World Disasters Report

Focus on HIV and AIDS

2008

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A global humanitarian organization

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Founded in 1919, the International Federation comprises 186 member Red Cross and Red Crescent societies – with an additional number in formation – a secretariat in Geneva and offices strategically located to support activities around the world. The Red Crescent is used in place of the Red Cross in many Islamic countries.

The International Federation coordinates and directs international assistance to victims of natural and technological disasters, to refugees and in health emergencies. It combines its relief activities with development work to strengthen the capacities of National Societies and through them the capacity of individual people. The International Federation acts as the official representative of its member societies in the international field. It promotes cooperation between National Societies, and works to strengthen their capacity to carry out effective disaster preparedness, health and social programmes.

National Red Cross and Red Crescent Societies embody the work and principles of the International Red Cross and Red Crescent Movement. National Societies act as auxiliaries to the public authorities of their own countries in the humanitarian field and provide a range of services including disaster relief, health and social programmes. During wartime, National Societies assist the affected civilian population and support the army medical services where appropriate.

The unique network of National Societies – which covers almost every country in the world – is the International Federation's principal strength. Cooperation between National Societies gives the International Federation greater potential to develop capacities and assist those most in need. At a local level, the network enables the International Federation to reach individual communities. Together, the National Societies comprise 97 million volunteers and 300,000 employees, who provide assistance to some 233 million beneficiaries each year.

The **International Committee of the Red Cross** (ICRC) is an impartial, neutral and independent organization whose exclusively humanitarian mission is to protect the lives and dignity of victims of war and internal violence and to provide them with assistance. It directs and coordinates the international relief activities conducted by the Movement in situations of conflict. It also endeavours to prevent suffering by promoting and strengthening humanitarian law and universal humanitarian principles. Established in 1863, the ICRC is at the origin of the International Red Cross and Red Crescent Movement.

Together, all the components of the International Red Cross and Red Crescent Movement are guided by the same seven Fundamental Principles: humanity, impartiality, neutrality, independence, voluntary service, unity and universality. In the same manner, all Red Cross and Red Crescent activities have one central purpose: to help those who suffer without discrimination and thus contribute to peace in the world.

Cover photo: Patricia Segigi is a volunteer with the South African Red Cross Society in Mabopone, Pretoria. She is one of the many people around the world working to mitigate the effects of the disaster that is HIV and AIDS. But humanitarian organizations must make greater efforts to ensure that the estimated 33 million people living with HIV and AIDS can live in greater dignity, free from stigma and discrimination and with access to treatment and information.

Photographer: David Chancellor/International Federation

Together for humanity
Ensemble pour l'humanité
Juntos por la humanidad
معاً من أجل الإنسانية

World
Disasters
Report
Focus on HIV and AIDS

2008

International Federation
of Red Cross and Red Crescent Societies

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HIV and AIDS – The challenges to the humanitarian world

HIV and AIDS confront the world with many challenges. Humanitarian organizations have worked hard to meet them and to make up for a lack of action in the first years of the epidemic. But far, far more needs to be done, in partnership with governments but also, above all, with communities whose wisdom and resilience offer so much to the HIV response. That is why we have selected HIV as the theme for this year's *World Disasters Report*. National Red Cross and Red Crescent Societies around the world have come together in a Global Alliance on HIV with the resolve *to do much more and much better* in our collective endeavour against this epidemic. This commitment to scale-up is linked to specific and measurable targets to double, by 2010, the magnitude of our HIV programming in prevention, treatment, care and support, and in tackling stigma and discrimination.

The AIDS epidemic has been with us for more than a quarter of a century but the statistics never fail to shock. Around 25 million people have died and about 30 million are living with HIV today. Many of these men, women and children are among the world's most vulnerable people and, although it is too simplistic to say that poverty is a main driver of the epidemic, many people living with HIV are among the poorest on earth – particularly women.

Supporting vulnerable people, and strengthening their own resilience and capacity, is the very essence of the work of humanitarian organizations. However, HIV has made our work more difficult for many reasons. In the most affected countries, those with high prevalence rates (approaching or exceeding 20 per cent) in sub-Saharan Africa, individuals and communities have been destroyed by the epidemic. About 15 million children have lost one or both parents to AIDS; children aged 10 or less run households and cannot go to school because they must look after their families. Grandparents struggle to care for their grandchildren, at a time when they should have been looking forward to being cared for themselves.

Even though anti-retroviral treatment is now available, it does not reach the majority of those who need it in developing countries. Nor are medicines for the opportunistic infections associated with AIDS readily available in many places. It is not just a question of funding, which has increased at a considerable rate. In most affected countries, as in many parts of the developing world, health services are overstretched, with poor infrastructure, and are losing the trained workers they desperately need to

the rich countries of the West. Development gains that were achieved in the past two decades have in many cases been reversed. Poverty reduction, income generation, food security – all remain on the agenda for the humanitarian world, and not just in places where major emergencies have occurred.

The AIDS epidemic is a disaster on many levels. It would be misleading to talk of a global disaster because in most countries, the prevalence rates are low – even though in populous countries such as India, the numbers of people living with HIV are high. In about 14 countries, it can certainly be called a disaster. In Swaziland, for example, 26 per cent of the population – one in four adults – is HIV positive. This is the world's highest HIV prevalence rate. Without a major change in the epidemic's trajectory, AIDS may claim the lives of two-thirds of all 15-year-olds. Life expectancy has fallen from 60 years in 1997 to just over 31 years in 2004. This is a disaster.

For many marginalized groups, HIV is a disaster. These too are people the humanitarian organizations sometimes work with, and if not, they certainly should. In countries with relatively low prevalence rates, such as Pakistan and Thailand, for example, rates among injecting drug users and sex workers are on the increase. But these two groups – plus men who have sex with men, another key 'at-risk' group – are stigmatized and often criminalized. Prevention programmes reach very few of them, yet they are the very ones who should be targeted in low-prevalence countries. They have the same human rights as everyone else, the same right to healthcare and protection from disease.
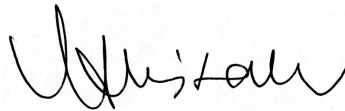
Stigma is a major contributing factor to worsening the plight of most people living with HIV, not just those groups most at risk. Stigma prevents people from being tested for HIV, and thus increases the risk of transmission. Stigma leads to the rejection of children orphaned by AIDS, and the casting-out of women from their homes (even if their husband infected them in the first place).

The impact of HIV on people living in disaster zones is still not fully understood. Some myths have rightly been dispelled – for example, that refugees and migrants inevitably bring HIV into host countries. But far more research is needed. An understanding of HIV is vital in disaster preparedness, especially in an age when all types of disasters appear to be on the increase. Conflicts, fragile states, the effects of global warming – all increase the numbers of people on the move, facing the misery of slums with no infrastructure, let alone health services, and the instability of poorly paid work. Some will already be living with HIV. The vulnerability of others, especially women, to infection is increased by the grinding poverty in which they live, when selling or bartering sex may be the only way of obtaining food.

New challenges appear quite unexpectedly. When violence erupted after the Kenyan elections at the end of 2007, there was a threat of disruption in the supply of anti-

retroviral treatment to thousands of people living with HIV. Quick action by non-governmental organizations, including the Kenya Red Cross Society and Médecins sans Frontières, and the government led to a free hotline, mobile clinics and other ways of helping people continue their treatment. We have to be prepared for such eventualities, throughout the world and at any time. If not, we will fail to reverse the spread of one of the most deadly viruses the world has ever known.

I would like to express my appreciation to Dr Mukesh Kapila, my Special Representative on HIV and AIDS, for his contribution to this issue of the *World Disasters Report*.

Markku Niskala
Secretary general
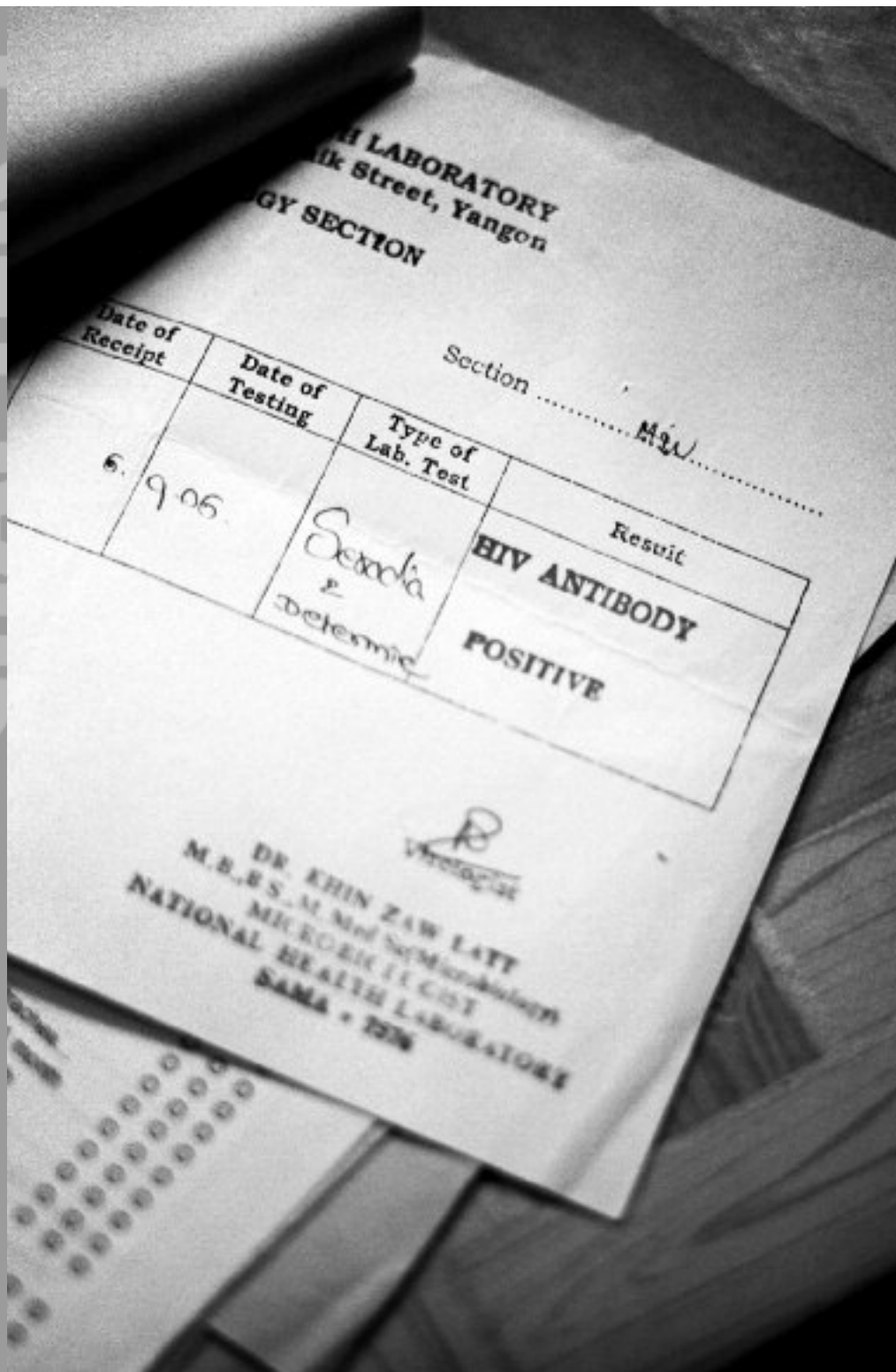
The challenge of HIV and AIDS

In 1993, the first *World Disasters Report* characterized the AIDS pandemic as a chronic, expanding disaster. At that time, an estimated 12.9 million people were living with HIV, 2.6 million people had developed AIDS-related illnesses and of those, 90 per cent had died (International Federation, 1993).

Some 15 years later, at the end of 2007, it was estimated that around 33 million people were living with HIV (see Figure 1.1). Although the latest revised data on HIV and AIDS (UNAIDS, 2007) show that new infections seem to have peaked in the late 1990s and global prevalence rates have apparently levelled since 2001, AIDS is the fifth major cause of death in middle-income countries, the third in low-income countries (WHO, 2007) and the leading cause in sub-Saharan Africa. More than 25 years since the first cases of AIDS were reported, there is no cure, no vaccine and not much optimism that these will be found in the near future, if at all.

In some countries, prevalence rates appear to have begun to drop, but in others – notably Indonesia and Viet Nam, and several countries in Central Asia and Eastern Europe – they are on the increase. In a number of Western European countries, the number of new HIV diagnoses attributed to unsafe sex between men nearly doubled between 1999 and 2006 (UNAIDS, 2007). To use a well-worn phrase, there is no room for complacency.

This year's *World Disasters Report* is the first to focus on one disease. Why? Because for a number of countries (all at present in sub-Saharan Africa) and for a significant number of groups of people where the epidemic is concentrated, the HIV epidemic is undoubtedly a disaster. Government services are overwhelmed by the need for support and treatment, stigma still prevents access for many, even where services exist, and communities are decimated by its effects. In 2000, the Pan African National Red Cross and Red Crescent Societies Conference, strongly supported by National Societies from other regions, adopted the Ouagadougou Declaration stating that National Societies in Africa commit to "responding to the HIV/AIDS pandemic as an unprecedented humanitarian and development disaster in Africa, by massively scaling up their response in terms of advocacy, prevention, care and mitigation".

A number of researchers have argued (see Chapters 2 and 6) that in southern Africa, HIV and AIDS have created a vast humanitarian emergency. This report analyses how the effects of HIV and AIDS on specific countries and key (at-risk) groups of people justify defining the epidemic as a disaster. Indeed, the future impact of HIV and

CHAPTER 1

AIDS may be far more serious than we can imagine, as economists from the World Bank and the International Monetary Fund (IMF) point out:

> "…in contrast with other epidemics, AIDS is overwhelmingly a fatal disease of young adults. Not only does AIDS cause unspeakable human suffering, but it also makes it difficult for these young men and women to provide for the education of their children, not to mention offer them the love and care they need to complement their formal schooling. The result is possibly a whole generation of under-educated and hence underproductive youth, who in adulthood will find it difficult to provide for their children's education, and so on. In this way an otherwise growing economy could, when hit with an enduring and sufficiently severe AIDS epidemic, spiral downward into a low-level subsistence economy in three or four generations. This threat of a progressive collapse of the economy is particularly insidious because the effects will not be felt immediately. Thus estimates of the economic impact of AIDS that look only at the short- to medium-term effects of reductions in labor supply are dangerously misleading. They risk lulling policymakers, especially those concerned with short-term economic fluctuations, into a sense of complacency."   (Bell, Shantayanan and Gersbach, 2004)

Adults and children estimated to be living with HIV in 2007
Total: 33.2 (30.6–36.1) million

North America
1.3 million
(480,000–1.9 million)

Western and Central Europe
760,000
(600,000–1.1 million)

Eastern Europe and Central Asia
1.6 million
(1.2–2.1 million)

East Asia
800,000
(620,000–960,000)

Caribbean
230,000
(210,000–270,000)

Middle East and North Africa
380,000
(270,000–500,000)

South and South-East Asia
4.0 million
(3.3–5.1 million)

Latin America
1.6 million
(1.4–1.9 million)

Sub-Saharan Africa
22.5 million
(20.9–24.3 million)

Oceania
75,000
(53,000–120,000)

Source: UNAIDS, *2007 AIDS epidemic update*

0   5,000 km

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The key point is that the HIV pandemic is a disaster whose scale and extent could have been prevented. But ignorance, stigma, political inaction, indifference and denial have all contributed to the deaths of millions of people. Interestingly, the 1993 *World Disasters Report* commented on the reluctance of some health advisers to call AIDS a 'health disaster', partly because "disaster terminology may… give the impression that catastrophe is inevitable. Nothing could be further from the truth: like almost every disaster, HIV/AIDS is preventable." Some 15 years later, the publication of this report shows how much more needs to be done to halt the spread of the epidemics.

Box 1.1 quotes the experiences – the personal disasters – of a number of people living with HIV, in different countries and at different stages of the epidemic.

Box 1.1 Experiences of living with HIV

Larry Kramer, US activist and founder of Act Up, New York, 1983

"Our continued existence as gay men upon the face of this earth is at stake. Unless we fight for our lives, we shall die. In all the history of homosexuality we have never before been so close to death and extinction. Many of us are dying or already dead.

There are now 1,112 cases of serious Acquired Immune Deficiency Syndrome. When we first became worried there were only 41. In only 28 days, from January 13th to February 9th (1983) there were 164 new cases – and 73 more dead… Of all serious AIDS cases, 47.3% are in the New York area.

These are the serious cases of AIDS, which means Kaposi's sarcoma, Pneumocystis carinii pneumonia, and other deadly infections. These numbers do not include the thousands of us walking around with what is also being called AIDS: various forms of swollen lymph glands and fatigues that doctors don't know what to label or what they might portend.

I have talked with the leading doctors treating us. One said to me: 'If I knew in 1981 what I know now, I would never have become involved with this disease.'… A third said to me, 'I'm very depressed. A doctor's job is to make patients well. And I can't. Too many of my patients die.'"

(Kramer, 1983)

Suzana Murni, Echidna, Uganda, 1999

"To be informed is empowering. It has enabled me to manage living with the virus. I know how to take care of myself. I know my body. I understand it. I know where to seek support if I need it. I feel courageous to ask questions. Even to protest. I know what are the choices for me. And I am capable of making careful considerations before making any decisions. All these wouldn't have happened, or might take an awfully long time to happen, if I hadn't been informed.''

(Healthlink, 1999)

Miriam Mbwana, Nkhotakota, Malawi, 2001

"In my life I have had 11 children, eight girls and three boys. Seven have passed away. The first, Lawrence, died in 1993 and one of my children has died every year since. Another six of my grandchildren have died. AIDS has carried my family away like a flood.

I look after 16 of my children's children. My granddaughter Madrin is in hospital with her son John, and they are both very weak. She has lost three children already. My daughter Mary is now very ill. We are very close. She is my best friend.

What have we done to deserve this? My father used to say, 'When death is there, pass by on the other side.' But it's not possible now. Death is everywhere."

(Mendel, 2002)

Dessa Chidhedza, Lilongwe, Malawi

Her story is not unusual. She was 23 when her husband died. She suspected he had died of AIDS and went for a test; she found she was HIV positive. She has had many infections and is too weak and frail to work. "I have no hope of ARVs [anti-retroviral drugs]," she says. She lives in her mother's house, with her mother and 13 other family members (11 children). Two of her own three children have been sent to her cousin in Blantyre, 360 km away, since she fell ill and lost her job as a cashier in a shop. Money is tight and food is scarce. Only a single small supper pot bubbles on a tiny fire as Dessa's brothers sit in the shade hammering out a discordant song as they reshape an old metal hub cap in hopes of bringing in some money. Dessa says, "I'm not sure how long I can go on because my immune system is declining."

(Boseley, 2003)

Mercy Makhalemele, South Africa, 2000

"I was married and HIV infected in marriage. My husband died in 1994 and a year later I lost my daughter Victoria at the age of two and a half years. These were two years of trauma for me and the experience and pain have still not gone away. Still by my side is my 11-year-old son Thabany which means 'rejoice'.

My daughter was put on AZT [azidothymidine] after her diagnosis. I was not told about side-effects, so I could not recognize them. This to me is unacceptable. Nor did anyone tell me at the time that I could infect my baby through breastfeeding. For various reasons my doctor recommended that I take the child off AZT and her condition did at first improve. But then my child developed a bad cough and I thought it was bronchitis. She was not breathing well, so my helper said I must take her to hospital. I refused, as she had already spent so much time in hospital. In the end, I was persuaded and she was admitted. The next day they called me very early in the morning. My daughter had passed away that night – she had not been able to breathe.

Women will move mountains to have a healthy baby. I myself have fought hard for women's access to treatment. I went on hunger strike for a week. Yet I know that treatment alone will not do but treating women with respect will help."

(Tapper, 2000)

Edwin Cameron, 2005

"…powerfully irrational responses to AIDS overshadow the epidemic even today. For stigma – a social brand that marks disgrace, humiliation and rejection – remains the most ineluctable, indefinable, intractable problem in the epidemic. Stigma is perhaps the greatest dread of those who live with AIDS and HIV – greater to many even than the fear of a disfiguring, agonising and protracted death.

Stigma manifests itself in hatred, discrimination, rejection, exclusion. Workers are sacked. Spouses are shut out. Friends are abandoned. Services, help and support are refused.

The external manifestations find an ally within the minds of many people with HIV or AIDS. Stigma's irrational force springs not

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only from the prejudiced, bigoted, fearful reactions others have to AIDS – it lies in the fears and self-loathing, the self-undermining and ultimately self-destroying inner sense of self-blame that all too many people with AIDS or HIV experience themselves."

(Cameron, 2005)

Xu, Anhui Province, China

Xu, 55, lives with his wife and two children. He tested positive in 2004. Xu worked as a doctor but needed money to support his family. Feeling he had few options, he went to an unregistered blood collecting station and became infected with HIV. At the beginning, he did not want to tell his children about his positive status. He worried that it would negatively affect their ability to study, work and live.

Once they became aware of his health condition, his children were understanding and supportive of their father and whatever the future held. One of his goals is to save enough money so that his daughter, now in her final year in high school, can finish her education.

