

HIV in emergencies – much achieved, much to do

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Entrenched misconceptions about HIV/AIDS in humanitarian emergencies have been refuted but there is still work to do to ensure that HIV is adequately and appropriately addressed.

A decade ago, HIV/AIDS in humanitarian emergencies was not considered a priority in either the HIV or humanitarian worlds but was rather thought of as a development issue. Provision of antiretroviral therapy (ART) for displaced people was thought to be inappropriate, and adequate guidelines for HIV in humanitarian situations did not exist. Furthermore, it was widely believed both that conflict exacerbated HIV transmission and that displaced people brought HIV with them and spread the virus to host communities.

Progress

The HIV and humanitarian worlds have come far in the past decade. In 2002, two large UN agencies – the World Food Programme and UNHCR – became co-sponsors of UNAIDS and started advocating for HIV strategies, policies and interventions

to be included in humanitarian emergencies. Around the same time, Médecins Sans Frontières (MSF) began advocating for and providing ART to persons affected by humanitarian emergencies. In 2003, the Inter-Agency Standing Committee (IASC) created a Task Force for HIV in Humanitarian Situations.¹ These efforts, and many others, have helped ensure that HIV is no longer considered solely a development issue but an important matter to be addressed in humanitarian emergencies.

HIV is a complex and ‘political’ disease that clearly goes beyond the health sector. Human rights and protection interventions are major components of addressing HIV in all populations, especially those affected by conflict. A decade ago, it was commonly believed that HIV transmission would increase

in areas affected by conflict. Since refugees and IDPs would be displaced from these same areas, they would have a higher HIV prevalence than surrounding host communities, and consequently be vectors of transmission. Although counter-intuitive, research has shown this generally not to be the case, although it is context specific.²

Factors in reducing HIV transmission during conflict compared with what would normally be seen during peacetime include isolated and inaccessible populations and reduced urbanisation as well as reduced migration and transportation due to insecurity and destruction of infrastructure. This knowledge has helped reduce stigma and discrimination towards HIV-affected persons displaced by conflict and has been used to advocate for their inclusion in policies, strategies and funding proposals. It has also highlighted the need for the international community to focus on post-conflict situations.

MSF led the way in advocating for access to ART for all as a basic right. It showed that provision of such essential medications and acceptable levels of compliance were possible in conflict and post-conflict settings. ART policies and guidelines followed. Although not always simple, the continuation of ART in the acute phase of conflict and the need to provide more comprehensive HIV services including ART in protracted and return situations is now considered the norm.

Shortcomings

The HIV and humanitarian communities, as well as governments, still have a long way to go to ensure that HIV is adequately and appropriately addressed in humanitarian emergencies and post-conflict settings. In 2001, the UN General Assembly Special Session passed a Declaration of Commitment on HIV/AIDS³ which aimed by 2003 to “develop and begin to implement national strategies that incorporate HIV/AIDS awareness, prevention, care and treatment elements into programmes or actions that respond to emergency situations, recognizing that populations destabilized by armed conflict, humanitarian emergencies and natural disasters, including refugees, internally displaced persons, and in particular women and children, are at increased risk of exposure to HIV infection; and where appropriate, factor HIV/AIDS components into international assistance programmes”.

Sadly, this commitment has yet to be met. Refugees and IDPs are generally excluded from national HIV strategic plans or proposals to the Global Fund to Fight AIDS, Tuberculosis and Malaria. In its 2009 annual list of the top ten ignored humanitarian crises, MSF included inadequate donor support for AIDS treatment.⁴ Besides the legal obligations of those governments that have signed the 1951 Refugee Convention, there is a public health imperative to include all groups affected by conflict in HIV national strategic plans and funding proposals as well as to develop contingency plans. It is essential for their inclusion if we are to achieve universal



Therapeutic nutritional centre in Cameroon where both local populations and refugees with HIV/AIDS and malnutrition are treated.

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access and other targets set out in Millennium Development Goal 6.⁵

Human rights violations have also not been sufficiently addressed in humanitarian emergencies and there have been few protection interventions. Gender-based violence – and its individual and community effects on the transmission of HIV – is an important issue that still needs much more political commitment and practical field intervention. Mandatory HIV testing for refugees, migrants and other displaced persons is still relatively common in many parts of the world and those found to be positive are routinely forcibly returned (refouled). The recent US decision to stop undertaking mandatory HIV testing for refugees accepted for resettlement is welcome and it is to be hoped that other governments will follow its lead. This measure needs to be augmented by robust public health measures to ensure that on their arrival in the US resettled refugees have the opportunity to choose to be tested and receive ART if indicated.

In 2005, UNAIDS developed the Technical Support Division of Labour⁶ in an attempt to simplify HIV support at the country level and provide improved accountability. This development was followed by the humanitarian reform process that aimed to provide increased predictability and accountability to conflict and natural disaster response.⁷ Unfortunately, the two processes were not coordinated and there has never been sufficient clarity on HIV response in non-refugee humanitarian situations. Thus, HIV coordination and response in humanitarian emergencies (and natural disasters) remains incoherent and ad hoc. The current revision of the UNAIDS Division of Labour

provides an opportunity for clarity in coordination and response of HIV in non-refugee humanitarian emergencies. This needs to be coordinated with the IASC at a senior level to ensure that the humanitarian reform process also addresses this issue in a clear manner that will result in an integrated HIV response within the cluster approach.

Conclusion

Recent research has confirmed the effectiveness of HIV interventions in post-conflict settings. As societies begin to recover from the trauma of conflict, factors that did not exist during conflict – such as the rebuilding of infrastructure, increased urbanisation, wide-scale migration and an improving economy – may provide a fertile environment for the spread of HIV. At this stage, as well as during the ‘transition’ phase between emergency and post-emergency settings, when a breach in funding mechanisms for HIV interventions may occur, appropriate funding and interventions for HIV in post-conflict settings are neglected priorities.

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- <http://www.unaids.org/en/Cosponsors/DivisionOfLabour/default.asp>
- See FMR 29 Humanitarian reform: fulfilling its promise? <http://www.fmreview.org/humanitarianreform.htm>