency can directly impact on people's regular work patterns and ability to earn a living. This leaves individuals and families with limited or no financial resources. With no income and productivity coming to a halt, food insecurity quickly increases. Lack of money and food can place people in a more exploitable and vulnerable position. Economic migration is often a consequence of emergencies, frequently causing break-up of families as male workers seek income elsewhere and female family members are left to cope by whatever means, heightening their vulnerability to physical and sexual exploitation or coercion.

Sexual exploitation and violence

With social, health and economic systems in freefall, the balance of power lies with those who can facilitate access to resources, or give permission to travel or cross borders. Those without any power become more vulnerable to extortion or abuse, including sexual exploitation. Anyone with power and control may purposefully or unwittingly use it over others. This includes humanitarian workers.

The incidence of sexual violence often increases in emergency situations. Opportunists and civilians may commit sexual violence, and military and militia can use systematic sexual violence to dehumanise and demoralise perceived enemy populations.

Transactional, survival, or sacrifice sex

When people have no income and no food, they may exchange their only asset – sex – for money or goods. This includes male and female children, a proportion of men, and women of all ages. These people do not consider themselves sex workers; they engage in *transactional sex* to access the resources they need, *survival sex* to protect themselves from death or harm and to meet basic needs for themselves and their families, and *sacrifice sex*: engaging in consensual sex or exposing themselves to the risk of sexual violence in order to protect another. For example, older women may engage in sacrifice sex to protect their daughters or granddaughters.

Judicial and law enforcement

A crisis will often divert the attention of the police force to emergency and recovery actions. This leaves gaps in policing and law enforcement for opportunistic crimes to take place, including sexual violence. Police officers can accept or encourage bribes or may abuse their power: in either case sex may become a tradable or exploitable commodity.

Military activity

In the case of conflict particularly, but also in other emergency situations, the presence of military personnel (government and/or independent) increases. According to UNAIDS, military personnel have sexually transmitted infection rates of two to five times greater than their counterpart civilian populations in peacetime. These figures can increase dramatically during conflict. In some countries with adult HIV prevalence rates of 20%, HIV infection could affect as many as 50% of military personnel. Many armed forces have responded to HIV in recent years, including testing new recruits, dismissing those with potentially AIDS-related symptoms, increasing awareness of HIV and promoting condom use.

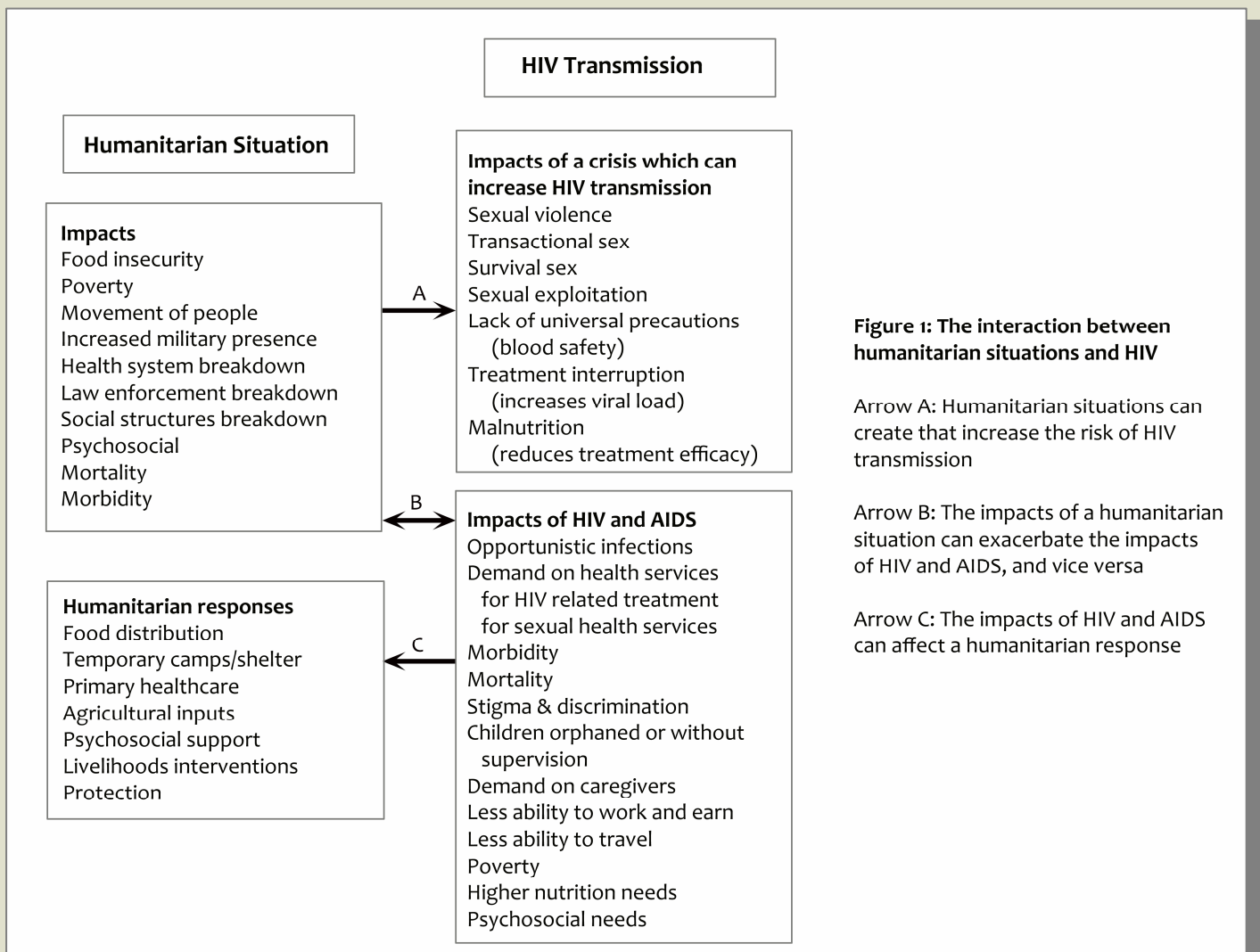
In general, however, many armies consist largely of men aged 16-24 – a highly HIV-affected age group. Their personal vulnerability to HIV infection can increase through their sexual behaviour which may reflect attitudes of masculinity which include risk-taking and having

