HIV and the internally displaced: Burundi in focus

by Raquel Wexler

"Special attention should also be given to the prevention of contagious and infectious diseases, including AIDS, among internally displaced persons." (Guiding Principles on Internal Displacement, 19.3)

While over 250,000 people in Burundi have died as a result of conflict since 1993, HIV/AIDS has become the country's primary cause of adult deaths and an important cause of infant mortality. In this small country of seven million, though the general population is as a whole vulnerable to HIV/AIDS infection and transmission, some groups are known to be more so. Among the prostitutes, truck drivers, refugees and repatriated who are known to be vulnerable, almost half a million internally displaced persons face considerable risks of HIV/AIDS infection. Acceding priority to the easy sell of traditional emergency assistance packages, the requisite attention, resources and programming for HIV interventions for the war-affected displaced have not yet been sufficiently available. In an attempt to formulate an appropriate response to HIV programming for IDPs, UNICEF Burundi conducted focus group research in four IDP sites. This article describes the nature of the problem and sets out broad areas for HIV/AIDS mitigation strategies.

Officially there were over 387,000 IDPs living at 226 sites in Burundi in May 2002.[1] These figures do not include the temporary displacements that follow the anticipation or launch of military and rebel attacks. Short-term, sudden acute displacements involving many thousands of people occur frequently throughout the country as uprooted families seek safety in schools, churches and military camps and with other households. Such displacements can last from a few days to a few months and occur in areas of the country that are at times difficult for the humanitarian community to access, monitor rights abuses and provide needed assistance, creating a major challenge to the implementation of HIV-related interventions. Even so there have been concerted efforts on the part of some humanitarian actors to conduct assessments and facilitate HIV activities targeting the internally displaced.

Attitudes and practices

The limited available evidence suggests that IDPs may have heard of HIV but have little knowledge of how it is contracted or avoided. It is commonly believed that the primary causes of transmission are sharing razor blades and having multiple partnerships. Only one in 20 IDPs identifies condoms as a means of protection from an HIV/AIDS-infected partner. Although 80% know what a condom is, only 70% have ever seen, and less than one-fifth ever used, one. False beliefs and misinformation are common among the displaced, as one in five IDPs believes that HIV can be contracted by kissing or dining with an HIV-infected person. However, one message has hit home: more than 90% know that HIV/AIDS has no cure.[2]

Young widows are common within IDP communities, comprising more than one-quarter of all heads of households. These young unattached women search for sexual partnerships with both single and married men for

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sexual fulfilment and for more children. Women comment that sexual relations provide psychological relief from daily stress. High fertility rates are commonplace with attendant consequences on the health of the women and their capacity to provide for their children. In an environment where women outnumber men, multipartnerships are not only common but, to a certain extent, culturally accepted.

Male participants in the focus groups said women should be sexually available. Refusal to engage in intercourse may be interpreted as a sign of infidelity and result in physical violence – which is largely tolerated in Burundian society. Men confirmed that sexual intercourse is unprotected almost all of the time. While men noted the high number of undesired and unrecognised children in the sites, women drew attention to the high number of unresolved extramarital paternity cases.

Child-headed households, highly vulnerable to exploitation, constitute more than 2% of all households in the two study areas. Some of these children rent out their house for sexual activities during the day while the adults tend to the fields. Promiscuity, sexual abuse and cases of sibling incest are reported.

Fleeing from poverty, young girls search for work in urban centres. Maturing rapidly in their new environments, many return to IDP settlements after having numerous sexual partners, pregnant and/or in search of a husband. Such young women are stigmatised and ostracised. Young IDP men without work postpone marriage. Uncertain about their future and unable to sustain a family, they prefer non-committed sexual relationships. Unlike the mature women, who are fearful of learning their seropositive status and of community stigmatisation, youth spoke positively of voluntary testing. Many feel testing should be required by law before marriage.

Abrupt, temporary displacements inhibit access to land as former homes and fields turn into military zones. Kabezi, ten kilometres from Bujumbura and far outside the capital city's 'safe' perimeter, has been the locus of numerous confrontations since February 2002. The number of displaced rises and falls in concert with security conditions. As their families go hungry, men depart to Bujumbura in search of day-work. Insecurity may not permit a return to the site, resulting in nights spent away from partners. Women in Kabezi report that as a result their husbands can easily have unprotected sex with other women. Both women and men cite a high degree of distrust in their marriage partnerships. Suspicions often lead to arguments and violence.

Young IDPs note that although some reproductive information is passed on from mother to daughter and father to son, this is largely counselling to avoid pregnancy; HIV/AIDS information is not shared between parents and their children due to ignorance and socio-cultural taboos.[3] All focus group participants said that they did not have enough information on HIV/AIDS, though the women were better informed due to their contact with health care providers at antenatal consultations.[4] They report that when humanitarian actors arrive at an IDP settlement they usually approach women's groups as an entry-point into the community. The women reasoned that "women are interested in health and men are interested in politics".