"Although I have HIV, I never give up my responsibility as a father. Providing for my family is one of the responsibilities that I take very seriously. Because of my HIV status this has become even more important for me. I never give up my hope for the future of my family. Now I depend on medicine to prolong my life along with my medical knowledge and my optimistic attitude. One effective method of maintaining my health is to take antiretroviral medicine continuously, and the other is to get rid of the mental burden. And part of that is the wonderful support I have received from my children. Just like I support them, sharing my HIV status with them has eased a lot of pressure for me.

I have their love and understanding. My only approach is to fight against this disease to my last breath. After I was open about my status, the greatest challenge was discrimination. Although my family members and some of my friends expressed understanding and sympathy towards my situation, most people look at me oddly. I know that it is discrimination. Although I live with HIV and am discriminated against by other people, I can endure the pressure and challenge in my positive life. I believe that I have enough capacity to meet any challenge, to earn my own living and to play the role of a father as before. If I want to fight against the disease, I must depend on myself. I think one of the most useful ways to prevent the spread of HIV is through education to the public and it would also to [sic] reduce discrimination. The government and relevant departments should provide cheaper or free testing. This act could reduce our burden in many ways."

(IPPF and GNP+, 2005) ■

The challenge to the humanitarian community

Another major – and clearly linked – focus of the report is on the challenge of the HIV epidemic to the humanitarian community. The epidemic adds a hugely complicating dimension to the community's work, whether it be reducing poverty, providing basic healthcare and welfare on a day-to-day basis or dealing with the aftermath of man-made and natural disasters such as conflicts, famines, droughts and earthquakes. Humanitarian organizations work with the most vulnerable people in the

world. The aim is to improve the lives of these people; it is this vulnerability, whether caused by poverty, inequality (including gender) or environmental factors, that often places them at risk of HIV infection. The effects of disasters (whether acute or long-term, man-made or natural) are among the very factors that drive the epidemic – dislocation and disruption of people's lives, sexual exploitation and violence against women and children but also men, the disruption of health services including provision of anti-retroviral treatment (ART), psychosocial support and blood screening. Migration too is a growing challenge across the globe, as people travel in their millions to find work and escape poverty. Migrants and mobile workers may face an increased risk of HIV as they travel, and when they arrive (see Chapter 4).

History: the response to HIV and AIDS

The first reported occurrence of what is now known as AIDS was published in June 1981. In the United States' Centers for Disease Control and Prevention's (CDC) weekly *Mortality and Morbidity Report*, doctors in Los Angeles wrote about five previously healthy, young, gay men who had contracted pneumocystis carinii pneumonia, a rare and fatal disease only seen before in people whose immune systems were severely damaged. Dr Michael Gottlieb explained that little could be done for these early patients: "They were very wasted… They looked like concentration [camp] survivors" (PBS TV, 2006).

Doctors in other American and European cities read the CDC's report and realized they were seeing very similar symptoms in some of their patients too. By 1983, there were reports of cases from several African countries including Zaire (now the Democratic Republic of the Congo) and Uganda. Indeed, it is now known that HIV existed in Africa since the late 1950s. By 1985, cases had been detected in every region of the world.

Experts first called the new condition GRID (Gay-related Immune Deficiency), because it seemed restricted to gay men. This meant that another familiar aspect of the disease's history – the reluctance of politicians to take action even when thousands of previously healthy young people were dying – was present from the start. Politicians feared spending large amounts of money from the national health budget on a group of people whom many of their citizens strongly disapproved of. Some saw this new disease as God's punishment.

When it became clear that women, and later children, were also experiencing the same symptoms and dying, scientists renamed it AIDS (acquired immunodeficiency syndrome), but the stigma and discrimination have remained.

Politicians were not the only guilty ones. In 1983, for instance, the editor of Britain's prestigious scientific journal *Nature*, John Maddox, wrote: "There is now a serious

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danger that alarm about the disease physicians call acquired immune deficiency syndrome... will get out of hand." He denounced the "pathetic promiscuity of homosexuals" and then wrote that "mercifully, the disease – whatever its causation – is neither especially infectious... nor certain in its effects" (Maddox, 1983).

There was nothing pathetic about the energy of American gay activists who, realizing that their government was unwilling to act, set up AIDS service organizations, such as the Gay Men's Health Crisis, founded in New York in 1981. These organizations provided – and many still do – a range of services, including education, awareness raising, advocacy, care and support for people living with HIV. Similar organizations followed in Europe, Canada and Australia, and eventually the developing world. In all the most affected countries, activists – mainly but not exclusively men and women living with HIV – have been at the forefront of pushing for a stronger response to the epidemic, for programmes of prevention, care, support and treatment for all, and combating stigma and discrimination.

The AIDS story is one of fairly rapid progress in certain areas of scientific research; the human immunodeficiency virus (HIV) was isolated as the cause of the new disease in 1984, quickly followed by the development of a blood test to detect the virus and confirmation that condoms prevent transmission. But in other areas, progress came at a snail's pace, notably in the response from political leaders across the globe.

During the early years of the AIDS epidemic, this incurable and inevitably fatal new disease was not treated as a major priority for the humanitarian community. In the early 1980s, the World Health Organization (WHO), the United Nations (UN) body with a mandate for maintaining global health, had only one person working on sexually transmitted infections (Berridge, 1996). In 1988, the then Director-General of WHO, Halfdan Mahler, admitted that denial had been a major cause of WHO's delayed response to AIDS. He said: "I know that many people at first refused to believe that a crisis was upon us. I know because I was one of them" (Mahler, 1988).

An Oxfam report explains: "Until now HIV/AIDS has not had a high profile in Oxfam's programming for a variety of reasons: it is difficult to measure; it is difficult to prevent; it was seen as a medical issue; it was not seen as an emergency issue" (Oxfam, 2006).

The experience of the Red Cross Red Crescent is somewhat different. The Norwegian Red Cross Society was the first to become involved in AIDS information and prevention work internationally in 1985. It may have been the first non-governmental organization (NGO) to start to work internationally on a bilateral basis on AIDS-related issues (Gnaedinger, 2007). Calle Almedal of the Norwegian Red Cross Society initiated the work after visiting African countries, such as Kenya and Uganda, where hospital wards were filling up with AIDS patients and funerals were becoming a far too regular occurrence.

Red Cross Red Crescent volunteers, often based in affected communities, were well placed to provide education and care and support for people sick and dying from AIDS. A major task, however, for many National Societies and other humanitarian organizations would be to overcome stigma against people living with HIV.

Almedal recalled that when the Norwegian Red Cross Society began working on HIV in Africa, the only people already involved in HIV and AIDS work (apart from members of the local community and health workers) were from the Roman Catholic church. "Nuns in particular were talking to people about what caused HIV infection, and listening to them. They understood the reality of people's lives. Some gave out condoms. Catholic hospitals and primary healthcare clinics were in too many cases the only ones caring for those people sick and dying from AIDS. But the same was true elsewhere; in New York at the beginning of the pandemic, hospitals refused to take in people with AIDS and funeral parlours refused to bury them. St Vincent's Catholic Hospital in Manhattan was for some time the shining exception." These nuns and priests in Africa and elsewhere understood that if communities were to be spared the ravages of HIV, they had to understand how it was transmitted, and then be given the means – both information and condoms – to prevent transmission. Faith-based organizations still provide a major part of the prevention, care, support and treatment services for people living with HIV and AIDS (see Box 6.3).

Much of the support for people living with HIV and AIDS in developing countries was provided by small organizations within communities, organizations that depended on unpaid volunteers. The AIDS Service Organization (TASO) was set up in Uganda by Noerine Kaleeba whose husband had died of AIDS. Initially, TASO had 15 volunteers, 12 of whom were living with HIV. Its work in providing counselling, information, medical and nursing care has been copied by other organizations in many countries. "[TASO] aimed at impressing upon people in the community, especially at the grassroots, that the person who has HIV infection or AIDS is not dangerous. They need our compassion, our concerted effort to be supportive… The emphasis is on positive living" (Kaleeba, 1991).

The Norwegian Red Cross Society worked with African National Societies, initially only the Rwandan Red Cross and Kenya Red Cross Society, developing health information materials and distributing them nationwide. Messages about HIV were also broadcast on local radio. It was also through the collaboration with the Rwandan Red Cross that the first group of people living with HIV was established in Africa.

The importance of such organizations is now recognized across the AIDS world, though their involvement in developing policies and programmes is not as wholeheartedly promoted in many countries as it should be.

There was also collaborative work on HIV between some National Societies and International Planned Parenthood Federation (IPPF), the World Council of Churches and, as part of the youth work programme, the World Organization of the Scout Movement. In 1987, the General Assembly, the supreme governing board of the International Federation of Red Cross and Red Crescent Societies (International Federation), passed a resolution calling on all National Societies to respond to the challenge of AIDS (very much prompted by the work of the Norwegian Red Cross Society). That same year, WHO launched its Special Programme on AIDS, to be renamed the Global Programme on AIDS a year later.

The epidemiological data of the period are not clear; although AIDS was declared a global challenge by WHO, in 1988 there had been only a total of 75,392 cases of AIDS officially reported to WHO from 130 countries in the world. However, many cases were unreported and at the start of 1988, WHO made a conservative estimate of 5 million people infected with HIV (Gnaedinger, 2007).

By 1990, at least 100 National Societies were actively working in prevention and care. In Thailand, for example, The Thai Red Cross Society was at the forefront of work on HIV and AIDS. The epidemic was the key international programme of the Australian Red Cross, which supported projects in a number of Asian countries. Since the early 1990s, HIV had spread substantially in Asia, especially in some South-East Asian countries, and in several Latin American nations.

By the mid-1990s, however, the International Federation had lost much of its original momentum on AIDS work. It had reduced its activities and support to HIV programming, and there had not been enough sharing and dissemination of experiences, monitoring and evaluation of programmes or sufficient encouragement to National Societies to develop and scale up their work (Knight, 2004). In 2000 there would be a revival in the International Federation's commitment to fight HIV and AIDS, and as this report shows (see Boxes 3.3 and 3.5), National Societies are actively involved in the whole range of prevention, care, support and treatment (International Federation, 2005).

The early- to mid-1990s was also a period when resources worldwide for HIV and AIDS had begun to fall (they had never been enormous), partly as a result of a reduction in overseas development assistance (ODA) globally and also due to the end of the Cold War. As HIV was reaching near disaster proportions in many African countries, Africa was losing its political relevance to the industrialized world.

It was decided to disband the WHO's Global Programme on AIDS and set up a new UN body, UNAIDS (the Joint United Nations Programme on HIV/AIDS), to coordinate the work of various UN agencies on AIDS. As the new organization opened its doors for business, an estimated 20 million people were living with HIV around the world (the majority in the developing world) and nearly 4 million had died.

A report to the UN Economic and Social Council (ECOSOC) in 1995 (UN ECOSOC, 1995), which described aspects of the new UN programme, stressed the continuing challenges of the epidemic. It wrote about "its urgency and magnitude… its complex socio-economic and cultural roots… the denial and complacency still surrounding HIV and the hidden or taboo behaviours through which it spreads… the discrimination and human rights violations faced by the people affected". However, until the late 1990s, the response to AIDS, whether from affected countries or donors, did not meet these challenges. Combined with stigma, the fact that there is about a period of eight to ten years between infection and the development of clinical AIDS may have lulled many politicians into inaction and reinforced denialism.

Nevertheless, the evidence of a disaster was clear. WHO's 1999 *World Health Report* stated that AIDS was the number one cause of death in Africa (WHO, 1999). As *The New York Times* journalist Larry Altman wrote: "If political and religious leaders had responded with effective public health programmes much earlier, they might have prevented hundreds of thousands, if not millions, of deaths. Some leaders simply denied the scientific evidence that HIV was being transmitted in their countries. Others mistakenly believed they had more pressing problems to address" (Altman, 1999).

Over the past decade, there has been a sea-change in the attitude of many political and other leaders, and of donors, towards HIV. Uganda's president, Yoweri Museveni,

publicly acknowledged the threat of HIV, and instituted prevention programmes in the mid-1980s, earlier than any other leaders. It took much longer for others to speak out. But on World AIDS Day, 1 December 1998, President Nelson Mandela of South Africa spoke for the first time about AIDS. South Africa was experiencing one of the fastest-growing epidemics in sub-Saharan Africa. Mandela spoke of "breaking the silence". Others followed suit.

The issue of AIDS was ratcheted up to a global level in January 2000, when the UN Security Council discussed AIDS in Africa as a major human security concern as well as an obstacle to development. It was the first time a health issue had ever been debated in the Security Council. This was followed in June 2001 by the UN General Assembly Special Session on AIDS at which, after much wrangling during late-night meetings, all the heads of state signed a Declaration of Commitment that contained time-bound targets on HIV prevention, resource mobilization and other aspects of the global AIDS response. It was a clear global mandate that made governments accountable (UNAIDS, 2001).

The combination of a considerable increase in political commitment and a huge hike in funding (from US$ 300 million in 1996 to US$ 10 billion in 2007) has inevitably strengthened the response to HIV in all the most affected countries. There are signs of optimism in that the latest data (UNAIDS, 2007) show a levelling-off of new infections, and even a reduction in a small number of countries (including Cameroon, Haiti, Kenya, Malawi, Rwanda, Togo, United Republic of Tanzania, Zambia and Zimbabwe), suggesting a change in sexual behaviour among young people. But many challenges remain, notably in meeting the need for prevention and treatment (see below) and also in providing care and support for groups that are too often overlooked.

In the most affected countries, older people provide the bulk of care for their sick and dying adult children and for their orphaned grandchildren. They too are at risk of HIV infection (see Box 1.2). At a different stage of their lives are children who are HIV positive and have reached adolescence. They, like all HIV-positive people, have a right to a fulfilling sex life but may need support and advice to achieve this – like many adolescents worldwide. Projects such as the Brazilian programme described in Box 1.3 try to meet this important need.

CHAPTER 1

Box 1.2 The toll of HIV and AIDS on older people

Older women and men are the backbone of AIDS care. United Nations Children's Fund (UNICEF) data show that between 40 and 60 per cent of orphaned children in severely HIV- affected countries are cared for by their grandparents. These figures are increasing. For example, in Namibia, the percentage of orphans living with grandparents increased

from 44 per cent in 1992 to 61 per cent in 2000. Households run by older women are twice as likely to include orphans as those headed by older men. However, older male heads of households take in more orphans than do younger men. In southern Africa, for example, 24 per cent of older male-headed households take in orphans compared to an average of 12 per cent for all male-headed households (Monasch and Boerma, 2004).

In addition to the enormous responsibilities that older people must shoulder at a time of their lives when they themselves could reasonably expect to be cared for, the risk of infection among older age groups remains unrecognized and the spread of infection goes undetected and unreported. Assumptions are made that older people are not susceptible to infection, because they are assumed to be sexually inactive. This neglect of older people's sexuality is reflected in the aggregated international data on HIV prevalence.

During a humanitarian crisis, loss of assets or displacement pushes coping mechanisms to the limit, increasing the burden of care faced by older people. Furthermore, in conflict settings such as Darfur, for example, older women describe leaving the safety of camps in search of firewood in order to protect younger women from sexual violence and rape, but putting themselves at risk (Feinstein International Famine Centre, 2005).

Caring for people living with HIV and AIDS

Many adults return to their parental home when they are sick, particularly in the terminal stages of an illness. For people of any age, caring for terminally ill family members is difficult, but the additional burden of supporting grieving grandchildren increases the stress. Stigma surrounding AIDS may result in older carers facing social exclusion. In extreme cases, superstition and fear can even lead to accusations of witchcraft and sorcery resulting in ostracism, physical violence and even death.

Yet carers have little time to deal with their own feelings and to care for themselves. An older woman from Cambodia describes the emotional impact of caring for her grandchildren after the death of her adult child: "Every morning I wake up thinking about how I will have money for my grandchildren… I can't sleep because I think about it so much." Another carer describes the risks to her own health through caring for her daughter living with HIV: "Sometimes I would fall down myself when trying to pick my daughter up and move her" (HelpAge International, 2007). Older female caregivers may have concerns of their own: reduced energy and stamina, or even serious health problems, including pain and disabilities.

The financial, and emotional, costs of HIV must also be shouldered by older people; the epidemic affects their economic roles, forcing them to become the main breadwinners for their families. The average household income for households run by older people in some communities affected by HIV and AIDS in Kenya is a third of the minimum required household expenditure. A WHO study on AIDS and older people in Zimbabwe found that nearly two-thirds of caregivers identified financial difficulties as the main barrier to caregiving (WHO, 2002).

In Tamil Nadu, India, older people caring for orphaned children reported selling property or pledging it with moneylenders at interest rates ranging from 36 per cent to 210 per cent.

Vanida, a 52-year-old woman carer in northern Thailand, explained how her assets were depleted: "The hospital expenses were getting higher and higher until we ran out of money. We finally had to sell the land that we

had bought for our child" (HelpAge International, 2005).

Even if anti-retroviral treatment (ART) is provided free of charge, there are additional costs that an older carer must assume: food for the patient, medical treatments, transport to clinics and caring for grandchildren's needs (food, school fees and other related expenses). The more caring responsibilities that older people have, the less time they have to spend earning income and farming land. Finding work is challenging: jobs that they are able to obtain are often low paid.

In war-torn northern Uganda, over half the children are estimated to live with grandparents. In Lira district where 80 per cent of the population have returned home following the cessation of hostilities, 80 per cent of those who remain are older people looking after numerous children. In one extreme case, a grandfather had 40 children in his care.

The lack of any educational provision in areas that these children have returned to, as well as the uncertainties of reduced access to food, clean water and shelter, was regularly stated as a major disincentive to return (Inter-Agency Standing Committee and HelpAge International, 2008).

Older people's susceptibility to HIV infection

The 2005 UNAIDS/WHO global epidemic update published statistics on people aged 50 and over in two countries, Botswana and Uganda, revealing high rates of HIV infection for this age group. In Botswana, 21 per cent of people in their early 50s are HIV-positive, compared to 25 per cent of people aged 15–49. In Uganda, 7 per cent of men aged 50 to 59 are living with HIV; this is the same as the national adult rate. The rate for women in their 50s is 5 per cent. To those for whom

older people are 'off the radar screen', the results are surprising. The report describes the level in Botswana as "unexpectedly high".

Wherever women have limited control over protective measures, where men and women have multiple partners and intergenerational relationships, and where practices of wife inheritance occur, older women and men are as much at risk as younger people. Older women may be biologically more susceptible to HIV infection because of the thinning of their vaginal walls with menopause; this can increase the risk of tearing and therefore transmission (American Association of Retired Persons, 1996). Where there is poor blood safety and screening, older people are at the same risk as others of HIV infection through contaminated blood products in procedures such as transfusions.

Medical staff can mistake HIV-related symptoms for conditions associated with ageing. Discriminatory attitudes extend to withholding testing and treatment for older people who may be suspected of being HIV-positive. In extreme cases, the value of the life of the elderly may be denied because they are perceived to be near its end. Older patients and younger clinicians may be equally disinclined to raise sexuality and sexually transmitted infections with each other.

Data gathered at individual sites and two mission hospitals in Zambia and Namibia also show that older people are HIV positive, and are coming forward for voluntary counselling and testing (VCT) and treatment. In Zambia, at Monze Mission Hospital, of the 605 HIV-positive people registered in the ART programme, 13.6 per cent were over 50. At Rehoboth Mission Hospital in Namibia, 12.6 per cent of the 530 HIV-positive women and men registered for ART were over 50. The percentage of HIV-positive women and men in the

upper age brackets has been sufficiently significant for the programmes to now collect data up to 60 years, and to consider disaggregating it to 70. As the UNAIDS/WHO update reports, the emerging trend of rising infection rates among older generations in some countries may point to "an important gap in prevention efforts".

Conclusion

To understand the critical role that older people are playing as carers is also to understand the massive impact of HIV on them. The challenge for service providers is to look beyond the most visibly affected groups to find the older men and women caring for the sick, grieving for lost children or resuming a parenting role for orphans and grandchildren.

During times of humanitarian crisis, older people caring for those affected by HIV must be included within vulnerability analysis and needs assessments; it is vital to recognize the protection issues they face that can increase their own vulnerability to infection.

Practical ways to support older carers and people living with HIV or AIDS

- Consult and involve older people in the design, implementation and review of HIV interventions, policies and services
- Target HIV and AIDS information and training to older people. Access to information and training are essential to ensure that older carers are able to protect themselves and those in their care from HIV infection
- Disaggregate data on HIV by age and sex to ensure an appropriate and informed response
- Support older carers economically. Income-generating schemes, regular cash payments (through state grants or community social funds) and social protection measures such as social pensions can ease the financial burden
- Recognize the importance of psychosocial support. Older people are under tremendous psychological pressures. Home-based care programmes need to listen to older carers, address their fears and anxieties, as well as provide health information and care support
- Assist older carers practically to claim their entitlements and use existing resources. Lack of awareness, combined with costly, time-consuming and complicated procedures, prevents older carers from accessing entitlements
- Vulnerable children should be entitled to free education. Older carers repeatedly stress concern about education for children in their care and frequently prioritize school fees over their own needs
- Those with protection responsibilities during humanitarian crises, especially child protection agencies, must recognize both the protection needs of older people and the role they are playing in protecting others. ■

Treatment

When the first effective 'highly active anti-retroviral treatment' was announced at the International AIDS Conference in 1996 in Vancouver, it gave hope to many people living with HIV. ART could delay the onset of AIDS for many years, but it was not a cure; it was very expensive (then about US$ 20,000 per year per person in the United States) and therefore beyond the reach of the majority of people who needed it. But by

As anti-retroviral drugs become more available, there will be increasing numbers of HIV-positive young people who need support. Brazil is one of the few countries in Latin America where there are already significant numbers of young people who have been living with HIV since childhood.