multiple sexual partners. The presence of peacekeepers, often with disposable income and time, can attract sex workers, and armed forces can drive sexually transmitted infections through casual sex.

Children used as soldiers and sex slaves in conflicts, already highly vulnerable to HIV infection, may also form drug taking habits, including injecting drugs, whilst in service or captivity and after their demobilisation, further adding to their risks of HIV infection.

Influx of humanitarian response agencies and workers

As mentioned, those who wield considerable power in disaster situations include humanitarian workers. With their influx comes the potential to abuse their power for personal gain, whether economic, political, social or sexual. Aid workers also often have disposable time and income, making attractive targets for those engaging in transactional sex. Humanitarian workers (often immersed rapidly and with little preparation in potentially traumatising situations) if unsupported, may use alcohol, drugs or transactional/ consensual casual sex as coping mechanisms. The influx of humanitarian workers frequently accompanies the wholesale importation of skills, supplies and resources from outside the area or even the country affected by the disaster. This can have damaging consequences for local markets and earning opportunities and a disempowering effect on local skilled communities. Again consequences of this can include an increase in transactional or coerced sexual activity.



Responding to HIV and humanitarian responses

How do we remain relevant and do no harm?

Responding to HIV in a humanitarian situation does not necessarily mean doing HIV-specific work or identifying people living with HIV. It does mean checking to see if humanitarian responses need adjustments: by analysing whether a crisis can impact on HIV transmission (in both low and high HIV prevalence areas), and whether the impacts of HIV and AIDS can affect a humanitarian response, particularly in highly HIV affected area. Failure to do this analysis when formulating a response can render a response ineffective, or at least less effective in contexts affected by HIV. It can also unwittingly result in the response heightening people's vulnerability to HIV. This section looks at two different situations in areas of high and low HIV prevalence, and gives examples of how programmes can make adjustments to take into account HIV vulnerability and impact.

Food insecurity in area of high HIV prevalence

In the first scenario a drought has caused crops to fail and increased food insecurity in an area of high HIV prevalence. A humanitarian agency plans to deliver emergency food relief and agricultural inputs to restore crop and garden vegetable growing among the semi-rural population.

The agency can see that HIV has caused high mortality and morbidity rates. People living with HIV have higher nutritional needs to maintain their immune levels and to take their medication. Trying to identify people living with HIV causes several problems: apart from the extra time it takes, it requires disclosure of HIV status, breaching people's right to privacy. Further, a proportion of those living with HIV do not know their status. Providing different food rations may cause confusion or create resentment towards those who receive more or different resources. Instead the organisation can raise the nutrition level of food parcels across the programme.