Opportunities for intervention

Despite the instability of conflict environments in Burundi and elsewhere, a number of HIV/AIDS interventions can be undertaken that focus on IDPs. Long-term institutional strategies for HIV prevention provide an important means to address HIV/AIDS mitigation for IDPs **before they are displaced**, as these activities are generally targeted towards improving access to essential information and HIV-related services for the general population. HIV/AIDS activities can be appropriately integrated with other interventions, i.e. food and water distribution; this requires coherent strategies and planning based on greater coordination of actors on the ground. The Guiding Principles on Internal Displacement should be circulated to affected populations and attention given to educating lawmakers, the military and humanitarian

actors about international standards to curtail and monitor rights abuses, and the role of Government as the guarantor of rights.[5] Yet, whether interventions are short-term 'one-off' activities, medium-term or developmental in scope, it is important that there are adequate safeguards to ensure that communities take part in problem identification, delivery and assessment of interventions.

However, there can be no uniform approach to HIV interventions for the internally displaced. The following list of recommendations is not exhaustive and may be modified in response to constraints and opportunities within particular programming environments.

- HIV/AIDS and STD prevention and awareness-raising programmes and condom distributions should be developed for government and rebel combatants.
- The principal activities of parents and children within and outside IDP sites should be identified, including linkages to transit corridors and urban centres; high risk areas such as truck stops, bars and guest houses should be mapped.
- Gender-sensitive placement of latrines, water gathering points and land for cultivation should be promoted.
- Greater attention should be given to assisting child-headed households, reuniting unaccompanied displaced children and integration into foster families.
- There is little point of engaging the internally displaced in discussions on HIV prevention if condoms are not readily available; condom accessibility must be greatly improved.
- Contingency planning is essential to prepare for the mass return of refugees from neighbouring Tanzania in the event of the brokering of a sustainable ceasefire.
- Appropriate focal points should be identified in IDP sites for peer learning; youth clubs should be supported in which reproductive health issues could be discussed.
- Evaluations should be undertaken with the assistance of external evaluators to ensure transparency and to inspire humanitarian actors to be more accountable; in-country partners may need training in developing appropriate measures of performance.
- Agencies should work with religious leaders to challenge prevailing attitudes towards HIV and domestic violence and to care for HIV-infected and HIV orphans.
- Reproductive health services should be available to the displaced so that women seeking antenatal services receive essential information on HIV prevention, Mother-To-Child-Transmission, and the identification and treatment of sexually transmitted diseases.
- HIV/AIDS information should be included in mainstream school curricula; where needed, emergency schooling should be established to provide normalcy to both children and their parents and to deter delinquent activity.
- Flexible communication strategies should be developed to facilitate community identification of problems, causes and appropriate responses, and to eradicate stigmatisation; training in interpersonal communication techniques may be required.
- Surveillance systems are needed to track trends in the spread of HIV and provide benchmarks with which to evaluate and plan; behavioural surveillance structures should also be supported to provide feedback on changes among high risk populations.

Resources

The international community has been wanting in its efforts to address HIV/AIDS prevention and programming for IDPs, particularly in Burundi. The 2002 Consolidated Inter-Agency Appeal, the major funding window for UN and NGO operations in-country, included only three IDP projects with HIV/AIDS components and one to do with basic reproductive health services. Of $295,000 requested by UNFPA in the 2002 Appeal, only $50,000 has been donated. Oxfam GB received no funding for prevention, diagnostic and care activities for IDPs. Faring somewhat better, UNICEF requested $700,000 for HIV prevention in general (to include IDP populations) but by September 2002 had been given only $384,000, slightly more than half of the sum required.

This devastating HIV funding shortfall has compelled UNAIDS[6] to rally humanitarian actors in country. During the preparations for the 2003 Appeal more than $4m for HIV/AIDS programming will be requested. It is hoped that the improved collaboration and enthusiasm of implementing partners on the ground will be matched by donor contributions.

Raquel Wexler is head of the Planning Project at UNICEF Burundi. Views expressed in this article do not necessarily represent official UNICEF opinion. Email: raquelwexler@hotmail.com

1. UNICEF, OCHA, UNDP Survey, Preliminary Results, June 2002.
2. 'Ministère de la Santé Publique et UNICEF, Enquête Socio-Comportamentale sur L'infection par le VIH/SIDA au Burundi dans la Population Sinistrée: Rapport Definitif', 2001 (pp26-27).
3. *ibid* (p23)
4. Public health structures are present, though their services are generally extremely limited, and not free, rendering health care through the public health system inaccessible to IDPs.
5. See FMR 15 pp43-45 www.fmreview.org/FMRpdfs/FMR15/fmr15.17.pdf
6. UNAIDS is the joint UN programme on HIV/AIDS: www.unaids.org

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A group of young poeple during a meeting of the UNICEF-assissted 'My Future is My Choice' youth health development programme, Namibia.