In March 2007, the International HIV/AIDS Alliance joined the NGO, *Saber Viver,* to work on a year-long project with adolescents in Brazil, many of whom have been living with HIV since childhood. Through the project, called 'Thinking about the future', the 13- to 18-year-olds have been writing about their experiences in a bilingual magazine called *Saber Viver Jovem (Youth Savoir Faire)*, which has been distributed in Portuguese and English in Brazil and other countries where the Alliance works.

'Thinking about the future' has been working with some 20 HIV-positive teenagers in two different locations – Rio de Janeiro and Niterói (a city located 60 km from Brasilia). The project, led by Saber Viver in collaboration with another NGO, *Pela Vidda*, has focused on how young people deal with the challenges of living with HIV, and builds on the Alliance's already significant role in HIV work with adolescents.

The project has created safe, inclusive and empowering spaces for young people to talk openly. For example, 24 arts and literature workshops have encouraged the young people to find out more about each other and about how they cope with the challenges of living with HIV as adolescents.

It has also helped those involved to explore issues such as young people's rights, participation, poverty, disclosure, gender and sexual and reproductive health rights. Discussions also cover planning for the future, social interaction with families, schools, institutions, health services and NGOs and stigma and discrimination, including self-discrimination.

The results so far have shown that adolescents want to talk to other young people, and some of them want to be involved in HIV prevention work as well. But the young people have also been experiencing HIV differently, depending on where they live. Most of the young people in the Niterói workshops were born with HIV. In Rio de Janeiro, by contrast, some acquired HIV through unprotected sex and violence. The Rio de Janeiro group rarely brought the subject of HIV up in the workshops, whereas in Niterói, HIV issues were routinely considered, possibly because HIV has always been part of the lives of these young people.

One of the most important messages from the young people, which is reflected in the content of the magazine, is that there is more to life than HIV. Indeed, a key part of the project has been to create a space for them to talk about themselves and their lives, as well as about HIV.

Breaking down barriers

"Before we came to the first workshop that Saber Viver organized, the first question that came to us was: will this be another one of these lectures where adults keep reminding us what we should or shouldn't do? However, the workshop started and we found out this wasn't true at all," says an editorial in *Saber Viver Jovem*. "We talked about everything, taking our stories as examples: how terrible it is to take our medication every single day, the difficulties of facing discrimination, how we miss our families or sometimes hate them, our plans

for the future, and things we are ashamed of telling others... We hope this magazine will help many youngsters living with HIV like us to realize that we are like all the other young people in the world. The difference lies just in the fact that we have to take medication everyday."

Adriana Gomez, coordinator of Saber Viver and a journalist by trade, says the project has been a huge challenge, but has had great results. "To add more value to the work we were doing, the editorial process of the magazine used participatory workshops to get direct involvement of young people. The result was very positive for Saber Viver and for the young people. They are now motivated to participate in other groups and help to build up similar processes. For example, they want to work on new publications with other young people living with HIV.

"For me as a journalist, this project was also a way to work with different generations, and to see other ways of doing my work so we can build up HIV prevention strategies that work and that respect the sexual and reproductive rights of young people. For this, it is crucial that there is direct participation of the group in the whole process."

Fábio Henrique de Moraes Souza is 20 years old and lives in Rio de Janeiro. He found out he was HIV positive four years ago. "When the doctor saw the swollen glands in my neck, she commented in front of everybody that I must be HIV positive," he says. "I hadn't been aware of it. That happened in the building where my mother lives, and the neighbours started to gossip. I made up my mind to take an HIV test, and the results were positive. When my mother found out, she said I was not the son she had asked God for, because I had this illness and I was a homosexual. She said a lot of bullshit in a moment of anger, but I got hurt."

Hopes and fears

Asked what thoughts they always come back to in their lives, the youngsters involved have clear insights into their hopes and fears. "I always think about... the time when I got infected," says Carla who is 16. "I had a very nice life until I met a boyfriend who had HIV and did not know. We had a romance, but did not protect ourselves. I got infected with HIV and since then my life has completely changed. I have to take medication. I had never thought that I would go through this: so young and dependent on medication. But with the support of my doctors who are very helpful, and the adverts on TV, I have realized that HIV does not mean death."

Marta, 17, talks about the life she feels she has lost: "When I close my eyes, I see the life I want to have: being sure that I will see my kids grow up and have a joyful and healthy life. There is something I haven't achieved: I am not happy. I experience moments of happiness, but they are few. I have a big load of responsibility in my life. I have to divide myself into so many parts that I don't know which of them I really am. I have to be mother, daughter, friend, lover, wife. But most of the time, I would like to be just a girl. I would like to be fragile, like a normal girl. I have to be all shoulders for other people, when sometimes I am the one who needs a shoulder for support."

Friendship

At one of the programme's workshops, a group of teenagers and adolescents discussed the topic of friendship. "Is it hard to talk about HIV to friends who are not positive?" one of them asks the group.

"I have never told any of my friends. I am ashamed," says Tamires. "I think they won't come close to me anymore. They will be dis-

gusted. There are times I want to tell them, but I don't know how, I just can't do it."

Another voice adds: "I have a friend who I talk to about everything. I want to tell him, but I keep thinking: what if we have a quarrel? What if he becomes spiteful and then tells everybody."

Suellen Chaves Alcântara, a 19-year-old from Niterói, who was born with HIV, says: "I am an HIV-positive adolescent. I wish people with HIV had a better quality of life and more choice of medication. I am 19 and I have been taking medication against HIV for 12 years. I have had to change my medication many times, maybe seven or eight times. What is available for me here no longer works for me. My doctor told me my body gets used to the medication. My viral load is very high; I have a high temperature and get the flu quite easily. I decided to be part of a study for a new medicine called Maraviroc."

Sero-discordance

The magazine candidly approaches the issue of sero-discordance, interviewing Elizana (15) and William (20), who have been dating for three years. They had been dating for more than two years when William found out he was HIV positive. "Are you afraid of transmitting the virus to her?" asks Suellen, the 19-year-old interviewer.

"Yes. I don't want her to go through what many other people are suffering," replies William. "My greatest concern is the medication. I am not taking it yet, but I know the day will come, and I don't want that to happen to her."

Medication – a love–hate relationship

I hate my treatment:
■ "when I have to take the pills before I go out with friends"

■ "when it feels like my body starts burning from within after I have taken them"
■ "when it 'explodes inside of me' like a bomb"
■ "because of the strict schedule"
■ "because of the side effects it can have"

But, I love my treatment when:
■ "I get the test results with a viral load below the limit of detection"
■ "my health condition improves"
■ "I think that, some time ago, people didn't even have the opportunity to go through treatment, because there was no medication"
■ "I make plans for the future: working, studying, having a family"

The magazine also looks at the story of Maison, a young man who found out that he had Type 1 diabetes when he was 12 years old, describing the difficult routine of his treatment. The story highlights the similarities between Type 1 diabetes and HIV as manageable conditions. "This is a disease for which, like HIV, there is no cure, but there are ways to treat it," says *Saber Viver Jovem*.

Workplace rights

The implications of HIV as a long-term manageable condition are explored in an article on workplace rights. "People living with HIV have the right to work in whatever profession they choose," says the editorial.

"Our young reporter Bianca Machado complains that she can't work as a stewardess or join the navy. She must have heard about cases of dismissals, or refusals to hire people with HIV. But this belongs to the past.

"After all, people with HIV can now assert their rights. Since 1990, every Brazilian under 18 years of age is protected by a law called the Statute on Children and Adolescents.

2007, through the combined efforts of activists in developing and developed countries and of humanitarian agencies (NGOs and the UN), the price of ART had dropped hugely. Most importantly, it has been shown that ART can be effectively prescribed in facilities where resources are very limited. In December 2006, in low- and middle-income countries, an estimated 7.1 million people were in need of ART, and of these, a reported 2 million had access to the treatment (UNICEF/WHO/UNAIDS, 2007).

However, treatment has to be sustained, until or if a cure is found. When people stop taking ART – and disasters such as conflict and natural events (see Chapters 5 and 6) often cause disruption of supplies – they may develop resistance to the drugs they were taking. The 'second-line' drugs that are then needed remain too costly in many countries (UNAIDS, 2006). There is also a concern that the funding needed to provide ART in low-income countries may not continue indefinitely.

Is 'universal access' just a pipedream, another of a long line of improbable global targets? Already there has been considerable criticism of the fact that so much money goes to AIDS compared with other public health needs such as safe water and drugs for preventable fatal illnesses, such as diarrhoea and respiratory diseases. It is also argued that the focus on treatment has sidelined work on HIV prevention. But it is not a question of either/or, treatment or prevention, HIV or clean water. All are inter-connected and extra resources are required across the board to prevent people dying.

The prevention gap

Prevention was, and still is, key to combating the virus, and by the late 1980s almost as much was known about ways to prevent HIV transmission as is known today (see Box 1.4). Although the evidence that male circumcision protects against infection only appeared in 2007, scientists and others had suspected this was the case for many years. But for much of the 1990s, it was not thought particularly cost-effective to devote resources to HIV prevention in the absence of a vaccine (Behrman, 2004).

Box 1.4 Major components of a comprehensive HIV prevention programme

Every country – even different parts of countries – has 'its own HIV epidemic' so prevention programmes must be tailored according to the features of the epidemic.

At all stages of prevention, local communities and people living with HIV must be involved; 'outsiders' imposed by donors and government authorities can make a contribution, particularly as regards early recognition of the need for action, but only local people have the detailed knowledge of their community that is necessary to drive and sustain behaviour change.

Preventing sexual transmission

- Programmes to change behaviour – to increase condom use, delay initiation of sexual behaviour in young people, reduce the number of partners
- Condom promotion
- Access to voluntary HIV counselling and testing
- Diagnosis and treatment of sexually transmitted infections (STIs)
- Adult male circumcision

Preventing blood-borne transmission

- Provision of clean injection equipment to injecting drug users
- Methadone or other substitution therapy for drug dependence
- Blood safety (including routine screening of donated blood)
- Infection control in healthcare settings (including injection safety, universal precautions and anti-retroviral prophylaxis following potential HIV exposure)

Preventing mother-to-child transmission

- Primary HIV prevention for women of child-bearing age
- Anti-retroviral treatment
- Prevention of unintended pregnancy in HIV-positive women
- Breast feeding alternatives
- Caesarean delivery (in the case of high maternal viral load)

Social strategies and supportive policies

- HIV awareness campaigns (including mass media)
- Measures to confront and mitigate HIV-related stigma and discrimination
- Gender equality and women's empowerment initiatives (including universal education for girls, international efforts to eradicate human trafficking, child marriage and harmful traditional practices)
- Visible political leadership
- Engagement of a broad range of sectors in HIV awareness and prevention measures: i.e., a multisectoral response to the epidemic
- Legal reform to create an environment supportive of HIV prevention (such as laws decriminalizing sex work, homosexuality and needle possession, laws recognizing and protecting women's inheritance, enactment and enforcement of laws against sexual violence – aimed at women and men)

Adapted in part from Bringing HIV Prevention to Scale: An Urgent Global Priority. *Global HIV Prevention Working Group. June 2007.* ■

As early as 1986 the United States Surgeon-General released a report arguing for parents and schools to have a "frank and open conversation" with adolescents and pre-adolescents about AIDS because of their vulnerability when exploring their own sexuality and perhaps experimenting with drugs (PBS TV, 2006). In 1997 UNAIDS published a comprehensive literature review of sexual health education across a range of cultures; this showed that good HIV education among adolescents does not lead to increased sexual activity but on the contrary delays the age of first sexual intercourse. It also confirmed that when the same adolescents become sexually active, they tend to avoid risky sexual behaviour (UNAIDS, 1997).

Like the strong evidence on the effectiveness of harm reduction approaches with injecting drug users, the reality is counterintuitive so it is not surprising that many parents worldwide continue to believe that sex education for children promotes sexual activity. Today a majority of young people in high-prevalence countries still do not have accurate and comprehensive knowledge of HIV (UNICEF/WHO/UNAIDS, 2007).

"We should be winning in HIV prevention. There are effective means to prevent every mode of transmission; political commitment on HIV has never been stronger; and financing for HIV programmes in low- and middle-income countries increased six fold between 2001 and 2006. However... the effort to reduce HIV incidence is faltering" (GHPWG, 2007). Yet again, a group of leading public health experts, other researchers and advocates, and people affected by HIV, produced a report showing the missed opportunities to prevent HIV. Most people at risk of HIV infection have little or no access to basic prevention tools (UNICEF/WHO/UNAIDS, 2007; UN 2007).

There are a number of reasons, some of which are dealt with in this report (see Chapter 7), why the money does not always reach the people who need it, and is not used effectively. Although political commitment has increased, political leaders are not necessarily consistent in supporting the range of services that must be provided to reduce HIV incidence; for example, compared with the efforts of senior political leaders in some of the most heavily affected countries to support efforts to bring AIDS treatment to scale, "fewer have spent political capital in energetically expanding HIV prevention" (GHPWG, 2007).

Even when governments take prevention seriously, they often aim at the wrong targets. There is still a considerable reluctance to engage with a major challenge; namely, that in many regions, particularly Asia and Latin America, the epidemics are driven by the behaviour of injecting drug users, men who have sex with men, and sex workers and their clients. These are not the groups of people politicians usually choose to mix with, nor to be seen to fund. These groups – with much higher rates of HIV than the population as a whole – face stigma, rejection and often criminalization. But if

programmes for HIV prevention, care and treatment are not provided, and politicians do not engage in combating stigma, rates among these at-risk groups will increase.

In 2005, only 8 per cent of injecting drug users worldwide had access to HIV prevention services (UNICEF/WHO/UNAIDS, 2007). Prevention services for men who have sex with men currently reach only 9 per cent of that group (UNAIDS, 2006) and fewer than 20 per cent of sex workers globally had access to HIV prevention services in 2005 (UN, 2007).

Financial and human resources are being wasted in some of these countries on mass educational and awareness-raising programmes for young people, most of whom are not particularly at risk of HIV infection. When dealing with natural or man-made disasters (see Chapters 5 and 6), humanitarian organizations need to take into account the particular features, including prevalence patterns, of the country's HIV epidemic. Matching the response to a country's epidemic is key to effective prevention. Prisoners are another major key group at risk of infection (see Box 1.5).

Box 1.5 Prisons are high-risk environments for HIV transmission

Prisoners have been identified as one of the four most vulnerable and at-risk populations for HIV transmission and infection. They tend to have a higher prevalence of HIV infection, not only because they engage in behaviour that puts them at higher risk of becoming infected, but also because the prison environment can be bad for health (Gatherer et al., 2005). Prisons can be considered a net driver of the HIV epidemic in many countries.

Living conditions in most of the world's prisons are unhealthy. Overcrowding, violence, a lack of light, fresh air and clean water, poor food and infection-spreading activities such as injecting drug use, rape and tattooing are common issues. Rates of tuberculosis (TB), HIV and hepatitis infection in prisons are much higher than amongst the general population (Coyle, 2007). HIV prevalence among prison populations varies considerably across settings, although several countries have reported rates in the range of 10 to 25 per cent and evidence of the rapid spread of HIV infection has been observed within specific detention settings.

Two important population streams contribute to the complexity of the situation: new inmates who may be uninfected and inmates who are already HIV positive flow in and out of prisons on a regular basis and thus increase the risk of infection.

Guiding principles for HIV work in prisons

The lack of HIV education, harm reduction measures and voluntary and confidential testing for HIV infection, adequate pre- and post-test counselling and treatment for HIV-infected prisoners, as well as mandatory HIV testing and segregation of HIV-positive prisoners, are all factors that undermine the public health response to HIV and AIDS, are contrary to human rights and compromise the human dignity of the person (International Federation, 2003).

The Declaration on Prison Health as part of Public Health, which was adopted at the WHO International Meeting on Prisons and Health in Moscow in October 2003, recommended that penitentiary health be an integral part of the public health system of any country; in other words, that prison and public health-care be closely linked. With regard to HIV, one of the recommendations is: "Public and penitentiary health systems are recommended to work together to ensure that harm reduction becomes the guiding principle of policy on preventing the transmission of HIV and hepatitis in penitentiary systems" (WHO, 2003).

Improving access to care for prisoners and increasing resilience

An essential part of the specific public health context of prison settings is improving access to care and building the resilience of former detainees and their families. In many cases, there is a risk that prisoners start TB treatment (and anti-retroviral treatment in some places) but stop once they are released. It is crucial to improve and ensure adequate and appropriate access to health services for former detainees when they are released back into the community, as well as psychosocial support for prisoners and their families.

For the International Federation, prisoners, former detainees and their families are people in situations of vulnerability and particularly exposed to harm such as HIV infection. The commitment of the International Red Cross and Red Crescent Movement to tackling the issue of health in prisons was reiterated in the *Agenda for Humanitarian Action* arising out of the 28th International Conference of the Red Cross and Red Crescent in 2003, which states:

"States in cooperation with the components of the Movement, are urged to implement policies and operational measures in prisons in order to create a safer environment and reduce the risk of transmission of HIV, tuberculosis and other diseases among detainees, prisoners and staff."

(International Federation, 2003)

Examples of National Society HIV-related work with prisoners

In addressing HIV-related challenges in prisons, National Societies can help follow through from inside prisons to community prevention and harm reduction programmes, ensuring drug substitution, anti-retroviral treatment and, in relation to TB, ensuring the completion of directly observed treatment, short-course (DOTS) therapy, thereby helping to control the rate of infection in the wider population. The health-related work of National Societies includes HIV, TB and psychosocial support work and covers different and sometimes overlapping time frames: pre-, post- and during detention periods.

The Italian Red Cross's Villa Maraini Therapeutic Community runs a centre for alternative detention outside Rome which provides an alternative to traditional prison settings and enables certain prisoners with substance abuse problems to carry out their sentences at the centre. The Italian Red Cross's HIV prison-related services include a range of activities: the provision of psychosocial support, harm reduction programmes, providing an entry point for drug users and supporting their reintegration into the communities.

The main area of health in the prison-related work of the Kenya Red Cross Society is focused on HIV, with programmes being conducted in, for example, the Malindi G.K. prisons. These are mostly peer education and HIV-prevention activities. The Kenya Red Cross Society also plays an important post-detention

role, bridging the gap and facilitating, as far as possible, the links and continuation of access to health services back in the community when detainees are released.

The Mongolian Red Cross Society started implementing its HIV-prevention project entitled 'Let's Go Home Healthy' in selected men's prisons through the Tuv and Baganuur Red Cross branches in 2004. The project involves many elements aimed at reducing the transmission of HIV, the provision of psychological support and training of peer educators. It involves activities not only in prisons but during the transition periods, also addressing the problems surrounding population flows in and out of prisons.

The Russian Red Cross Society is involved in HIV and TB work in certain parts of Russia. As with the Mongolian Red Cross Society, a large part of Russian Red Cross activities is aimed at reducing the transmission of HIV, through organizing information sessions in prisons and with former prisoners. It also helps to facilitate the follow-up of DOTS therapy and other health services when detainees are released back in the communities. ◼

Donor priorities may also not be in line with a country's priorities for prevention. As the report of the Global HIV Prevention Working Group (GHPWG) explains, the United States government's ban on using funds for needle exchange "prevents the resources of the single largest AIDS donor from being used for a highly effective strategy to prevent HIV transmission as a result of drug use" (GHPWG, 2007). The report also explains that the independent US Government Accountability Office "concluded in 2006 that abstinence earmarks in US foreign assistance legislation often impede the ability of national programmes to tailor US-supported HIV prevention programmes to national needs."

Another significant factor in the failure of prevention programmes is that they are too often imposed by 'outsiders', consultants from industrialized countries, with little involvement of local people. The attitudes of these 'experts' and much of the 'AIDS industry' are perceived as arrogant and racist. The lack of progress in the early days to halt the epidemic's spread is partly rooted in centuries-old cultural and social attitudes that are not easy to overcome. Thus it is essential that the local experts – people living with and affected by HIV, community leaders and shakers, the country's doctors and other experts – are involved in all HIV and AIDS policy and programming. Such local involvement, leadership and mobilization are a key component of the dynamic of empowerment that drives successful HIV responses though building community and individual resilience. Outsiders can be a support, but communities must be actively engaged rather than waiting for outsiders to come and solve the problem.

Conversely, as Helen Epstein and others have argued (Epstein, 2007; Hudson, 1999), some HIV experts have been reluctant until fairly recently to acknowledge a key feature of the epidemic. The HIV epidemic in many African countries has been driven by sexual networks, consisting of overlapping partnerships. These networks, it is suggested, created a kind of 'superhighway' for HIV, even if everyone in the network had

fewer partners than people in other countries who have engaged in serial monogamy. Epstein writes that such partnerships are now "widely acknowledged" as major drivers of the epidemic, and, she asks, if people had known this, would they have changed their sexual behaviour and would many lives have been saved?

Indeed, James D. Shelton of the Bureau for Global Health at the United States Agency for International Development (USAID) argues that "our priority must be on the key driver of generalized epidemics – concurrent partnerships" (Shelton, 2007). As he writes, this aspect of behaviour has been neglected for a number of reasons: "the culture wars between advocates of condoms and advocates of abstinence, because it smacks of moralizing, because mass behavioural change is alien to most medical professionals, and because of the competing priorities of HIV programmes".