The impact of AIDS has resulted in a large number of intergenerational households, many made up of children and older people only, or including sick adults. Given the high rates of adult morbidity, and families' reliance on older people and children to participate in the distribution scheme, the programme can decentralise drop points as much as possible so people have less far to walk. Similarly smaller and more frequent delivery of food parcels will make it easier for less physically able people to carry, as will the willingness of the agency to allow older or chronically ill household heads to deputise a younger family members to collect food packages for them. Some members of the community have caring responsibilities, while some have paid work or spend time looking for work; so flexible collection times for accessing resources will accommodate people's family and work commitments. At the same time, the programme can limit distribution times to daylight hours and reduce the need for overnight stays or travelling, thus minimising vulnerability to sexual and physical violence.

Taking the demographics into account, the programme can provide agricultural equipment suitable for older and/or younger people to manage. It can also facilitate both individual and community gardens so that people with full time caregiving responsibilities can garden at home, while others (both carers and people with morbidity) can share labour in a community garden and support each other. The programme can include labour saving inputs, such as drip irrigation to lessen the burden of carrying water and smaller livestock. Once implemented, everyone can benefit from such adjustments rather than solely families affected by HIV. An analysis prompted by HIV

provides the lens that enables the strengthening of the overall programme design to benefit/include those otherwise unable to participate instead of singling out people affected by HIV for different services.

The programme can introduce mechanisms to ensure greater transparency and accountability in decision-making and distribution of resources, ensuring the participation of women as well as men in these processes. Additionally the organisation can establish staff codes of conduct and accountability systems, and ensures that staff understand their contents and implications.

Conflict in an area of low HIV prevalence

In the second scenario a conflict in a low HIV prevalence area has forced people to move from their homes. A humanitarian agency plans to build a temporary camp to provide shelter, latrines, water and basic healthcare.

Whilst the country has overall low HIV prevalence the conflict has seen high incidence of sexual violence among the survivors, and the experiences of other agencies indicate that sexual violence continues in temporary camps. Accommodation and camp layout can minimise people's vulnerability to HIV infection, by keeping families together, housing them in single family units rather than larger shelters, ensuring unaccompanied women and children have safer locations, constructing a perimeter fence or barrier. Replicating norms of accommodation can reduce tensions and violence, including sexual violence. By decentralising tap-stands, washing facilities and latrines as much as possible the agency can ensure that women and children have less far to walk, especially at night. Providing good lighting and locating the facilities within rather than on the periphery of or in isolated areas of settlements can further increase people's safety. The need to collect firewood outside of camps puts women and girls at particular risk of violence; the agency can provide mills to reduce cooking times of raw food materials and other equipment, such as solar ovens, to reduce the need for firewood. The programme can provide basic healthcare and also introduces support for survivors of sexual violence with specialist, gender appropriate staff in sexual and reproductive health, and psychosocial support.

The agency can also carefully plan and manage the distribution systems for food and non-food items and emphasise transparency about entitlements. Similarly it can introduce mechanisms to ensure transparency in decision-making, the involvement of women as well as men, and adherence by staff to agreed codes of conduct and accountability measures.

Resources

Where to start (resources in italics are hyperlinked)

The interactions between HIV and humanitarian responses

Mainstreaming HIV/AIDS in Humanitarian Action: an introduction, Dochas (The Irish Association of Non Governmental Development Organisations), 2005

Mainstreaming HIV/AIDS in humanitarian and development programmes, Sue Holden, Oxfam Publishing, 2004, in association with ActionAid and Save the Children UK

HIV/AIDS and emergencies: analysis and recommendations for practice, Humanitarian Practice Network Paper 38, Ann Smith, 2002

HIV and emergencies: One size does not fit all, ODI Briefing Papers 50, March 2009

Mainstreaming HIV/AIDS into development: what can it look like, Oxfam, 2002

HIV/AIDS and emergencies: A reference guide, ODI Humanitarian Policy Group, Paul Harvey, 2004

Toolkits to analyse and adapt humanitarian responses

Development and disasters in a time of HIV and AIDS: An HIV mainstreaming toolkit for development and humanitarian response workers, CAFOD, 2008

A Guide to Mainstreaming HIV in Emergency and Humanitarian Work for the ACT Alliance, ACT Alliance, 2010

Guidelines for HIV/AIDS interventions in Emergency Settings, The Inter-Agency Standing Committee (IASC)

UNDP Haiti, Section conjointe DDR-PNUD / MINUSTAH (2006) *Evaluation de la situation des femmes dans le cadre de la violence armée en Haïti*. Rapport présenté par Wiza Loutis, Consultante

Food security, nutrition & HIV

Bryceson D. and J. Fonseca. (2006) 'Risking Death for Survival: Peasant Responses to Hunger and HIV/AIDS in Malawi'