It is not just behaviour change that is needed. Women and children in particular are often powerless to negotiate safer sex, let alone say "no". Sex is something to trade when you have nothing else to bargain with. As Annacius Duportal, a worker in a Haitian drop-in centre for HIV-positive women, explained: "For the poor, the whole notion of sexuality is difficult; it's not a matter of identity as we see it in a modern, affluent Western society. Rather, in poor societies sexuality is something you use to find shelter, food and safety. It has a use; it has a value" (Renton, 2007).

Thus poverty may increase someone's vulnerability to HIV but HIV is not a classic disease of poverty. It is too simplistic to say poverty is a driver of the epidemics. The most affected countries are among the world's poorest nations but HIV affects all social classes within those countries. Recent evidence clearly indicates that AIDS is a disease of inequality, often associated with economic transition, rather than a disease of poverty itself (Piot et al., 2007). Moreover, in some countries (such as Zimbabwe) HIV has declined without major improvements in poverty and discrimination ("notwithstanding substantial economic and social distress") (Shelton, 2007).

Conclusion

Responding to HIV and AIDS is probably one of the greatest challenges faced by the humanitarian, religious and political worlds. Epidemics vary from country to country, and responses must vary accordingly and be tailored to the reality of the epidemic. Social and legal changes are needed, as well as targeting and empowering the right people, if prevention programmes are ever to be fully effective. Such changes would contribute to the fight against stigma and discrimination, which have crippled the response worldwide. As this report describes, myths abound about those 'other' people that spread HIV – refugees, migrants, people escaping from conflict and poverty. What is abundantly clear is not just the need for more effective and targeted prevention and treatment, but also the need for more committed political leadership to ensure a sustained response to the epidemic and eradicate stigma.

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There are many lessons for the humanitarian community in this report but a significant one is to understand, and act on, the fact that the response to HIV requires a longer-term reaction than the usual response to emergencies. There are no short-term solutions to underlying causes of vulnerability such as discrimination against marginalized groups and gender inequality, although more than 25 years since the first cases of AIDS, so much more could have been done. On a more positive note, responding to HIV is an opportunity to strengthen those aspects of humanitarian work that build resilience and empower communities rather than merely to provide assistance when disaster has overwhelmed their capacity to cope.

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The disaster of HIV

According to the United Nations, a disaster is any "serious disruption of the functioning of a society, causing widespread human, material or environmental losses which exceed the ability of a society to cope using only its own resources" (OCHA, 1996). There is no doubt that HIV meets this definition.

Although it was intended to refer primarily to 'natural' disasters such as earthquakes and droughts, in certain contexts HIV is either the primary or one of the leading factors behind a "serious disruption of the functioning" of a society or community. HIV has had society-wide catastrophic effects in several distinct parts of the world – in many sub-Saharan African nations, in particular – and among numerous specific communities, for example, sex workers and men who have sex with men (MSM), at a global level.

A group of researchers writing in the *British Medical Journal* concluded: "HIV/AIDS, which has a long (approximately ten years) latency period from infection to death, is comparable to other so-called 'slow onset disasters' (e.g., famine) that often have an insidious onset, but can have death rates and secondary consequences no less devastating than classic acute onset disasters (e.g., floods)" (Stabinski et al., 2003).

Jargon and theoretical analysis aside, the facts alone serve to reinforce the classification of HIV epidemics as disasters for many nations and communities. The scale and scope of personal tragedy are massive and relentless. UNAIDS estimates that some 2.1 million people around the world died of AIDS in 2007, bringing the total number of deaths from HIV infection since 1981 to more than 25 million (UNAIDS, 2007a). Perhaps 2.5 million more contracted HIV in 2007 alone, which translates into an estimated 6,800 or so new infections every day (UNAIDS, 2007a). At the end of 2007 an estimated 33 million people around the world were living with HIV (UNAIDS, 2007a).

HIV as a national and society-wide disaster

More than a quarter century after HIV was first identified, adult HIV prevalence has never exceeded 0.1 per cent in many nations, while in a handful of southern African countries it is higher than 20 per cent. There are cases in every country in the world but there is not a global epidemic, or therefore a global disaster. HIV is a disaster in national contexts – that is, from an overall, society-wide perspective rather than purely personal – only where it has become generalized and widely pervasive. The one region where that has occurred is sub-Saharan Africa, home to about two-thirds of the world's HIV-positive individuals (UNAIDS, 2007a). (Asia is the continent with the second highest number of HIV cases. In comparison with much of Africa, however, national HIV

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prevalence rates are quite low throughout most of Asia. That is because the populations of many Asian nations are so large that prevalence is low even when absolute numbers of HIV cases are similar to those found in some high-prevalence African countries.)

The devastation wrought by HIV over the past 25 years in several countries in southern and eastern Africa is unprecedented. At least one adult in ten is living with HIV in nations that include Botswana, Lesotho, Malawi, Mozambique, Namibia, South Africa, Swaziland, Zambia and Zimbabwe. Adult HIV prevalence is not far below 10 per cent in Cameroon, the Central African Republic, Kenya, Tanzania and Uganda, among other countries.

Millions of people have already died from HIV-related illnesses, and millions more with the virus live in fear that they soon will. HIV is considered the primary factor behind most of the dramatic negative demographic changes in recent years throughout the region. Life expectancies have plunged over the past two decades in several nations, including Botswana, Lesotho, Swaziland and Zambia: in those countries, the 'average' child born in the past few years cannot expect to live to 40 (US Census Bureau, 2004).

Even the World Bank's optimistic *Africa Development Indicators 2007* report, released in November 2007, acknowledged that sobering trend: "Between 1990 and 2005 life expectancy at birth in Sub-Saharan Africa declined from 49.2 years to 47.1. Although life expectancy increased in 25 countries [such as Ghana, Guinea and Senegal] by an average of eight years, it declined in 21 more populous countries [including Kenya, Mozambique, South Africa and Tanzania, among others] by an average of four years. HIV/AIDS, malaria, and armed conflict have contributed to these falling life expectancies" (World Bank, 2007a).

The findings of a 2007 United Nations Development Programme (UNDP) report on Namibia illustrate the disconnect between improved macroeconomic indicators (as highlighted by the World Bank in its recent development report) and negative demographic and health measures in many nations with high HIV burdens (UNDP, 2007).

According to the report, entitled *Trends in Human Development and Human Poverty in Namibia*, the average income in Namibia increased from 5,500 Namibian dollars (US$ 700) in the early 1990s to nearly 10,500 Namibian dollars (US$ 1,340) in 2004. However, the report also noted that average life expectancy in Namibia had decreased by more than ten years since 1991 – a "direct result of the HIV/AIDS epidemic, which represents the greatest cause of death in the country". The report concluded: "The single greatest threat to the expansion of human capabilities in Namibia today remains the HIV/AIDS epidemic, which, through its impact on mortality, is undermining human development objectives" and thereby reversing the positive effects of development.

World Health Organization (WHO) data and projections further illustrate the extent of HIV's impact on individual and public health (WHO, 2006). A report from November 2006 compared DALYs (disability adjusted life years), a common health measure used by researchers and statisticians. As noted in WHO's definition of DALY, the higher the number, the more serious the problem (WHO, 2006). For HIV and AIDS, the estimated DALYs in 2005 were just 63 in high-income countries, yet 2,205 in low-income countries. Projections for 2030 are even worse, with the measure staying the same – 63 in high-income countries but reaching 5,081 in low-income countries.

The cumulative devastation has made HIV a fully-fledged social and economic crisis in these high-prevalence countries (Whiteside and de Waal, 2003; Whiteside, 2002). Yet this overall impact is sometimes obscured by promising-sounding data and developments at the macroeconomic level. When the World Bank released its *Africa Development Indicators 2007*, Obiageli Ezekwesili, the Bank's Vice President for the Africa Region, observed: "Over the past decade, Africa has recorded an average growth rate of 5.4 percent, which is at par with the rest of the world" (World Bank, 2007b).

Yet what the Bank calls an "encouraging trend" is mostly due to surging global demand and higher prices for raw materials such as oil and minerals. In few countries do those benefits reach the whole of society, beyond relatively small business and government elites. As noted in a *New York Times* article about the Bank's report, "Africa still occupies the bottom rung of the world's economic ladder. Forty-one percent of sub-Saharan Africans live on less than $1 [US] a day – an improvement from 47 percent in 1990, but still the world's worst poverty rate" (LaFraniere, 2007).

Indeed, reflecting on the lives of most people living in sub-Saharan Africa raises more alarm than hope. In the hardest-hit nations, hard-won gains in living standards have stagnated or even fallen. The virus is directly responsible for restraining and reducing human and resource capacities across societies because HIV infections and AIDS deaths are common among workers of all qualifications and expertise, and in all industries. Coupled with the high costs of caring for people living with HIV, those capacity constraints lead to withered health and education systems, declining food security, skilled labour shortages and an increasingly ramshackled infrastructure. Little has changed since the following observation was noted in a UNDP report in 2001:

> "The devastation caused by HIV/AIDS is unique because it is depriving families, communities and entire nations of their young and most productive people. The epidemic is deepening poverty, reversing human development achievements, worsening gender inequalities, eroding the ability of governments to maintain essential services, reducing labour productivity and supply, and putting a brake on economic growth. These worsening conditions in turn make people and households even more at risk of, or vulnerable to, the epidemic, and

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sabotages global and national efforts to improve access to treatment and care. This cycle must be broken to ensure a sustainable solution to the HIV/AIDS crisis."

(Loewensen, 2007)

Measures and indicators of disaster in highest-prevalence nations

The wrenching, complex and wide-ranging impact of HIV in the hardest-hit nations can be seen in a host of other trends, measures and indicators. Combined, they are the building blocks of the HIV disaster. Among the more notable are the following, some of which expand upon capacity constraints referred to previously.

Macroeconomic dislocation and priority-shifting

When HIV epidemics become generalized, HIV often has a direct (and negative) economic impact. In general, it

- reduces or slows growth in the supply of labour, particularly skilled labour (through increased sickness and mortality)
- lowers productivity (due to HIV-related illnesses among members of the active workforce and relatives they may be caring for)
- damages governments' economic health.

The impact referred to in the final bullet point above tends to occur when two negative developments occur simultaneously. The first, falling tax revenues, results from stagnant or declining growth coupled with a smaller pool of workers to tax (Quattek, 2000). The second is the increased public spending needed – the level of which depends on internal and external pressure and available resources – to deal with expanding HIV epidemics. Moreover, the perceived lack of economic stability or adequate skilled labour capacity also limits the ability of many countries with major HIV epidemics to attract much-needed foreign direct investment.

Some companies in high-prevalence regions have tried to counter the negative direct and indirect effects of HIV on their businesses. A growing number of leading firms in the sub-Saharan Africa, including South African-based Anglo-American (a mining company) and Vodacom (telecommunications), offer in-house medical insurance schemes that provide anti-retroviral treatment (ART) and other HIV-related care to employees and their families. In the absence of such programmes, most individuals in need would be forced to rely solely on public sector systems that face critical supply and capacity shortages.

Although these companies' programmes are important and welcome, they cover a relatively small percentage of people and thus do not represent a long-term solution.

Unemployment rates are quite high throughout much of the region – with estimates ranging from 25 per cent to 40 per cent in South Africa, by far the largest economy in the region – and only a small percentage of those who are employed work for private firms with the financial capacity to provide comprehensive medical coverage. By far the majority of HIV-affected people, and essentially all of the poorest, must rely on the public sector or services provided by donors.

Increasingly burdensome public sector healthcare costs

In contrast to many wealthier countries which have private and public health insurance schemes and where much of the population can afford to purchase healthcare, most people in sub-Saharan Africa are poor and must rely on the government or other funding entities for all their healthcare needs.

Therefore, the costs of HIV-related care and services represent a major financial burden for governments in many countries, even though most receive aid and other forms of assistance from multilateral agencies, donors and other external sources.

As part of its home-based care programme, the Kenya Red Cross Society provides medication to people living with HIV. Here, a community health worker gives Gladis Akinyi the drugs she needs.

© Yoshi Shimizu/ International Federation

The provision of ART – which has become increasingly available to those in need over the past five years – represents a growing share of healthcare budgets. The extent of financial and human resources needed to provide ART and related health services will only rise as treatment access is expanded and (hopefully) sustained. In Tanzania, for example, it has been estimated that providing ART to all those who need it would require the full-time services of almost half the existing healthcare workforce (UNAIDS, 2006). Public expenditure must also be allocated for other key HIV-related services, including education and awareness campaigns, building clinics and hiring, training and paying the salaries of healthcare workers and counsellors. Most governments of those nations critically impacted by HIV are already struggling to meet these demands.

The negative economic impact on individuals and families

HIV also imposes significant economic burdens at more basic levels – on individuals, families and communities. Those affected by HIV must devote often scarce personal resources on purchasing medicines, hospital visits and funeral costs, among other things (Whiteside and de Waal, 2003; Whiteside, 2002). At the same time, their income levels may be reduced by illness or death among wage earners or relatives' need to focus on caregiving. As a result, they are unable or unwilling to spend money on other needs.

A study in South Africa found that already poor households coping with HIV-positive family members were forced to reduce spending on many necessities, including clothing (by 21 per cent) and electricity (by 16 per cent). Moreover, "two-thirds of households in the survey reported loss of income as a consequence of HIV/AIDS" and "[a]lmost half reported not having enough food and that their children were going hungry" (Kaiser Family Foundation, 2002).

Food insecurity

As examined in greater detail in Chapter 6, food insecurity is a direct outcome of HIV epidemics in some areas. In Malawi, for example, chronic and devastating food shortages in recent years stem in large part from diminished agricultural output due to HIV and AIDS (BBC, 2005). The situation is not expected to improve. UNAIDS has projected that by 2020, Malawi's agricultural workforce will be 14 per cent smaller than it would have been without HIV and AIDS (UNAIDS, 2006).

The agency's report added that reductions in the size of agricultural workforces – albeit due not only to HIV but also to population shifts from rural to urban areas for the sake of greater work opportunities – would probably exceed 20 per cent by 2020 in other countries, including Botswana, Mozambique, Namibia and Zimbabwe.

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Human capacity shortfalls in healthcare and education sectors

HIV disproportionately affects young adults – individuals who should be in their prime productive years. Not only do those individuals and their families suffer, so do societies that desperately need their income-generating capacities and intellectual and social capital for overall development purposes – now and in the future (UNAIDS, 2006; de Waal, 2003).

Two sectors most critically affected are healthcare and education. In many nations, including Malawi and Zambia, the epidemic is reducing the supply of qualified health workers even as it prompts increased demand for health services. In Botswana, for example, an estimated 17 per cent of the healthcare workforce was 'lost' to AIDS between 1999 and 2005 (UNAIDS, 2006).

Education systems face similar crises when experienced teachers become sick or die. Such developments have reversed any results of the longstanding efforts to respond to an inadequate supply of teachers in many African countries. Much of the current evidence indicates that the situation will remain grim for the foreseeable future, especially in countries and regions with slow or substandard scale-up of HIV treatment and care services. A study in South Africa found, for example, that 21 per cent of teachers aged 25 to 34 are living with HIV (UNAIDS, 2006).

Growing numbers of children orphaned by AIDS

The November 2007 World Bank report estimated that there are currently some 15 million children (defined as those younger than 18) orphaned as a result of AIDS (World Bank, 2007a). Of those, some 12 million live in sub-Saharan Africa; the number of children orphaned by AIDS in each of five countries alone (Kenya, South Africa, Tanzania, Uganda and Zimbabwe) tops 1 million. Given the concentration of HIV among young men and women, the number of orphans is expected to continue increasing in the most heavily affected nations. In South Africa, for example, the age groups with the highest HIV prevalence are 25–29 (for women) and 30–39 for men (Shishana et al., 2005). A majority of those individuals will become sick and die in the near future unless access to appropriate treatment improves substantially (see Box 2.1).

Gender-related obstacles

Women comprise half of all people living with HIV worldwide, but in most societies they face significant legal, political, social and economic obstacles to obtaining appropriate access to HIV prevention, treatment and care. Their vulnerability is particularly acute in sub-Saharan Africa. Across the region overall, an estimated 61 per cent of

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Box 2.1 'Auntie Elizabeth' and the orphans

Around 4.6 million children in the southern Africa region have lost their parents to the AIDS pandemic. In many rural areas, entire villages have been decimated. Very often, only the children remain – and they are sometimes infected with the virus too, struggling to survive as best as they can.

The picture is much the same in urban areas. This is the reality for five of the nine children in the care of Elizabeth Magalefa, a dynamic 37-year-old who lives in Mabopane, some 30 kilometres from the South African capital Pretoria.

Far from the grand buildings and luxury shopping centres that are springing up on the outskirts of the city, Elizabeth tells her story in the modest, dilapidated garage, where she lives with her brothers and the children. "When my sister died of AIDS in March 2003, her partner of the time disappeared overnight, and I had no choice but to take in her five children, who would otherwise have been left to fend for themselves," she said.

"The youngest, aged 10, is also HIV positive. Happily, he is much better now, thanks to the anti-retroviral treatment that he is receiving," explained the young woman who, in spite of the great difficulty of feeding such a big family, always has a radiant smile on her face that lights up the room the family is crammed into.

"I have been through difficult times, and things are still not easy," she continued. "Fortunately, I now receive support from South African Red Cross Society volunteers, who come to see us regularly."

Each week, Patricia Sebiji pays the family a visit. This South African Red Cross Society (SARC) volunteer also lives in Mabopane and is all too familiar with the problems that peo-ple in the community face. She makes sure that both the grown-ups and the children have what they need, providing food assistance and blankets, if necessary. She also watches out for any secondary effects of the little boy's ART. If she were to notice anything, she would send him straight to the nearest hospital.

When necessary, the Red Cross also pays school fees for children who do not receive a grant from the state. Dikeledi, who is 18, is lucky that she is supported by her aunt, but there are thousands of children who have to leave school each year to provide for their brothers and sisters.

"An important part of my work when I visit the family is to provide advice on health matters, particularly sex education, to prevent unwanted pregnancies and ensure that they all know how to protect themselves against becoming infected with HIV," explained the volunteer.

"Patricia also provides the family with psychological support," added David Stephens, who is in charge of the SARC health programme. "Many of these orphans have psychological problems stemming from the loss of their parents and also from the discrimination that they often suffer within their own communities."

The Red Cross encourages depressed and parentless children to go to Red Cross youth camps to alleviate their loneliness, get away from their environment and meet with other young people.

"It is true that the neighbours are sometimes wary of us, even in our area, as if the fact that members of our family have died of AIDS poses some kind of danger to them," confided the woman they call 'Auntie Elizabeth'. "My neighbours' children would never

make the first move to play with my children, who, tired of trying to make friends in the neighbourhood, always end up playing together in the yard."

Elizabeth has learnt a lot during these troubled years and, instead of giving in to despair, she has decided to share her experience. She has studied to become a social worker and hopes to open a centre to look after orphans in the town. Dikeledi also tells us that, in spite of her ordeal, she would like to become a Red Cross volunteer herself one day.

"What we saw in Elizabeth's family highlights the importance of the work carried out by Red Cross volunteers within the framework of home-based care programmes," said Patrick Couteau, the HIV coordinator of the International Federation in southern Africa.

"By 2010, we aim to be providing care for 460,000 orphans in southern Africa, which is more than doubling the current support. Ten million children are expected to be orphaned by AIDS between now and 2010. We need additional resources for the enormous task of offering these children a window of hope for the future and a minimum level of services providing psychological support, food assistance and school aid, whether they live in urban areas, such as this one in the Pretoria region, or in rural areas," he added. ∎

all people living with HIV are women – a share that rises to as high as 75 per cent among HIV-positive individuals aged 15 to 24 (UNAIDS, 2007a).

As the report of the Special Rapporteur to the UN Commission on Human Rights states:

> "The vulnerability of women and girls to HIV and AIDS is compounded by other human rights issues including inadequate access to information, education and services necessary to ensure sexual health; sexual violence; harmful traditional or customary practices affecting the health of women and children (such as early and enforced marriage); and lack of legal capacity and equality in areas such as marriage and divorce."
>
> (UN Economic and Social Council, 2004)

Women are particularly vulnerable to HIV because of cultural mores and their economic dependence on men. Girls are less likely to receive education than boys (in many African countries they are taken out of school early to care for relatives sick and dying from AIDS) yet education is known to protect against HIV (UNAIDS, UNFPA and UNIFEM, 2004). It is a 'crisis of gender inequality' (UNAIDS, UNFPA and UNIFEM, 2004) because women generally have less power over their bodies and lives than men. Women, whether single or married, are unable to negotiate the use of condoms. In many Asian countries, for example, increasing numbers of married women are becoming infected because their husbands visit sex workers; marriage increases the vulnerability of many women to HIV. Sexual violence is a major threat to girls and women; rapists and violent partners do not use condoms (see Box 2.2).

Box 2.2 **The impact of violence on HIV**

Violence – physical, sexual and psychological – is a global pandemic that affects everyone – children, women and men. Within the world of HIV, violence can be both a cause and a consequence of HIV infection.

The complex relationship between HIV, violence and gender discrimination is often neglected in prevention and response programmes. Too often 'gender' is considered by humanitarian agencies to encompass the needs of women and girls only; in real terms, the unique needs of boys and men are excluded. Men who have sex with men who are HIV positive are more at risk of psychological, physical and sexual assault than their HIV-negative peers (Greenwood et al., 2002). In addition, children who are trafficked, abused or orphaned by AIDS are more likely to face violence, exploitation, stigma and discrimination which increase their risk of sexual violence and thus HIV (Rothschild and Nordstrom, 2006; Yamashita, 2007).

Gender and choice

While many HIV prevention programmes are predicated on the belief that people who are infected with HIV have a choice in whom, when and under what terms they have sex, the reality is very different for those experiencing violence, especially sexual violence. A study from South Africa (WHO, 2004) shows that women who experience coerced sex by intimate partners use condoms nearly six times less consistently than women who are not coerced. In the coastal areas of Kenya, it was found that 30 per cent of girls aged 12–18 years are involved in the sex trade; no condoms were used in 32 per cent of all sexual penetrative acts and 42 per cent of all anal sex acts (Jones, 2007).

Another study from South Africa (Human Rights Watch, 2005) highlights the fact that women in physically violent relationships were 48 per cent more likely to be infected with HIV than women in non-violent relationships.

A woman from Uganda describes her experience: "He would beat me to the point that he was too ashamed to take me to the doctor. He forced me to have sex with him and beat me if I refused. This went for every [wife]. Even when he was HIV positive he still wanted sex. He refused to use a condom. He said he cannot eat sweets with the paper [wrapper] on" (Karanja, 2003).

Violence and fear

Violence continues to affect its victims throughout their lives. A woman from Swaziland recalls: "When I was diagnosed I had a partner. The relationship became more violent – he said I brought a new problem into the family. The violence became more, he had other relationships. You get told off because you have HIV" (ICW and GCWA, undated).

Women are often reluctant to disclose that they are HIV positive because they are afraid of abandonment, rejection, discrimination, violence, upsetting family members and accusations of infidelity from their partners, families and communities (ICW and GCWA, undated).

"He was abusive before I had told him I was HIV positive, and afterwards, well, the beatings got worse… They happened more regularly. I say that because I remember his statement, 'I should kill you since you're trying to kill me'" (amfAR, 2005).

Thus fear also prevents HIV-positive people from accessing care, treatment and support. Often people feel it is better to 'not

know' than to 'know'. Fear and violence feed off one another in an insidious cycle.

Children and men

The risk of violence based on discrimination and a lack of social support not only makes women vulnerable but also children and groups of men, such as men who have sex with men. Human Rights Watch describes an example: "Jamaica's growing HIV/AIDS epidemic is unfolding in the context of widespread violence and discrimination against people living with and at high risk of HIV/AIDS, especially men who have sex with men" (ICW, 2005).

Stigma against MSM is widespread, with discrimination prevalent in numerous countries – often supported by laws and social customs that declare sexual behaviour between men as illegal, with sanctions that include prison. Violence against MSM may be tolerated with no consequences by state authorities.

Children are the smallest, weakest and least powerful members in any society. This is compounded by their dependency on adults not only for life and safety but also for justice. Often children's voices are denied and they are the least able to defend themselves against violence. The *UN World Report on Violence against Children* reveals that 150 million girls and 73 million boys are sexually abused in any given 12-month period around the world (Pinheiro, 2006). A study from India showed that of a sample size of 12,447 children more than 50 per cent were sexually abused (Kacker, Varadan and Kumar, 2007).

A 9-year-old girl relates her experience of contracting HIV through sexual abuse: "What transpired after that shall remain forever inscribed in my mind. I was bloodied and aching all over. Then he was ordering me out of the truck. I jumped into the mud and my school bag landed with a thud at my feet as he threw it after me. In the weeks that followed I had many nightmares about the incident. I found myself hating all men, including those male teachers I had used to admire so much. I felt dirty all the time and could still smell my rapist on me. The result of the [medical] examination shocked me more than the rape itself. Not only was I pregnant but I had also been infected with HIV" (UNICEF, 2006).

Steps forward

Violence prevention can be better linked to HIV prevention through several concrete steps (adapted from GCWA, undated):

- Increase support for programmes that address the linkages between violence and HIV through bilateral and multilateral funding mechanisms
- Maximize coordination between AIDS and violence prevention services, particularly in countries and communities highly affected by these intertwined epidemics, and remove barriers to integrating these essential services on the ground
- Integrate violence prevention, including the protection of children, into HIV prevention programmes from assessments, policies and education to accountability systems
- Provide dedicated funding and support to evidence-based programmes seeking to stop violence and reduce its impact. The Global AIDS Alliance calls for dedicated budgets of 4–10 per cent
- Provide funding for research and evaluation of programme strategies to reduce violence – against women, children and vulnerable men – and its links to HIV. ■

Poverty – and it is estimated that 70 per cent of the world's poorest people are female – often pushes women into transactional sex, bartering for food or other necessities of life or into sex work. In many countries, when husbands die, widows have no rights to property or land and are thrown out of their homes. So sex work may be the only alternative to starvation.

The AIDS epidemic has many effects on women. They are usually the carers in the family and if the husband is ill or working away from home, the women grow the bulk of the family's food supply. Women living with HIV face even more stigma and discrimination than men.

Psychological impacts

HIV epidemics can have profound mental health consequences. Even if they have no symptoms, people living with HIV in all parts of the world have more reason than most to be concerned about their future health and well-being; in consequence, they may suffer from a host of psychological ailments including anxiety and depression.

Their situation may be exacerbated by HIV-related stigma and discrimination and suffering and death among spouses, children, parents, other family members, friends and colleagues.

The scope and extent of such psychological trauma have received little attention in most of sub-Saharan Africa, where HIV prevalence is highest, and services and expertise to treat depression and most other mental health concerns are limited in the region (Baingana, Thomas and Comblain, 2005).

The negative psychological impacts of HIV extend beyond those who are living with the virus. Many HIV-negative individuals – especially those in high-prevalence areas – face the same kinds of loss, anxiety and worry as their HIV-positive counterparts. Children are perhaps the most vulnerable; as one observer noted, their "psychological vulnerability begins long before the death of a parent", and an important factor in their mental health "is the mental health of their parents" (Whitman, 2005).

The potential impact on children is much wider as well: "The health and mental health of ill or depressed caregivers, unable to provide basic nurturing and stimulation, can have a profound impact on children's developing brains – their cognitive, emotional and social development" (Whitman, 2005).

In such instances, children's opportunities and ability to integrate into society are severely constrained. They may be unable or unwilling to attend school, for example, which only serves to further isolate them from their communities and limit their future chances of finding work and social involvement.

HIV as a disaster among specific groups

HIV is a disaster among specific communities and population groups not just in sub-Saharan Africa, but in numerous countries elsewhere around the world. This section concentrates on two such groups: injecting drug users (IDUs) and men who have sex with men.

Such communities, which are considered to be at 'higher risk' in terms of contracting HIV and dying from AIDS, generally meet one or more of the following criteria:

- They have higher than average HIV prevalence in comparison with the general population in a country.
- They engage in practices that may heighten their risk of contracting HIV.
- They are poorer than the general population on average.
- They face extensive and potentially debilitating economic, political, legal and/or social barriers, many of which are related to stigma and discrimination.
- Their access to adequate social and welfare services, including healthcare, is far lower than among members of the general population. As such, their ability to obtain vital HIV prevention and care services usually ranges from insufficient to impossible.

IDUs, MSM, migrants, mobile workers, prisoners and sex workers are among the key groups of people for whom HIV has had a disastrous worldwide impact, because in most settings they generally meet all the criteria listed above. However, it is important to note that other sections of the population also face many of the same social and economic challenges but they are more properly categorized as part of the general population rather than specific, key groups. For example, women, young people and the poor are frequently considered to be at relatively heightened risk of contracting HIV and as being vulnerable to other developments, such as abuse and denial of care, that negatively affect their health.

Injecting drug users

Sharing and re-using contaminated injection materials are among the most efficient methods of transmitting HIV and other blood-borne diseases, especially hepatitis C. Thus HIV spreads quickly in IDU communities, wherever they are in the world, in the absence of adequate precautionary measures taken by users and where there are no effective harm reduction policies and programmes in place.

IDUs make up the largest share of HIV infections throughout the nations of the former Soviet Union as well as many Asian countries, including China, Indonesia and Malaysia (UNAIDS, 2007b). In these countries and most others, HIV prevalence is often several times higher among IDUs (especially in specific urban areas) than the general population. For example, in Karachi, Pakistan's commercial capital, a report-

ed 30 per cent of IDUs are infected with HIV (IRIN/PlusNews, 2007a). Yet overall HIV prevalence in the country is low – less than 0.2 per cent (UNAIDS 2007b).

Despite the widespread transmission of HIV through injecting drug use, only 8 per cent of users worldwide had access to HIV prevention services in 2005 (Global HIV Prevention Working Group, 2007).

Experience in many parts of the world shows that rates of HIV transmission plunge sharply when IDUs have safe, consistent and easy access to safer injecting materials and substitution treatment programmes (Open Society Institute, 2006). Yet in some parts of the world with the highest numbers of IDUs, including Russia, policy-makers continue to limit the availability of clean syringes and needles and forbid the use of methadone as a substitution therapy for people who are opiate-dependent (see Box 2.3).

Stigma and discrimination related to both drug use and HIV are the main reason for policy-makers' opposition. In all but a handful of nations, injecting drugs is illegal.

Public attitudes toward drug users are rarely anything but hostile, based not only on legal considerations but just as often (if not more so) on moral judgements and real and perceived assumptions regarding crime and delinquency. IDUs are therefore isolated and shunned, and tend to limit contact with important social and health services.

The following two accounts by IDUs in different countries highlight the deep-seated and extensive discrimination they often face:

> "The treatment [is] not like what they [healthcare workers] give to normal people, there's a difference. Like touching you… they feel reluctant to touch. When the doctor tells them to draw blood… ah… they will think twice. They will ask us whether you can draw your own blood or not. If they touched also, immediately they go and wash their hands. [It] is happening everyday. You can go to the ward and see."
>
> (Zulkifli et al., 2007)

> "I still have many problems with the police. A few weeks ago I was stopped on the street for no reason and then taken to the station. The police said they wanted to check if I was using drugs and that detaining me was the only way to do it. They kept me there for 24 hours before letting me go. Also, they didn't register my detention officially, so there was no record of my arrest. My girlfriend called the station to try to find me, but no one had any information to give her. I didn't have my ARVs [anti-retroviral drugs] with me and missed a dose."
>
> (Hoover, 2007)

Government policy-makers and health officials often contribute directly to the stigma aimed at vulnerable populations. In few places has this been more apparent than in Russia and Ukraine, home to two of the world's fastest growing HIV epidemics over the past decade.

In both countries as well as most others across the former Soviet Union, HIV has largely been concentrated among injecting drug users. UNAIDS estimates that 10 per cent of all new HIV infections globally are among IDUs, a percentage that rises to 30 per cent when Africa – where nearly all infections are attributed to heterosexual intercourse – is excluded. The agency has noted as well that more than 100 countries have reported HIV infection among drug injectors, and that HIV prevalence among IDUs exceeds 5 per cent in some 40 of those nations.

Already on the margins of society in most countries, IDUs receive little or no sympathy from the general population. Harassment against those individuals is common everywhere, but it is particularly pronounced in Russia and Ukraine because the sheer numbers are so large.

Government at all levels in both countries has generally failed (or more accurately, refused) to offer even basic services for these marginalized people despite escalating criticism by multilateral agencies (including the UN and World Bank) and international civil society. The type and scale of discrimination and abuse against IDUs in Russia and Ukraine vary greatly, from petty ignorance and corruption to calculated denial of potentially life-saving treatment.

In Lviv, Ukraine, for example, 30-year-old Andrei acknowledged having a difficult relationship with his parents, with whom he still lives, because they object to his drug use. Yet he cannot afford to move out and live on his own because it is impossible for him to find a job.

"Society sees me as useless," he said during an interview in April 2007. "I stopped using for a year or so and tried to get a job. But whenever people found out I used drugs, they refused to give me a job. I got depressed and started using again" (Hoover, 2007).

Andrei said he has been diagnosed with hepatitis C. He added, however, that he had not been tested for HIV even though he freely acknowledged having shared needles in the past. "It's not necessary to get tested for HIV," he said. "There's nothing I can do if I have it." Andrei's situation and attitude are far from unique in Ukraine. Although he and most other IDUs in Lviv have regular access to clean needles and syringes, as of June 2007 ART had yet to be made available (with limited exceptions) in the public sector.

His disinclination to be tested for HIV is hardly surprising. If no treatment options exist, what is the point of knowing? An HIV diagnosis would only add stress. Without a test, it is possible to maintain hope in such an environment.

As noted in the following two examples, IDUs face other kinds of discrimination across all sectors of society:

"I've had many problems with the police over the years. Recently, for example, I was detained and brought to a police station, where some police officers tried to put drugs in my pocket. I resisted and was beaten. This wasn't the first time they tried to set me up, and I acted the way I always do. My feeling is that it's better to be beaten than to be put in prison for a year.

After they beat me, I went home and stayed there for a week until I felt better. I didn't report the beating because there would only be more problems if I did."

('Ruslan', a 33-year-old IDU from Odessa, Ukraine)

"One friend had a problem with his kidneys so he called an ambulance. It came, but the drivers refused to take him when they found out he used drugs. It's even worse sometimes if there's an overdose. At one apartment, someone overdosed so they called the ambulance. They came and demanded 1,400 roubles [US$ 55] for naloxone to treat the guy. The users didn't have any money, so the ambulance left without treating him. He ended up dying."

('Sergei', a 32-year-old IDU from Tomsk, Russia)

Such accounts are not uncommon. It is therefore unsurprising that individuals most at risk from contracting and transmitting HIV are unable or unwilling to obtain vital services and information.

Although the AIDS epidemics are not yet remotely at sub-Saharan African levels, in Ukraine and Russia they are now the largest in Europe. Even the most conservative estimates from UNAIDS indicate that absolute numbers of HIV cases have reached around 1 million in Russia (UNAIDS, 2007c) and more than 400,000 in Ukraine (UNAIDS, 2007c). The situation is especially tragic because the epidemic arrived relatively late in that part of the world, after it was clear from evidence elsewhere that certain measures such as harm reduction programmes, implemented comprehensively and compassionately, could halt HIV in its tracks.

Glimmers of hope instigated by civil society

There have been some hopeful signs recently. In particular, civil society in both Russia and Ukraine has played a crucial role in improving service delivery to IDUs and other vulnerable groups and, by extension, helping reduce HIV-related stigma and discrimination. Such organizations' ability to have a demonstrable impact is remarkable given the fact that many engage in technically illegal behaviour and are chronically short of money. The latter problem is particularly acute in Russia, where foreign non-governmental organizations (NGOs) are viewed with suspicion by the government and are largely barred from any type of engagement (including funding local groups). A weak civil society tradition also means that authorities at all levels continue to view even local NGOs as law-breaking irritants at best, if not adversaries to be confronted and shut down.

Even so, courageous and dedicated individuals in NGOs continue to devise and implement innovative ways to reach as many people in need as possible. In St Petersburg in Russia, for example, the health and human rights of the city's more than 100,000 drug users have been the primary focus of the NGO Humanitarian Action since it was founded in the mid-1990s. The group formed an important partnership with healthcare providers at St Petersburg's largest infectious-disease complex and initiated a mobile outreach initiative to provide harm reduction and medical services to IDUs and sex workers. In 2006, more than 4,000 clients paid a total of nearly 14,000 visits to the outreach units.

Humanitarian Action remains the largest (in terms of both staff and clients served) and arguably the most influential harm reduction provider in Russia. Its reputation has ensured

that many of its strategies and methods have been adapted for use elsewhere in the country, even where drug use trends and levels of harassment differ greatly. In Tomsk for example, the NGO Center Anti-AIDS's outreach efforts focus primarily on scheduled visits to 'cooking flats' where groups of IDUs gather to prepare and inject *hanka*, a relatively inexpensive homemade opiate especially popular in that Siberian city.

In Balakovo, meanwhile, the Saratov branch of No to Alcoholism and Drug Addiction (NAN) offers a wide range of health-promotion and social-welfare services aimed at improving the lives of vulnerable individuals. Although many of its services are not directly related to harm reduction among IDUs, they all tend to focus on drug use prevention and helping end drug dependence. For example, the organization's extensive outreach work among sex workers is buttressed by a referral scheme to doctors and counsellors carefully chosen and screened to offer confidential and anonymous care at no cost. The group also seeks to reduce HIV-related stigma and discrimination by conducting training sessions for police officers and teachers throughout the city.

The efforts of these NGOs are bearing some fruit. At least partly in response to civil society advocacy, a few key government policy-makers in Russia and Ukraine are responding more aggressively and appropriately to their countries' devastating HIV epidemics. Since 2005, they have allocated far more substantial resources for treatment and prevention not only for HIV but also for other key conditions closely related to HIV in the region (notably tuberculosis (TB) and sexually transmitted infections).

With the prominent exception of Moscow – where needle and syringe exchange is still not permitted – authorities in a growing number of Russian cities and towns have recognized that more pragmatic and comprehensive health-promotion assistance for IDUs is vital to prevent further degradation in public health in general.

Overall, however, far too little has been done. Although policy-makers' recent steps are important, for the most part they have not directly addressed the most crucial factors behind the local epidemics. Far too few IDUs have access to safer injecting materials such as clean needles. Although now available in Ukraine (albeit at levels yet to meet demand), substitution treatment for drug users remains illegal in Russia. Drug users therefore lack realistic options to help treat their addiction. As observed recently by the director of Humanitarian Action's case management programme: "A lot of people have died because methadone is illegal and they are unable to stop injecting drugs through other means."

Such persistent obstacles result directly from lingering social attitudes that have proved impervious to change. As observed by Vitaly Djuma, the head of the Russian Harm Reduction Network:

> "A lot of people, especially those [at the federal level] in Moscow, still think harm reduction 'comes from elsewhere' and thus is not only irrelevant but immoral. In their view, drug use is 'anti-Russian', as is homosexuality. Therefore, harm reduction must also be anti-Russian. Their attitude is: 'Helping people engage in immoral behaviour is also immoral.'" ▪

Men who have sex with men

In many wealthier nations, including the United States and in Europe, HIV was first identified among MSM and they remain by far the most at-risk and affected individuals in those regions. A recent review of evidence from 39 low- and middle-income countries from all regions found that, on average, the HIV prevalence rate among MSM is 12.8 times the rate among the whole adult population. In countries with very low rates of HIV prevalence, the difference is often extreme. For example, in Mexico, the rate among MSM is 109 times the rate among all adults. In countries with high rates of HIV prevalence, the difference is still very considerable. For example, in Kenya, the rate among MSM is 6.9 times the rate among all adults. This trend is found in all regions of the world except Eastern Europe and Central Asia, where injecting drug users account for most cases of HIV (Baral et al., 2007).

MSM are at high risk of contracting HIV for a number of reasons, but perhaps the most significant are stigma, discrimination and isolation. Sex between members of the same gender is taboo in many cultures. Seventy-nine member states of the UN have laws criminalizing sex between men and, even where it is legal, sex between men is often strictly taboo. A recent study found that, because of criminalization and taboo, MSM are 'off the map' in most of sub-Saharan Africa, so that little effort is made to cover them with serological or behavioural surveillance or address their unique needs for HIV prevention, treatment, care and support (Johnson, 2007).

Even in societies without such laws, widespread social stigma often prevents MSM from obtaining important HIV education, information and treatment services. One consequence is increased risky behaviour. In Pakistan, according to a news report from November 2007, "Less than 25 percent of MSWs [male sex workers] reportedly used a condom for anal sex with their last client, and even fewer used any form of lubrication aside from saliva" (IRIN/PlusNews, 2007a).

According to amfAR, infection rates among MSM are "as high as 14 percent in Phnom Penh [Cambodia's capital]; 16 percent in Andhra Pradesh, India; and 28 percent in Bangkok, Thailand… dramatic increases in some areas [of Asia] have been seen" in recent years and this trend is particularly alarming given that MSM activity "in the region is diverse, often completely hidden, and beyond the reach of current prevention efforts" (amfAR, 2006).

The impact and sources of stigma and discrimination

Both the extent and the type of stigma faced by key groups at high risk vary. Wherever they live, however, members of such groups are in the main more likely than the general population to face legal, economic, political and social neglect at best, opprobrium and abuse at worse – regardless of their HIV status or risk-related behaviour.

HIV, and the fear of HIV, have compounded those attitudes (Human Rights Watch, 2007).

Discriminatory attitudes and judgemental decision-making vis-à-vis certain at-risk groups are not limited to low- and middle-income nations. Donors and wealthy countries often impose barriers on aid and other forms of assistance based on domestic moral agendas. Even today, the country with the world's largest economy, the United States, bars the use of federal funding for domestic needle exchange programmes for IDUs. That ban persists in the face of overwhelming evidence that such programmes drastically reduce HIV transmission risk among injecting drug users (Open Society Institute, 2007).

Official guidelines of the US government's President's Emergency Plan for AIDS Relief (PEPFAR), undeniably one of the most important global health initiatives ever undertaken, place restrictions on funding for groups working with sex workers and mandate that one-third of programme funds allocated for HIV prevention must be spent on activities promoting or encouraging abstinence. This promotion of abstinence programmes through PEPFAR and other initiatives continues despite any evidence of their effectiveness as population-based HIV prevention strategies. The US government is essentially telling recipient governments and organizations that its moral guidelines and assumptions must take precedence over local stakeholders' ability to identify appropriate responses on their own, based on their unique local knowledge. The ban on domestic needle exchange funding and PEPFAR guidelines also appear to signal official US discrimination against certain groups because of their behaviour and lifestyles.