Christian Aid HIV Unit 2003, HIV and food security in sub Saharan Africa: enhancing the impact of responses, Christian Aid

de Waal, A. 2007. AIDS, hunger, and destitution: theory and evidence for the 'new variant famines' hypothesis in Africa. In *The New Famines: Why Famines Persist in an Era of Globalization*, ed. S. Devereux. London: Routledge

FANTA 2002, Potential Uses of Food Aid to Support HIV/AIDS Mitigation Activities in Sub-Saharan Africa, Food and Nutrition Technical Assistance

Food Economy Group 2002, Household food security and HIV/AIDS: exploring the linkages A concept paper

Mano, R., Isaacson, B., & Dardel, P. 2003, Identifying policy determinants of food security response and recovery in the SADC region: the case of the 2002 food emergency

Mason, J., Bailes, A., & Mason, K. 2003, Drought, AIDS and child malnutrition in southern Africa: preliminary analysis of nutritional data on the humanitarian crisis

UNAIDS/UNHCR (2006) The Development of Programme Strategies for Integration of HIV, Food and Nutrition Activities in Refugee Settings. UNAIDS Best Practice Collection

Gender & HIV

Gupta, G. R. 2000, Gender, sexuality and HIV/AIDS: the what, the why and the how, Plenary Address XIIIth International AIDS Conference, Durban, South Africa

Injecting drug use, conflict & HIV

Todd, Catherine, et al. "Association between expatriation and HIV awareness and knowledge among injecting drug users in Kabul, Afghanistan: A cross-sectional comparison of former refugees to those remaining during conflict." *Confl Health*. 2007; 1: 5

Land & HIV

Drimie, S. 2002, The impact of HIV/AIDS on land: Case studies from Kenya, Lesotho and South Africa, FAO

Livestock & HIV

Engh, I., Stloukal, L., & Du Guerny, J. 2000, HIV/AIDS in Namibia: the impact on the livestock sector, FAO Women and Population Division

Military, sex work & HIV

Allred KJ. (2006) "Peacekeepers and Prostitutes: How Deployed Forces Fuel the Demand for Trafficked Women and New Hope for Stopping It." *Armed Forces Soc* 2006; 33(1): 5-23

Poverty & HIV

Barnett, T. & Whiteside A. 2002, 'Poverty and HIV/AIDS: Impact, coping and mitigation policy,' in *AIDS Public Policy and Child Well-Being*, G. A. Cornia, ed., UNICEF

Refugees, mobile populations & HIV

Health Policy Research Associates (2006). *The living situation of refugees, asylum-seekers and IDPs in Armenia, Ecuador and Sri Lanka: Millennium development indicators and coping strategies*. Sri Lanka Country Report

IOM, 2006. *HIV and People on the Move: Risk and vulnerabilities of migrants and mobile populations in Southern Africa*

Lubbers, R. 2003, *HIV/AIDS and Refugees: misperceptions and new approaches*

Women's Commission (2003) *Still in Need: Reproductive Health Care for Afghan Refugees in Pakistan* Women's Commission, 2003 http://www.rhrc.org/pdf/pk_rh.pdf

Sexual exploitation, violence & HIV

IASC (2002) *Report of the Task Force on Protection from Sexual Exploitation and Abuse in Humanitarian Crises*

IASC (2005) *Guidelines for Gender-based violence interventions in humanitarian settings*. Inter-Agency Standing Committee Task-force on Gender in Humanitarian Assistance

WHO/UNAIDS/Global Coalition on Women and AIDS (2004) "Sexual Violence in Conflict settings and the Risk of HIV" in *Violence Against Women and HIV/AIDS: Critical Intersections* Information Bulletin (2):2

Violence against women & HIV

ActionAid International Africa, 2006. *Links between violence against women and HIV and AIDS in situations of conflict/emergencies: A desk study*

Women, disasters & HIV

Chew, L. and K.N. Ramdas (2005). *Caught in the storm: the impact of Natural Disaster on Women*. Global Fund for Women, 2005

Further reading

Conflict & HIV

Gordon, P., Jacobson, R. and T. Porteous (2004). *A Study to Establish the Connection Between HIV/AIDS and Conflict* JSI

Hankins, C.A. et al. (2002). "Transmission and prevention of HIV and sexually transmitted infections in war settings: implications for current and future armed conflicts" in *AIDS get vol*. Etc.

Holmes, W. 2003, *Protecting the Future: HIV Prevention, Care and Support Among War Affected Populations* Kumarian Press and the International Rescue Committee, Bloomfield, Connecticut

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