Stigmatization of HIV-positive people in general

HIV-related stigma is not just confined to groups at higher risk, however. All people living with HIV meet with suspicion, contempt and distrust (see Box 2.4). They even meet stigma in countries with relatively high education and income levels, where HIV awareness efforts often have been extensive and regular, and/or where legal provisions not only bar discrimination based on HIV status, but are actually followed.

The findings of a recent multi-country survey "highlight the prejudice, fear and stigma that surrounds AIDS", according to news reports from November 2007 (Brown, 2007). The survey, conducted by the MAC AIDS Fund, involved a total of 4,510 interviews in Brazil, China, France, India, Mexico, Russia, South Africa, the United Kingdom and the United States. A summary of the results noted: "Overall, almost half of respondents said they felt uncomfortable walking next to an HIV-positive person, 52 percent did not want to live in the same house, and 79 percent did not want to date someone harbouring the virus." Perhaps unsurprisingly, such stigma tends to be particularly extensive and pervasive in countries, including those covered by the

Box 2.4 A survey on people's knowledge, attitude, practice and behaviour regarding HIV and AIDS in KwaZulu Natal province

In 2007, the South Africa Red Cross Society (SARC), with British Red Cross (BRC) support, undertook a survey on people's knowledge, attitude, practice and behaviour regarding HIV and AIDS in KwaZulu Natal (KZN) province where BRC supports HIV programming.

The population of KZN province (10 million people) accounts for 21 per cent of South Africa's total population. Many people live in rural areas, some of which are remote and difficult to reach. KZN has the lowest life expectancies (42 years for women, 45 for men) and the highest prevalence of HIV in South Africa.

Approximately 40 per cent of people attending antenatal clinics in KZN in 2005 were HIV positive, and 19.7 per cent of young people aged between 2 and 18 have lost one or both parents to HIV – the highest rate in the country. The current TB epidemic is driven largely by HIV; the cure rate for TB in KZN in 2004 was 36.4 per cent compared to the national average of 54.1 per cent.

The survey

The survey was carried out in September 2007 in the districts of South Coast, Zululand, Pietermaritzburg and Umzimkulu. Its aim was to collect, compile and analyse baseline information so the programme could be planned, designed and developed effectively, and supported by monitoring and evaluation.

The survey included young people and adults in the community. To observe the difference the work of SARC was making, at least one village not covered by the Red Cross was selected in each district. Community leaders, households and individuals were interviewed.

The process can be repeated to monitor trends over time and between different sites.

Summary of findings

Interviews with community leaders

Some 61 community leaders and resource people (such as counsellors, church leaders, traditional leaders, and youth and women's group members) were interviewed in 14 villages in four districts.

While all community interviewees acknowledged HIV and AIDS as a problem in their community, 26 per cent of the communities reported no activities in place to address HIV and AIDS; in Umzimkulu, no mechanisms were in place.

Stigma and discrimination were a concern in 57 per cent of the villages surveyed. Of those, while 36 per cent did not have the means and the information to address it, the same proportion are encouraging and educating the community to talk about stigma and discrimination. Some 9 per cent of communities have established support groups, have a disciplinary committee or report discrimination to the police.

Young people (aged 15–19)

In some areas, understanding of HIV was very poor. Condom use and knowledge about female condoms varied between districts. Stigma and discrimination were high – a factor linked to knowledge and understanding. Many taking advantage of voluntary counselling and testing (VCT) services do not return for results. Crucially, the age range of sexual activity among those interviewed was from 10–19 years. Most prevention activities currently target only the latter half of this bracket.

Adults

Overall, uptake of condoms was very low; 30 per cent of those with multiple partners in Umzimkulu reported very high rates of unsafe sex. The Red Cross will need to ensure that it is providing appropriate information, education and communication (IEC) services and advocating effectively for services. Knowledge of HIV prevention, including mother-to-child transmission (MTCT) during pregnancy, was also low. Again, effective life-skills training and IEC are crucial to increase knowledge.

Key findings

Young people aged 15–19 in school

- While 99 per cent lived with family members, 27 per cent were living with relatives other than their parents
- 78 per cent were at secondary school; on average they had ten years of schooling
- 55 and 40 per cent of young men and women respectively were sexually active in the 12 months prior to the survey
- The range of ages at first sexual encounter was between 10 and 19 years, with an average age of 15.5 years
- In South Coast, 83 per cent of the women and 67 per cent of the men were involved in several concurrent sexual relationships
- Young men tended to have partners of the same age while females had slightly older partners
- 3 per cent of the sexually active males reported having paid for sex in the last 12 months, while 2 per cent reported being paid for sex

Young people aged 15–19 out of school

- 64 per cent of the 138 young men and 137 young women interviewed lived with their parents and 12 per cent with grandparents; 8 per cent were head of their households
- 82 per cent of young men had finished primary school and almost four years of secondary education
- 75 per cent of young women completed primary school and over three years of secondary education
- 81 per cent of the young men and 58 per cent of the young women reported having had sexual intercourse
- The range of ages at first sexual encounter was between 10 to 19 years old with an average age of 15.7 for males and 16.1 for females

Reproductive age (20–49 years old) male and female

- Of 373 people interviewed, 183 were male and 190 female. The median age of adults was 28 years for females and 27 for males
- 57 per cent of males and 47 per cent of females were living with their parents
- Over 85 per cent of all males and females interviewed reported having had sexual intercourse in the last year
- 54 per cent of men and 33 per cent of women had had sex with more than one partner in the last 12 months – with only one in three using condoms
- Lowest condom use with non-regular partner was found in Umzimkulu – 88 per cent of the respondents were having unsafe sex. Reasons given for unsafe or risky sex vary between sexes
- 4.6 per cent reported having paid for sex in the last 12 months; 1.5 per cent reported being paid for sex

The communities interviewed were aware of HIV and AIDS, stigma and discrimination and gender-based violence; however they do

not feel empowered or informed enough to respond within their communities.

Comprehensive knowledge about HIV and AIDS remains low in the four districts surveyed across all adult and youth target populations. Adults and youths expressed difficulties in accessing information and services. Incorrect beliefs about HIV are still prevalent among adults and youth populations. This leads to fear and increasing stigma and discrimination.

The survey has highlighted a number of opportunities where increased support can be provided more efficiently. Through sharing and using the valuable information gained, the Red Cross and other stakeholders can plan, deliver and monitor more effective interventions. ■

MAC AIDS Fund survey, where HIV is concentrated among specific groups. HIV-related stigma may persist in countries with generalized epidemics, such as those in sub-Saharan Africa, but its virulence and impact are often muted in such environments because so many people are living with the disease themselves and have known at least one person who has died of AIDS.

The survey does reinforce the views of long-time advocates such as the Executive Director of UNAIDS, Peter Piot, who regularly states that stigma and discrimination, along with gender inequality, are the major barriers to comprehensive, compassionate and effective provision of HIV care in nearly every country in the world (Piot, 2006). Stories abound of social ostracism, even within families and otherwise close-knit communities. Even if widely available, uptake of HIV testing has lagged behind in many parts of the world because people are afraid of being identified with the virus in any way. As a result, individuals are often only diagnosed with HIV when they are very ill and near death. By then, their immune systems may be so ravaged that ART offers limited benefit, if any.

Is HIV an 'emergency' as well as a 'disaster'?

Is HIV also an 'emergency' in the contexts where it is a disaster? And does it matter even if defined as such? The short answers are 'yes' and 'yes'.

Definitions of the two terms differ of course, but there is a remarkable symmetry between them. A recent report about the HIV and AIDS crisis in Swaziland concluded, following a literature review, that emergencies and disasters "are defined in a myriad of ways [sic]", adding, "While there is no shared definition of what constitutes an 'emergency', there is broad agreement reflecting concern with reducing suffering and preserving human dignity." The authors continued: "An emergency can be thought of as an event affecting a group of people, causing a social, infrastructural or health impact which places the population under an excessive amount of stress and exceeds their coping capacity" (Whiteside and Whalley, 2007).

Such a view mirrors the definition of disaster put forth by the UN's Disaster Management Training Programme (DMTP) (OCHA, 1996). This is important because it offers the possibility of reframing and re-conceptualizing the HIV epidemic, both globally and locally. Academic and stakeholder definitions aside, disasters are frequently perceived as localized events with specific area, time and impact parameters. An emergency, meanwhile, by its very name appears to be unbounded and threatening. It demands action, even by those not directly affected.

One reason global, regional and national responses have for the most part been only fitfully successful is that HIV is rarely referred to as an emergency in any context. Yet as succinctly observed recently in *The New York Times*, "Despite the revised estimates, the epidemic remains one of the great scourges of mankind" (McNeil, 2007). For far too many people, however, 'mankind' in terms of HIV appears to have a limited instead of expansive implication. That limitation in perception is perhaps the biggest emergency of them all. It is also the one that must be addressed first before sufficient responses can be implemented elsewhere in response to the epidemic.

This chapter was written by Jeff Hoover who is a freelance researcher, editor and writer based in New York, USA and Cape Town, South Africa. He also contributed Box 2.3. Box 2.1 was written by Jean-Luc Martinage, International Federation. Box 2.2 was written by Gurvinder Singh, Prevention of Sexual Exploitation & Abuse (PSEXA) Officer, Canadian Red Cross. Box 2.4 was written by Alyson Lewis, HIV and AIDS Adviser Africa, British Red Cross and Elena Ruiz Roman, independent consultant.

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CHAPTER 2

The humanitarian interface: using the HIV lens

The word 'interface' usually conjures up the image of a human interacting with a machine. In disaster management and responses to complex emergencies, however, the reality is one of many interfaces: e.g., those between humans, administrative systems, governmental and non-governmental organizations (NGOs), and a variety of local, national and international actors.

Relationships between and within these different groups are complicated by the unique nature of each disaster, the conditions and magnitude of which are always different. Is the event accompanied by mass migration? Are road access and communications heavily compromised? What was the state of the medical, security and administrative systems when the disaster began?

Affected populations have different levels of resilience, and local or national governments have varying capacities to respond – as well as willingness to ask for help. Moreover, different responding organizations arrive with very different skill sets, resource levels and various and often contradictory political or ideological agendas.

In the past two decades, HIV has thrown a number of perplexing factors into the complex mix and relations between disaster and development. Some of these factors can be addressed by relatively straightforward adjustments that responders have always had to make in the field when conditions change and needs become clear. For example, the importance of nutrition in maintaining the health of HIV-positive people requires a re-thinking of ration sizes and types of food when providing emergency food aid in situations with high numbers of people living with HIV (PLHIV) (Harvey, 2004a).

Beyond such operational questions, however, the impact of the epidemic on entire societies in sub-Saharan Africa has resulted in more fundamental reflections on disaster responses. For example, a recent analysis of responses to the epidemic in Swaziland argued that with the advent of HIV, disasters should no longer be viewed as linear – with a discrete beginning, middle and end – but as long-term events requiring a different paradigm for responses:

> "Traditional humanitarian thinking focuses on the short-term, and is often aimed at returning affected populations to 'normality'. HIV/AIDS in Swaziland has been characterized by a slow onset of

Photo opposite page: The US navy delivers bottled water to the Nicaraguan village of Krukira, after it was hit by Hurricane Felix in 2007. Krukira is one of the locations where a Netherlands Red Cross project is integrating climate change impacts into Nicaraguan Red Cross disaster preparedness efforts.

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impacts that have failed to command an emergency response. With insufficient resource allocation and a lack of capacity, slow onset events can become emergencies. This characterisation is supported by the lack of an agreed definition of a 'disaster' or an 'emergency'. The nature of these terms is changing. The case of Swaziland emphasizes that emergencies can be long-term, complex, widespread events that evolve over years."

(Whiteside and Whalley, 2007)

The humanitarian organizations: taking HIV on board

The humanitarian organizations involved in disaster response do not always share common interests and approaches. There is a wide range of groups and structures involved in one or more aspects of humanitarian work. These include the agencies of the United Nations (UN); governmental ministries or agencies; international, national and local NGOs; faith-based organizations; foundations and bilateral donors; and a wide variety of contractors run on business or non-profit models.

These entities have different opinions about what is a continuum, with disaster relief-oriented organizations at one end (i.e., those concerned with responding to specific, acute and random events) and development-oriented organizations at the other (those focused with longer-term objectives of reinforcing or building capacities in target societies). Some of the larger organizations cover both ends of the continuum, recognizing that some aspects of relief and development are very much interrelated.

As well as having different mandates and interests, organizations also have highly varied levels of expertise. This is particularly true in relation to HIV. Some organizations have made great efforts to integrate HIV in their operations, while others have little knowledge or experience to rely on when dealing with emergencies in which HIV is a significant factor.

Oxfam has reflected carefully on how best to integrate HIV and AIDS in its operations; a recent manual is called *Humanitarian Programmes and HIV and AIDS: A Practical Approach to Mainstreaming* (Walden et al., 2007) (see Box 3.1). The manual proposes that an 'HIV lens' should be used in all stages of the programme cycle, but also states that basic data on HIV prevalence are an essential input to decision-making. The conceptual approach used by Oxfam is taken from a previous document, published jointly with ActionAid and Save the Children UK, which makes the following distinctions between specific programming, on the one hand, and mainstreaming approaches on the other:

■ The term HIV and AIDS programming refers to HIV prevention and treatment, care and support for PLHIV, or HIV and AIDS-focused interventions that are

integrated within broader health and related programming. The goal of HIV and AIDS programming relates specifically to HIV and AIDS.

■ The term 'mainstreaming' HIV and AIDS refers to "adapting development and humanitarian programmes to ensure they address the underlying causes of vulnerability to HIV infection and the consequences of HIV/AIDS". The focus of such programmes, however, remains the original goal (in the case of Oxfam providing water, sanitation and hygiene promotion as well as livelihoods, for example) (Holden, 2004).

Box 3.1 Mainstreaming HIV and AIDS: the Oxfam experience

What impact will our programme have on the HIV and AIDS scenario in the communities with which we work, and how can HIV and AIDS affect our programme? Answers to these two basic questions help Oxfam to mainstream HIV and AIDS into all aspects of their humanitarian work.

One recent incident illustrates how simple and yet effective mainstreaming HIV can be. Last year Oxfam was working in two regions of eastern Uganda that were badly affected by floods. These are also regions with high HIV prevalence. Oxfam workers found that people were in urgent need of jerrycans for collecting water. In discussion with the community, they also discovered that there had been problems in the past with an initiative when the government had distributed free jerrycans to people living with HIV. The problem was the colour: the free ones were white and those sold in the shops were yellow. This meant that a person using a white jerrycan was identifiable as someone infected or affected by HIV, and this reinforced stigma.

In planning their humanitarian response, Oxfam staff discussed the issue and decided that the solution was to distribute white jerrycans to everyone, in the hope that it would break down the stigma.

So far 60,000 white jerrycans have been distributed. One of the beneficiaries told Oxfam: "I am extremely thankful as I can now carry my jerrycan to the communal water point. Previously I could not bring them outside my house even while cleaning them. I had always thought that the white jerrycans had been specially designed for people living with HIV and AIDS." This is a good illustration of the importance of mainstreaming HIV. "It shows how things can go horribly wrong if one doesn't take care," says Oxfam adviser Jesee Kinyangui. "It was such a simple solution. People really appreciate that."

This example shows that having good information about HIV is essential for mainstreaming. This means hard data, such as HIV prevalence, as well as understanding the community's experience, their attitudes and values.

Mainstreaming HIV has become a way of life for Oxfam, and examples can be found in many programmes. In camps for internally displaced people in northern Uganda, water and sanitation programmes have been adapted for families affected by HIV. Water pumps that are easy to use have been installed for families headed by a child and those weakened by illness. The community has also agreed that families with chronically ill members do not have to

pay for water. Housing programmes in the area have also been adapted to reduce girls' vulnerability to rape and HIV. Oxfam and other NGOs have ensured that single-sex housing shelters with well-lit latrines are provided for girls who seek shelter overnight.

There are many examples where mainstreaming has ensured that the emergency response does not exacerbate vulnerability to HIV. For example, during the Zambia food emergency, Oxfam was bringing in food from distant suppliers by truck, and this meant that the drivers had to sleep in guest houses overnight. Oxfam provided condoms and information about HIV and the drivers themselves became distributors and educators.

In Zimbabwe, Oxfam works with other NGOs to assist vulnerable and displaced people in urban communities in a programme that prioritizes families affected by HIV. Here, food baskets are provided through a system of food vouchers that targets the most vulnerable. Toendepi Masodzi is a beneficiary of this programme. An HIV-positive artist, Masodzi used to make a living by selling the metal bird sculptures that were so popular in the gardens of Zimbabwean farmers. After the land invasions, his market dwindled and he found it increasingly difficult to feed his family. His own health suffered. Since receiving the food basket, which contains peanut butter and beans, his health has improved.

The programme also helps people living with HIV to meet their extra nutritional needs by planting 'low-output' gardens. These include a variety of vegetables that require less labour and fewer agricultural inputs than the crops usually grown. People are also encouraged to grow herbs with known benefits for opportunistic diseases of HIV. These gardens are also suited to the physical abilities of older people, many of whom are caring for orphaned grandchildren. One such person is Mbuya Sabawu, a 67-year-old grandmother who must feed 11 grandchildren. "In the past," she said "we never used to grow so many vegetables. Now if we get hungry we can go into the garden and find enough to prepare a meal."

The experience of this programme showed that many people could not afford the very basic items needed for the care of their sick family members. The programme was then adapted to supply 'primary caregiver kits' along with the food baskets. These contain items like soap, cotton wool, antiseptic, bandages, vitamins and iron tablets. The kits are replenished monthly and people are given training in home-based care. One beneficiary, 68-year-old Gogo Sibanda, was found caring for two chronically ill family members in their 30s. "My son, I did not know all this you are teaching us," she told the programme officer, "especially the fact that one can get the disease through nursing the sick if no proper care is taken."

For Oxfam, mainstreaming begins at home. That is because Oxfam staffers working in high-prevalence areas are often as vulnerable to HIV as the beneficiaries of their programmes. This applies as much to international workers as to locals. "When staff members speak, you realize they have something in common with displaced people," says Oxfam's health team coordinator, Marion O'Reilly. "They talk about what it feels like to be struggling without networks and families. It is well known that aid workers can be a risk to communities and to themselves."

Oxfam has long been committed to ensuring that HIV is mainstreamed into their own management practices, for example by considering whether staff members need time to care for sick relatives or attend funerals. Inter-

nal mainstreaming, as it is known, involves ensuring that policy and practice reduce the organization's own vulnerability to HIV. It may result in HIV and AIDS workplace policies, or awareness-raising work with new staff on HIV prevention or treatment needs. Some country offices choose one person to be the HIV focal point for staff welfare. His or her job includes ensuring that condoms are available at the office and that staff members know where they can find local HIV services. The focal point must also brief new staff members about HIV mainstreaming and what it entails. This practice of internal mainstreaming provides a solid basis for mainstreaming HIV into all development and humanitarian work. ∎

Some of the UN agencies with particular responsibilities for disaster response have long been active in attempting to mainstream HIV in their operations. For example, the Food and Agriculture Organization (FAO), along with its related agency the World Food Programme (WFP), has for many years formally included policies to "integrate an AIDS dimension in its emergency assistance... This is first and foremost relevant for rural areas in sub-Saharan Africa, where there are frequent emergencies, and where rural livelihood vulnerability merges with high HIV prevalence" (FAO, 2001). The FAO worked systematically to find the cost-effective measures to achieve this integration, with considerable internal discussion about both its comparative advantages (vis-à-vis other organizations) and its mandated mission. Several organizational focuses for building or increasing internal expertise have emerged; these include rural reconstruction, HIV as a factor in rural women's vulnerabilities in disasters (as well as their capacities to respond to the epidemic) and nutritional aspects of care for PLHIV. For its part, the Office of the United Nations High Commissioner for Refugees (UNHCR) has included HIV in its strategic planning for several years now, regularly producing documents like *UNHCR's strategic plan for HIV/AIDS and refugees, 2002-2004* (UNHCR, 2004).

Government organizations, too, have increasingly accepted the importance of mainstreaming HIV in all their operations, including those specifically related to disasters. The Deutsche Gesellschaft für Technische Zusammenarbeit (GTZ, or German Technical Cooperation) has been doing so for more than a decade. The GTZ strategy has both internal and external focuses: the internal one aims to provide a comprehensive HIV workplace programme for all staff around the world, while the external focus makes it a priority for GTZ country teams in sub-Saharan Africa to engage with all opportunities to respond to HIV and AIDS in their work (Adams, 2007). These opportunities may arise, for example, through GTZ teams' ongoing relationship with the UN Development Programme (UNDP), the UN system's HIV/AIDS Theme Groups and the national structures of the Global Fund to Fight AIDS, Tuberculosis and Malaria.

Some major NGOs have recognized and dealt successfully with the difficulties of integrating HIV considerations into established ways of working. The International

Federation of Red Cross and Red Crescent Societies (International Federation) began a process in 2000 to engage with HIV issues in a more comprehensive manner by instituting a Global HIV Programme. One of the initiatives undertaken within this process was to set up a partnership with the Global Network of People living with HIV/AIDS (GNP+). The initiative had a somewhat rocky start, in part because it challenged internal culture and established ways of working, but also because of worries about how National Societies might react (Knight, 2003). However, the two partners persevered, and the partnership has become a close one. A 2005 report noted that:

> "…after 4 years of implementing the Federation's renewed Global HIV/AIDS Programme, National Society HIV/AIDS work is growing from strength to strength. It is evident that National Societies are engaging with the Federation's Global Programme three-pillar structure as a foundation and see stigma and discrimination reduction as a crucial pre-requisite for an effective HIV/AIDS response.
>
> Increasingly National Societies realise the importance of the principle of greater involvement of people living with HIV/AIDS (GIPA) in HIV/AIDS and stigma reduction work and 2004 has seen a significant interest in partnerships with people living with HIV/AIDS (PLWHA). Many National Societies who 4 years ago could not envision working with or employing PLWHA are starting to talk about engaging PLWHA and several even employed PLWHA in their National Society during 2004."

<div align="right">(International Federation, 2005)</div>

Box 3.2 The Red Cross Red Crescent Global Alliance on HIV: "Rising to the challenge"

The International Federation has the world's largest voluntary network with millions of members and volunteers among 186 National Red Cross Red Crescent Societies living in communities in every corner of the globe. Mobilizing the power of this humanity to make the difference is at the heart of the International Federation's approach to HIV.

In 2006 the Red Cross Red Crescent Global Alliance on HIV was formed to boost in-country HIV programming, in support of national HIV and AIDS programmes, to reduce vulnerability to HIV and its impact. The Global Alliance is about scaling up to do more and better through strengthening and making better use of the combined capabilities of the Red Cross Red Crescent Movement. It also brings in regional networks and other funding and operating partners, to support community-level action. The HIV Global Alliance methodology is based on:

- simplifying what is done
- harmonizing how it is done
- scaling up what can be done well.

The HIV Global Alliance aims by 2010 to double Red Cross Red Crescent programming

in targeted communities. This means dealing with 10–20 per cent of client load in some countries. This is being done through three programmatic outputs:

- **Preventing further HIV infection** by focusing on: peer education, community mobilization; information, education and communication (IEC) for targeted vulnerable groups; voluntary counselling and testing (VCT); preventing mother-to-child transmission (PMTCT); and promoting skills for personal protection, including condom use.
- **Expanding HIV care, treatment and support** by focusing on: assisting children and orphans made vulnerable by HIV; providing treatment, support and care (home- or community-based and through health institutions) for PLHIV; and providing livelihood and food support for the most vulnerable.
- **Reducing HIV stigma and discrimination** by focusing on developing community support groups and networks of PLHIV, and partnerships with PLHIV organizations; ensuring that HIV in workplace policy and programmes for all staff and volunteers are in place in National Societies; tackling gender inequalities and sexual and gender-based violence; and peer education, community mobilization and population-based IEC.

These are bolstered by a fourth enabling output:

- **Strengthening National Red Cross Red Crescent Societies** capacities to deliver and sustain scaled-up HIV programmes by focusing on improving governance, accountability and leadership of National Societies for discharging planned commitments; improving volunteer and staff support and management; strengthening

programme cycle management; and widening partnerships and expanding resource mobilization.

The HIV Global Alliance's programming principles are that interventions must:

- **Be evidence-based** – informed by locally prevalent patterns of HIV risk, vulnerability and impact, and driven by a demonstrable understanding of what is effective in a particular context.
- **Be mainstreamed**, wherever feasible – not only within structures and programmes of the Red Cross Red Crescent, but importantly, they should be integrated into and seek to strengthen community and institutional systems for health, education, social care and livelihood promotion. Thus HIV activities should be carried out jointly with maternal and reproductive health, tuberculosis, safe blood and other related interventions.
- **Seek out the most vulnerable and build resilience** by prioritizing reaching and empowering the people that are most in need. Particular emphasis is on involving PLHIV and their families. Crucially, in the face of an increasingly feminized epidemic, addressing gender inequalities – and sexual and gender-based violence – is also a priority feature.

The comparative advantage of the Red Cross Red Crescent is the capacity to undertake direct action at community and family level while also having access to policy-makers and building sustainable systems for service delivery. A strong emphasis is placed on tracking results with the aim of doubling outreach to at least 137 million beneficiaries worldwide by 2010. ■

The 2005 General Assembly of the Red Cross Red Crescent resolved to make HIV a corporate priority within its Global Agenda. A high-level position of Special Representative was created and, on World AIDS Day, 1 December 2006, the International Federation launched its Global Alliance on HIV (Box 3.2) aimed at doubling its programming by 2010. The majority of National Red Cross Red Crescent Societies around the world are scaling up HIV programmes covering prevention, treatment, care and support, and countering stigma and discrimination (see Boxes 3.3 and 3.5).

Box 3.3 Russian Red Cross support for HIV-positive women in Siberia

Over the past decade, the Russian Federation has experienced one of the fastest-growing HIV epidemics in the world. In 2007, UNAIDS estimated that approximately 1 million Russian adults (aged 15 to 49) were living with HIV. Injecting drug use remains the main mode of HIV transmission in the Russian Federation, although HIV is also transmitted by increasing numbers of male injecting drug users (IDUs) to their sexual partners.

The East Siberian region of Irkutsk has the fourth highest caseload of HIV in the Russian Federation.

Fuelled by needle sharing among IDUs, the HIV epidemic expanded fast in Irkutsk. Only two cases of HIV had been reported in 1998; a year later, 2,631 cases had been reported.

Currently, there are 21,500 registered HIV cases in Irkutsk. The pattern of the epidemic is also rapidly changing, with sexually transmitted HIV cases making up a growing share of new diagnoses, and over 40 per cent of new HIV cases found among women, particularly among young women (aged 19 to 25). Another alarming trend has been the rising number of children born to HIV-positive mothers, and the growing risks of mother-to-child transmission (MTCT) of HIV.

When the Irkutsk branch of The Russian Red Cross Society began working on HIV in Irkutsk City in 1999, few non-governmental or civil society organizations were active in the response, the local government refused to acknowledge that HIV was a problem, limited health services or anti-retroviral drugs were available for PLHIV, funding for HIV and AIDS was negligible, and there was virtually no public discussion about the epidemic. Since then, the climate has changed, largely due to the persistent efforts of members of the Irkutsk branch, and their demonstration that high-quality care and support services can be provided and can make a difference.

The foundation for the Irkutsk branch's HIV and AIDS programmes was built on existing community outreach, care and support services that targeted the most vulnerable populations in Irkutsk. For the first two years, HIV interventions focused on basic IEC campaigns and peer-to-peer outreach, especially with IDUs. As the HIV epidemic matured and the problems confronted by community members became more complex, the Irkutsk branch, under the direction of Anna Zagainova, at the time Director of The Russian Red Cross Society's Eastern Siberian Zone, actively sought collaboration and partnerships with the Ministry of Health and other ministries, the Federal AIDS Centre, healthcare workers and state agencies concerned with social issues of its

citizens. The dedicated staff at the Irkutsk branch went out of their way to learn from doctors, epidemiologists and other health experts who were tasked with monitoring the health status of the HIV-positive population in Irkutsk.

However, it was not until February 2003, with grants from the Anne Ray Charitable Trust and in partnership with the American Red Cross, that the Irkutsk branch was able to design and implement comprehensive community-based care and support programmes aimed at expanding access to HIV-positive pregnant women and new mothers to interventions to prevent MTCT, and to provide care and support to people living with HIV.

The Irkutsk branch's care and support initiative integrates PMTCT into family-focused care through a visiting nurse programme; provides high-quality and free psychological and social counselling through trained social workers, lawyers, peer support groups and hotlines; supports treatment protocols for HIV-positive pregnant women in coordination with the Federal AIDS Centre and other healthcare providers, and develops training materials and curricula for caregivers of PLHIV and children of HIV-positive mothers, and healthcare professionals. Through the project, the Irkutsk branch has, since 2003, provided psychological, legal and social assistance and PMTCT support to more than 18,000 people affected by HIV and AIDS in Irkutsk City.

One of the unique aspects of the care and support programme are services offered by visiting nurses who make home visits to children born to HIV-positive women. As part of the visit, nurses assess a child's health, development and living conditions, counsel the mother and provide food parcels and vitamins. Any problems in a child's physical and/or psychological development are tracked, and referrals to the Irkutsk branch counselling or medical services are made. Providing these services has required implementing and promoting a referral system among the regional AIDS Centre, other government agencies and NGOs, and medical and social services in Irktusk. During 2006, the Irkutsk branch visiting nurses made 2,320 home visits to children under the age of 2, and 373 children and 52 pregnant women received food parcels and nutritional supplements on a monthly basis that same year.

The care and support services provided have evolved over time, based on the suggestions of clients, medical providers and others working in HIV programmes. The Irkutsk branch learned early on that PLHIV were a critical group to partner with; as such, they are both primary clients and primary actors in their programmes. A significant number of the branch's paid staff and volunteer workforce are openly HIV positive and have a keen interest in making a difference in their community.

The stigma and discrimination associated with HIV and AIDS still present a major hurdle for all programmes that focus on prevention, treatment or care of people living with HIV in Irkutsk. HIV-positive women seeking care for themselves and their children continue to feel stigma from health workers, relatives and friends, but the situation is improving.

Eugenia, who became HIV positive after a sexual encounter with a boyfriend at the age of 19, is pregnant and works as a peer counsellor at the Irkutsk branch, where she met her husband, who is also HIV positive and works at the same branch.

Both talk openly about the harsh treatment they continue to face in the healthcare system, but they find refuge and purpose in the supportive environment of the branch, and Eugenia is thriving under the care of the

professional staff there. "I worry every day about delivering a healthy baby, but with the support I receive from the branch counsellors and the infectious disease doctor, I am able to maintain a level of optimism that all will be well!"

Another client was equally enthusiastic about the services: "If I had not visited the Irkutsk branch, I would have probably had an abortion. No one at the local polyclinic told me that an HIV-positive person could give birth to a healthy child. Now I am very happy that I have had a baby and I am also proud of that."

The Irkutsk branch is now focusing on developing the capacity of other Russian Red Cross branches to design, implement and monitor their own HIV prevention, care and support programmes, in partnership with the American Red Cross, and with funding from the Anne Ray Charitable Trust. ∎

Unlike organizations with a broad humanitarian 'portfolio', many NGOs have a mandate or organizational ethos that is tightly focused on specific aspects of disasters. Médecins sans Frontières (MSF) is one of the best-known of the organizations that provides 'front-line' medical services in disaster situations. Since MSF designs its services to include care of all common major health problems, HIV programming is a solid part of those services. For over a decade, the organization has built up substantial expertise in treating PLHIV, and has pioneered the provision of anti-retroviral treatment (ART) in difficult situations. However, MSF is careful to dismiss expectations that it will initiate large-scale programmes, stating firmly: "The responsibility for scaling up comprehensive HIV/AIDS treatment programmes rests with governments which have a responsibility to provide adequate health care to their people" (Calmy, 2004).

Other NGOs such as the International HIV/AIDS Alliance very much focus on working with community-based organizations; their work includes support programmes for ART provision (see Box 3.4).

Faith-based organizations, too, have been involved in HIV responses for as long as the epidemic has been apparent, particularly in clinical and community-based care services. Faith-based organizations differ widely, ranging from small groups with a single programmatic focus to fully-fledged international organizations responsible for dozens of projects. In recent years, some have become more politically outspoken, taking on a role as advocates for development policy changes in areas that relate to HIV. One of these is the UK-based Tearfund, a Christian organization that currently works in 70 countries. Of Tearfund's 450 partner organizations around the world, about 120 are working on HIV-related activities. Within the UK, it has actively lobbied the responsible government ministry, the Department for International Development (DFID), to increase funding to local-level AIDS initiatives, whether Christian or not (Tearfund, 2004).

Box 3.4 **Positive partnerships for treatment support in Zambia**

The Zambian government's national implementation plan for scaling up ART states: "Communities can make major contributions to ARV [anti-retroviral] treatment programmes." Thus one of the key principles of the government's plan to scale up ART effectively is to promote partnerships between government, private sector, civil society and communities.

The International HIV/AIDS Alliance's Antiretroviral Treatment Community Education and Referral (ACER) project in Zambia is providing an important example of an effective community-driven and -led ART programme. The overall aim of the ACER project is to improve health-seeking behaviour, prevention, equity of access and adherence to ART for people living with HIV. It does this through community education and referral, with the participation of PLHIV and other community stakeholders.

The ACER project links existing community organizations and support networks – traditional healers, home carers, positive people's groups and church groups – with government health services. The project employs people openly living with HIV to promote uptake of treatment, to support treatment adherence and to promote prevention efforts in community and clinic settings.

A key feature of the project is the two-way referral system between community support services and healthcare providers, developed around the concept of a treatment journey. Following training on ART and on HIV prevention, the communities involved enable the project to address gaps in the care and support of PLHIV. Developing a referral system recognized by and appropriate for the community has resulted in excellent cooperation between traditional healers, positive people's networks, home-based care providers, healthcare workers and other community support providers, as they now understand each other's services better.

PLHIV have been very directly involved at all stages of the design and implementation of ACER. The positive people's support group system has been used by all organizations within ACER, enabling people to share information and personal experiences as part of the process of supporting one another. The support groups are an important strategy in promoting adherence through sharing and encouragement among positive people, in addition to providing them with a collective voice.

As well as referring people to appropriate services, ACER partners have also provided treatment literacy education to the community; this has reduced stigma among people on treatment, their families and communities.

The ACER project's community referral system has maximized community resources, has shortened and facilitated the treatment journey, and provides continuity of HIV and ART support within the community.

The ACER project currently employs four treatment support workers and two treatment mobilizers. All have been living openly with HIV for a number of years. The treatment support workers help people visiting the clinics by listening and offering advice on issues related to ART. They have strong relationships with community organizations and health services, to which they refer clients for further care, support and prevention. The treatment mobilizers' work involves raising awareness of HIV and ARV treatment, increasing treatment literacy and linking communities with the treatment

support workers in health clinics. They coordinate community education and referral activities, reaching over 80,000 people with intensive ongoing activities.

Eric Mweemba Nachibanga is one of the treatment support workers in the ACER project. Eric grew up in the copper belt of Zambia, in a town called Ndola, but currently lives in Lusaka, the capital city.

In 1992 he tested HIV positive and for a while he lived in denial of his status and led a double life. "Then I decided to come out of my shell, and went down to a local clinic to talk about my HIV status," he says.

He came into contact with the Zambian Network of People Living with HIV (ZNPLH) which, along with his local clinic, helped him to answer lots of questions about how to continue living with HIV. This ignited his 'activist spirit' and before long he was speaking publicly, encouraging others to talk openly about their HIV status.

"Through my volunteer work with ZNPLH I worked alongside other NGOs and HIV programmes. This work led to my involvement with the International HIV/AIDS Alliance as a local consultant at first and later to my current role within the ACER treatment support programme.

"My week is split into two. I spend Mondays, Wednesdays and Fridays at the clinic in University Teaching hospital in Lusaka, the rest of the time I can be found at the Ngombe Urban health clinic. This approach is used so that as many people in the urban and the rural locations can easily gain access to the treatment that is available.

"I usually have two or three counselling sessions in the mornings. The questions can be wide-ranging from 'Can I still have sex with my partner?' to 'Do I have to take drugs straight away?' In Zambia there is a lot of confusion about drug treatment. People don't realize that if they have a good diet and look after themselves they will not need the ART straight away.

"In the afternoons we focus on our outreach work with local faith and community leaders. We try to dispel some of the very dangerous myths that surround HIV and AIDS. We recently had to work on dispelling the myth that you are able to cleanse yourself of the virus by sleeping with a virgin. Through our work with the community leaders we hope to help people to come forward for testing and treatment without worrying about the alienation that they fear.

"One particular day, I attended to two clients. The first was a 30-year-old woman, divorced due to her status and illness. She has a sick 1½-year-old baby and two other children. This is what she had to share with me on stigma from the family: 'I'm facing a great burden of problems with my mother. I feel my mother has been treating me like I am not her daughter. I feel this could lead me to death as I can see it coming. I am responding well to the treatment I am taking – I am on Triomune 30 – but the problem is with my mother who blames me from time to time. Mother's actions will lead me to taking my own life and child's life. She treats me like a doormat where everyone leaves the dirt from the shoes. My father is very supportive to me and my children. I did not want to get this HIV. I didn't parade myself before men other than the man of her choice, who I got married to and later divorced because of the illness he brought into the house. This man has made me suffer this stigma from my own family. I am given food and separate dishes with my youngest child away from the rest of the family on marked dishes and utensils. I feel like exploding inside myself from the stigma I suffer. If only I could have

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someone like you to talk to my family, especially my mother. I see my days to be numbered. Please help me before it is too late.'

"I was very touched by this revelation. I made a follow-up visit and shared with the family information on how to support her and on modes of HIV transmission. Today, my client has been accepted by the family with apologies from the mother. On the same day, another client shared this about her treatment journey: 'These drugs are really working wonders. Some of us had come to the brink of death, facing bouts of severe diarrhoea and vomiting before ART. I used to soil my pants with loose watery stool before I could even reach the toilet. I did not have strength to spread my bed nor bath myself. But today things have changed for the better. My stomach used to protrude like an anthill and I did not want to eat at all. I used to have a pretty face, but despite being young I started looking like an old woman or a monkey. As you look at yourself in the mirror while naked, you can easily get scared of yourself and start thinking "What next?" I weighed as little as a chicken. This morning I can boast that I am weighing more than 40kg from a weight of 27kg. I know God is a miracle performer. For this reason, I have a duty to help those who are in denial to accept their status and encourage others to go for voluntary counselling and testing.'

"These people are now living happily, leading positive lives with support from family members," concludes Eric. "They have also become active members of the treatment support group and the ZNPLH Lusaka chapter."

While maintaining adequate funding is perhaps the biggest ongoing challenge for the ACER project, the success of the treatment support workers has itself brought about another challenge. Over time, appreciative and overworked medical staff in the clinics have become quite dependent on the work of the treatment support workers, who have been willing to take on extra duties such as supervising trainee counsellors and keeping counselling registers up to date. In the long term, it will be necessary to see how counselling services from non-nursing staff can become an integrated part of clinics' ART services without depending on ACER. It is also important to make sure that the potential pressure and stress arising from this dependency does not undermine the health of the treatment support workers, as they themselves are living with HIV.

A wider challenge for the project is the hidden cost of ART which continues to hinder access. While the government has now made ART free, thanks to advocacy work by the Alliance and others, many of the tests necessary for the continuation of treatment are not free. For people living in rural areas, who have to travel long distances to reach their nearest clinic, transport costs can still be very high. The ACER programme has collaborated with community advocacy initiatives to pressure the government into covering all the costs of treatment, but this is not yet a reality. ◾

Donor organizations, too, are also taking HIV very seriously, and not just in the high-prevalence countries. For example, the Bill & Melinda Gates Foundation is currently working closely with the Chinese government, the International Federation and both the Red Cross Society of China and the American Red Cross on implementing a long-term programme of prevention activities in large cities, targeting

high-risk groups, particularly men who have sex with men (MSM) (International Federation, 2007). As a strategy, the Foundation will work not only with the Chinese authorities but also with a number of local organizations which have proven outreach capacities. These will be provided with small capacity-building grants, which may lead to larger, more long-term funding for HIV prevention programmes. This initiative comes at the same time as the International Federation has been scaling up its own collaboration with the Red Cross Society of China, moving from relief to recovery activities (specifically on the construction of houses that have been destroyed by the floods and typhoons) and on improving disaster preparedness.

Box 3.5 Responding to the HIV and AIDS emergency in Iran

There were no HIV and AIDS cases reported in the Islamic Republic of Iran until 1987 when Ali, a 6-year-old boy from a poor family, was diagnosed as HIV positive. His doctors were very surprised because they believed Iran had a very low risk of HIV prevalence. But Ali suffered from haemophilia and had needed a blood transfusion. After thorough investigations, the doctors found that the blood used for the transfusion, imported from abroad and untested for HIV, had caused the infection. Another 60 people were also infected with HIV, most of them children under the age of 15.

Over the years Iran has witnessed a sharp rise in HIV prevalence, especially among IDUs and young people. It is currently estimated that there are 270,000 IDUs in Iran.

According to September 2007's statistics from the Iranian Ministry of Heath, the total number of HIV-positive people (both registered and unregistered) is estimated at 60,000–70,000 in the country. Men accounted for 94.4 per cent and women 5.6 per cent of the total number of cases reported from 1986 to 2006.

The Ministry of Health and the World Health Organization consider Iran to be now in a concentrated epidemic stage since the normal population prevalence rate is less than

0.1 per cent and the high risk prevalence rate (among key groups) is more than 5 per cent.

Like many countries in the Middle East and North Africa region, the level of HIV infection among prisoners is significantly higher than among the general population. In its December 2005 *Epidemic Update*, UNAIDS cited incarceration as the biggest risk factor for HIV infection in Iran and other countries in the region. A sharp increase of HIV infection among IDUs has been reported in a number of prisons in recent years. The wives of prisoners are also at risk of infection.

Leila, a 20-year-old woman who had been tested HIV positive at a VCT centre, told her story, weeping: "My husband has ruined my life and family and deprived me of my hope for the future." A few years ago her husband served a two-year jail sentence following a car accident. Leila became pregnant one year after his release from the prison. However, during her pregnancy test the doctors discovered that she was infected with HIV. After testing her husband and after further investigation, they discovered that he had been infected with HIV as a result of sharing syringes in the prison. Despite treatment during her pregnancy to prevent transmission, her baby was HIV positive.

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HIV infection is spreading among young people. Iran has a population of nearly 70 million, 50 per cent of whom are under the age of 25. Recent studies show that the mode of transmission is changing from IDUs to unsafe sexual behaviour because the general public, especially young people aged between 14 and 25, do not know about the risks of HIV transmission and methods of prevention. There is a lack of educational material and discussion about HIV in schools. Many people, as in other countries, are reluctant to seek treatment or counselling services for fear of stigma and discrimination.

The Iranian government and the Red Crescent Society of the Islamic Republic of Iran (IRCS) regard the current HIV situation in the country as an emergency because it could reach the dangerous level of generalized epidemic if the right measures on prevention and treatment are not taken.

The IRCS formed a 'committee of the campaign against behavioural disorder', which is responsible for policy-making, planning and directing the society's HIV and AIDS-related activities and which aims to increase their impact. In the light of its mandate and specific roles in the country, the Iranian Red Crescent is focusing its activities on four areas in the fight against the spread of HIV and AIDS. It provides IEC to young people, volunteers and the general public and has arranged for its trainers from 30 provincial branches to be trained by specialized university professors. The trainers then return to their local branches and teach target groups of vulnerable people. Some 2.2 million people have been trained so far.

The Iranian Red Crescent has established 32 VCT centres throughout the country, where it provides about 40,000 to 45,000 people with HIV counselling and testing services every year. If the test result is positive, the patients are referred for treatment and care to Ministry of Health clinics which deal with cases of HIV, sexually transmitted infections (STIs) and addiction and provide, free of charge, methadone maintenance therapy.

Through its VCT centres, the National Society has been involved in harm reduction by encouraging condom use and syringe exchange, and through the implementation of a joint harm reduction project in cooperation with other partners. The Italian Red Cross and the IRCS have agreed to set up and run three mobile units in Tehran as a pilot harm reduction project. Based on the experience and outcome of this pilot phase, both sides are expected to expand these activities to other parts of the country.

Meanwhile, with the support of the Empress Shôken Fund, the IRCS's women's affairs department is implementing a project aimed at helping the wives of HIV-positive men to have a better understanding of the ways and means of prevention and self-protection from HIV and AIDS infection.

A series of training workshops conducted as part of this project was welcomed by many women. Zahra, a 23-year-old woman who attended one of these workshops, said she learned very useful and important things there. "I felt huge relief when I came to know the ways and means of protection from HIV infection at the workshops," she said. "My husband has just been released from prison and stays at home with my family. Although we heard that he had been infected with HIV at the prison, we did not know how we have to protect ourselves from possible infection by him. Had there been no training by the IRCS, my three children and myself would have been infected with HIV."

As a lead agency in disaster response in the country, the IRCS also pays attention to HIV and AIDS intervention during emergencies. As disasters and complex emergencies increase the incidence of HIV infection, the Red Crescent trains the midwives and nurses who will provide disaster survivors with reproductive health services in the first hours after a disaster.

"HIV/AIDS has more complex implications than a health problem," said Dr Seyed Ahmad Mousavi, Under-Secretary General for Health, Treatment and Rehabilitation of the Red Crescent Society of the Islamic Republic of Iran. "Therefore, it is crucial that all parties concerned in the country make joint efforts and play their part to the full. We believe prevention is better than cure and the National Society has a clear role to play in this regard. With more than 2 million volunteers and a nationwide network of branches, the Red Crescent is in a better position than any other organization in the country to make a real difference in containing the spread of HIV/AIDS." ■

Relief, development, HIV: competing or disconnected?

Over the years, the tasks associated with disaster responses have multiplied. Originally concerned with restoring what were considered 'basics' (in the first instance, food and shelter) and providing emergency healthcare, the mandate has extended to areas traditionally seen to be part of the 'development' agenda. The Inter-Agency Standing Committee (IASC) of the UN and non-humanitarian partners have delivered several sets of guidelines that cover some of these areas. In 1999, it issued guidelines on gender considerations in emergency responses, flagging several areas where gender-related rights needed additional attention in crisis situations, including access to healthcare of quality and participation of women in programme planning and decision-making (IASC, 1999). More recently, it published a guideline document on human rights and natural disasters (IASC, 2006).

HIV can thus be seen as one of these areas of concern that, having formerly been outside the traditional concerns of emergency responses, has now gained a much more visible profile, through both the 'push' of advocacy and the 'pull' of increased funding. All this has not happened without debate, some of it related to an ongoing controversy about whether HIV captures more than its fair share of healthcare resources, but rather more about the question of the time frames used to characterize terms like 'disaster' or 'emergency'. Paul Harvey, of the Overseas Development Institute, has eloquently described the problem. After noting that humanitarian (i.e., relief) aid must be understood as only part of a much larger international response to the impact of the HIV and AIDS pandemic, Harvey emphasizes the importance of recognizing that relief systems have limits to what they can accomplish:

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> "The overall response to HIV/AIDS needs to take place over decades, and requires a rethinking of relief modalities, development modalities and of the links between humanitarian aid and development… A response across entire countries and regions over a period of decades is obviously ill-suited to the ways in which humanitarian aid is currently delivered, based as it is on short-term time horizons and funding cycles. The core business of humanitarian relief should remain focused on saving lives and alleviating suffering in response to acute crises."
>
> (Harvey, 2004b)

Part of the problem, too, may stem from the policies and rhetoric of the UN system. The first UN guidelines on HIV in emergencies were published jointly by the World Health Organization, UNHCR and the newly created UNAIDS in 1996, and focused on how to prevent transmission of the virus. The guidelines went largely unimplemented for the rest of the decade, partly because of competing organizational priorities but also because of the low priority accorded to them by humanitarian organizations (IASC, 2007). Moreover, the focus of the guidelines was almost entirely medical, which put them out of step with the prevailing doctrine of 'multisectoral' responses rather than 'medicalized' ones.

The orientation changed, however, with the 2001 UN General Assembly Special Session on HIV/AIDS (UNGASS), which unanimously adopted a wide-ranging Declaration of Commitment on HIV/AIDS. Among other things, the Declaration called on *all* member states to create national emergency strategies incorporating "HIV/AIDS awareness, prevention, care and treatment elements" (UN, 2001). The reason, stated the Declaration, was the "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" (UN, 2001). Such a statement, however stirring, is clearly not of any practical use to most member states. HIV and AIDS are not important health issues in *all* conflicts, emergencies or natural disasters, as other chapters in this report explain, and some countries would be wasting valuable resources if they observed the Declaration to the letter.

Neglect or rational prioritization?

UNAIDS, the UN programme mandated to "lead, strengthen and support an expanded response to HIV and AIDS" (UN, 2005), has identified a different source of controversy: the different orientations of three streams in the international structures created to provide assistance coordination and cooperation. The following acronym-laden paragraph also illustrates the challenges of coordinating the coordinators:

"[T]he development system has planning frameworks such as PRSPs, I-PRSPs, UNDAFs, and CCAs; the humanitarian system has CAPs and transitional recovery frameworks and appeals; and the HIV/AIDS system has the UBW [Unified Budget and Workplan] and the recently agreed GTT [Global Task Team] approach. All the systems seek internal coherence, coordination, and harmonization while some efforts have also been made on linkages among the systems. At the country level, the Resident/Humanitarian Coordinator system is mandated to provide the necessary linkages. At the same time, there are also UN Theme Groups for HIV/AIDS along with other coordination groups in countries where there is Global Fund programming (i.e. Country Coordinating Mechanisms). These multiple arrangements can be challenging to sustain effectively. The development, humanitarian and HIV/AIDS systems all have one shortcoming in common: beyond token acknowledgements, they largely neglect the HIV/AIDS-related needs of people of humanitarian concern…"

(UNAIDS, 2006)

This 'neglect' is apparent from a quick scan of some key international documents. For instance, the Hyogo Framework for Action – named after the Japanese city where the International Conference on Disaster Reduction was held in 2005 – is currently the world's 'blueprint' for disaster risk reduction (UNISDR, 2005).

Signed by 168 nations, it is an attempt to improve countries' preparedness for disasters, aiming to substantially reduce disaster losses by 2015 and (significantly) to bridge gaps between disaster management, risk reduction and sustainable human development. The 25-page *Framework* mentions HIV only once, at the end of a long list of "increasing vulnerabilities" (namely "changing demographic, technological and socio-economic conditions, unplanned urbanization, development within high-risk zones, under-development, environmental degradation, climate variability, climate change, geological hazards, competition for scarce resources, and the impact of epidemics such as HIV/AIDS") (UNISDR, 2005).

A similar sense of HIV's low overall priority in disaster management can be seen in statements by government bodies. For example, DFID's major policy statement *Saving lives, relieving suffering, protecting dignity: DFID's Humanitarian Policy* does not specifically mention HIV (except on the back cover, in relation to DFID's major areas of work). Instead, the document emphasizes that "humanitarian assistance must be balanced, and needs to address the variety of people's basic requirements, and be appropriate to their context" (DFID, 2006). It places considerable emphasis on the vulnerabilities of the poorest people, and in reducing such vulnerabilities, particularly through building social security systems.

Photo opposite page: An Iranian prisoner consults with a physician on drug use and AIDS at a clinic inside in a special ward of Qesel-Hesar prison about 480 kilometres west of Tehran.

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'Wheres' and 'whens'

Two of the key questions regarding the HIV-related responses needed in disasters are: where has the disaster occurred; and at what stage is the disaster? The first question is largely about HIV prevalence and the type of epidemic in the disaster area; the second is about what responses are appropriate and cost-effective at any given stage of the specific disaster.

Currently, it is only responses to crises occurring in sub-Saharan Africa, Central America and the Caribbean, and a few Asian countries that will have to deal with the high prevalence which characterized a 'generalized' epidemic. In other parts of the world, the epidemic is considered to be 'concentrated' when it occurs in less than 1 per cent of the general population but more than 5 per cent of any key population at higher risk such as injecting drug users (IDUs), MSM and sex workers – migrants and prisoners are also frequently included in the list (see Chapters 2 and 4). The challenges of providing treatment and prevention services are very different in these two types of epidemic. In a generalized epidemic, for example, coverage of prevention programming should be wide, targeting all age groups and both males and females. By contrast, coverage in a concentrated epidemic must be carefully targeted at the groups at greatest risk if it is to be cost-effective.

Moreover, from a fund-raising or public relations point of view – an important consideration in disaster relief – it is much easier to raise resources for a generalized epidemic affecting men, women and children than to do so for the marginalized populations in concentrated epidemics. Few politicians or donors will argue with appeals to fund ART for preventing mother-to-child transmission (PMTCT) of HIV, or home support for families affected by HIV and AIDS. In contrast, finding funds to work with IDUs or prevent HIV transmission among sex workers or MSMs is notoriously difficult (UNAIDS, 2004).

This is doubly true in emergencies – one need only imagine the difficulty of asking for money to establish a needle-and-syringe exchange for IDUs as part of an earthquake disaster appeal, or announcing an outreach programme for men who have sex with displaced men in *any* African setting.

The question of 'when' revolves around the stage of disaster. It is also a question about 'who' since different organizations have their own special expertise and priorities, and the responsibilities of host governments also come into play. (Note that the following apply most closely to disasters characterized by sudden crises; for conflict situations and slow-onset disasters, see Chapters 5 and 6 respectively.)

Acute stage. HIV is unfortunately not among the top priorities for humanitarian efforts in the early stages of any disaster. Nor are most of the early responders likely to send personnel with the specialized skills needed to deal with HIV and AIDS. However, some HIV-related interventions are certainly priorities, notably ensuring safe blood supplies (universal precautions and screening), and security for women and children. These should be maintained in the following stages. Where possible, HIV-positive people in need of anti-retrovirals should be identified and attempts made to supply medications if they are in danger of running out of them.

Post-emergency/stabilization phase. In a stage where humanitarian concerns are shifting towards re-establishing (and in some cases creating) health systems – and where prevalence justifies the effort on a cost-effectiveness basis – responders should be working on integrated HIV interventions within broad health concerns related to reproductive and sexual health (antenatal clinics, condoms, sexually transmitted diseases treatment) or tuberculosis (TB) control. They should also be setting up certain specialized HIV interventions, notably PMTCT services (babies keep coming, disaster or no disaster) and Post-Exposure Prophylaxis (PEP). Treatment should be restored to patients already on established anti-retroviral regimens bearing in mind the dangers of drug resistance if treatment is interrupted (Spiegel et al., 2005).

Long-term programming phase. In the long-term follow-up to a disaster, humanitarian organizations and both source and host governments often need to consider questions of repatriation or, if that is not possible in the forseeable future, local inte-

gration and resettlement. This is the stage at which the principle of mainstreaming is most applicable, since it is where the 'humanitarian' stream interfaces most fully with the 'development' stream, and where multisectoral collaboration with government HIV structures (and health systems more generally) are most likely to bear fruit.

The question of prescribing ART for those in need at this stage – in addition to the task of identifying not only who is HIV-positive but who would benefit from ART– begs a number of hard questions.

The UNHCR's recent *Antiretroviral Medication Policy for Refugees* outlines some of the issues that need to be taken into account for refugees (note that refugees are only part of the wider group that are of concern to humanitarian aid organizations):

> "The number of refugees needing ART is very small compared with the approximately 6.5 million persons worldwide who are estimated to need ART at present; of the 8.9 million refugees of concern to UNHCR, approximately 25,000-35,000 would currently need ART. Therefore, it would be much more efficient for host countries to provide ART to refugees through national health facilities, in conjunction with those organisations already working with refugees, than for another entity to do so on its own."
>
> <div align="right">(UNHCR, 2007)</div>

On a case-by-case basis, UNHCR or NGOs that have earmarked funds for at least one year may decide to pay for long-term ART while continuing to advocate for the inclusion of refugees in the host country's ART programme. Paul Spiegel's essay 'HIV/AIDS among conflict-affected and displaced populations: dispelling myths and taking action' illustrates some of the specific challenges facing humanitarian organizations concerned with providing treatment to PLHIV by examining the similarities and differences in delivering TB treatment and ART (Spiegel, 2004). The latter tasks involve more complex diagnosis and patient follow-up; treatment is lifelong and more expensive.

In addition to health providers, other sectors such as agricultural extension, economic development and education may have useful roles to play providing HIV and AIDS-related programming to cover the long-term needs of affected populations. Community-based approaches, particularly those involving HIV-positive people and their representative organizations, are particularly recommended. Recognition of this can be seen, for example, in the conceptual work being carried out by UN Educational, Scientific and Cultural Organization (UNESCO) in collaboration with UNHCR (see their *Educational Responses to HIV and AIDS for Refugees and Internally Displaced Persons: Discussion Paper for Decision-Makers* (UNHCR and UNESCO, 2007), among others).

In search of consistency and balance

In recent years, much effort has been invested in systematizing practical knowledge about how to deal with HIV in disaster contexts, notably in the creation of codes and guidelines. In many cases, such codes and guidelines reflect a high degree of consensus as a result of the consultation processes that went into their creation.

One of the major advances in this regard was the 2004 revision of the *Sphere Humanitarian Charter and Minimum Standards in Disaster Relief* to include HIV prevention within responses in disasters. The 2004 revision added Standard 6 (HIV/AIDS) to the Health Services chapter within the rubric of controlling communicable diseases. It advised that people affected by disaster should have access to a "minimum package of services to prevent transmission of HIV/AIDS" and goes on to specify that during the post-emergency and rehabilitation phases "…more comprehensive surveillance, prevention, treatment, care and support services should be introduced" (Sphere Project, 2004).

The text stopped short of recommending the provision of ART in most post-disaster settings on the grounds of still-limited feasibility, but added that "this may change in the future as financial and other barriers to their use fall" (Sphere Project, 2004). (It is worth noting that one of the faith-based organizations which had participated in the Sphere Project since its beginning dissented from Standard 6 on the grounds that the minimum package included condom distribution. This illustrates one of the dangers, as well as the strengths, of consensus-based projects involving many participants.)

The Sphere Project was an important point of reference in the creation of *Renewing our Voice: Code of Good Practice for NGOs Responding to HIV/AIDS* (Cabassi and Wilson, 2004) (see Box 3.6). Like the Sphere Project, the NGO HIV/AIDS Code of Practice Project was a joint initiative of different organizations. The Code of Practice covers many aspects of HIV/AIDS responses, including emergency responses:

> "Increasingly, attention is being directed to addressing vulnerability to HIV infection and the effects of HIV/AIDS in emergency settings, including natural crises such as droughts and earthquakes, as well as situations of armed conflict. Humanitarian work in emergency settings has much in common with development work, where programmes address the water and sanitation, food security, housing and healthcare needs of people who are not displaced from their homes."
>
> (Cabassi and Wilson, 2004)

Again, the relationship of humanitarian and development work – and the issue of HIV within these two areas of endeavour – is flagged.

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Another, highly influential set of guidelines was issued by the IASC in 2007, following extensive consultations by a task force specifically set up to examine responses to HIV and AIDS in emergencies. The *Guidelines for HIV/AIDS interventions in emergency settings* covers an array of responses to address the possible impact of the epidemic in a variety of conditions. Responses range from including HIV-specific interventions (e.g., condom distribution, integrating HIV within sexual health and primary healthcare) and 'mainstreaming' strategies such as factoring HIV into planning for sanitation or water facilities. The Guidelines also discuss HIV as a factor to be considered in preparedness planning, in minimum responses for the acute phases of emergencies and in more of the comprehensive activities to be implemented in the stabilization phase.

Box 3.6 The *Code of Good Practice:* ensuring everyone is 'on the same page' in responding to HIV

The *Code of Good Practice for NGOs Responding to HIV/AIDS* was developed in response to the growing numbers and diversity of NGOs involved in the response to HIV. Drawing on lessons learned over the past 25 years, the Code outlines evidence-based principles that are necessary for effective responses to HIV. These include the meaningful involvement of PLHIV and affected communities, and the promotion of human rights and public health principles. In addition to overall organizational and programming guidance, the Code addresses sectoral responses to HIV, including HIV in emergency settings.

Like the Sphere Project, the *Code of Good Practice* is a joint initiative by a number of organizations. A broad consortium of NGOs developed the Code, including development and humanitarian agencies, AIDS specialist groups, networks of PLHIV, sexual and reproductive health initiatives and faith-based organizations. In this way, the Code is relevant to all NGOs involved in the response to HIV, thereby fostering consistency, collaboration and coherence, as well as mobilization at all levels. Unlike Sphere's minimum standards,

the *Code of Good Practice* provides aspirational guidelines on a wide range of HIV-related issues – a shared vision of good practice to which NGOs can commit and be held accountable.

To date, the *Code of Good Practice* has been endorsed by 204 organizations – many of whom, in their effort to mainstream HIV into their programming, use the Code as a guide on the key issues that underscore best practice in responding to HIV. NGO signatories see the Code as a unifying set of standards in NGO-friendly language, which helps 'get everyone on the same page' without searching through endless reports and handbooks targeted at guiding the response of NGOs.

Many NGOs, such as Concern Worldwide, use the Code's principles as a reference for their HIV policies, organizational plans and systems, and as a 'unifying guide' and framework for building partnerships with other NGOs, governments and stakeholders. One of the key principles that Concern identifies as being essential for addressing HIV in emergencies, is mainstreaming HIV. Integrating

HIV work into all areas of support as part of a comprehensive HIV strategy is possible even if an NGO is not an expert on HIV issues.

Another of the core issues outlined in the Code is the meaningful involvement of PLHIV in a variety of roles at different levels and in terms of humanitarian work. This is particularly relevant during disaster preparedness. In the experience of the Australian Red Cross, the organization's commitment to 'giving PLHIV a voice' has led to new partnerships with PLHIV networks and programmes to support the network's organizational capacity to engage in advocacy.

But while signatories agree that the theoretical nature of the *Code of Good Practice* makes it a powerful reference tool, they also acknowledge that it puts the Code at risk of being another unopened book on a shelf, never put into practice in the field. The Australian Red Cross notes that in order for the *Code of Good Practice*, or any code, to reach its full potential, everyone at all levels (NGOs, governments and donors) must commit to it

and fashion their programmes and systems around this commitment. In order to step up its profile and achieve the buy-in of this diverse group of stakeholders, the project has recently relaunched its endorsement process and is actively engaging new audiences with new tools and in different languages.

NGOs have also cited the need for tools to make the Code more practical, to help them see where they stand along the lines of good practice and be supported to take tangible steps to improve their programmes. In response, the project, in partnership with signatories and other NGOs, is developing a series of self-assessment checklists that address 21 topics outlined in the *Code of Good Practice*, including a module on HIV in emergency response.

This has been developed by Tearfund, also a key NGO contributing to the revision of the IASC guidelines, therefore ensuring that this NGO response will complement the work of the UN and fully utilize its system of coordination and policies. ∎

Other guidelines are more specific, dealing with more detailed aspects of HIV services in emergencies. An example is UNHCR's *Antiretroviral Medication Policy for Refugees* (UNHCR, 2007), which discusses a variety of practical options for the provision of ART. The document emphasizes the importance of preparation for the early provision of services and for continuity once treatment has been started.

Preparedness and development

The issue of preparedness, which became prominent with the publication of the 1994 Yokohama Strategy (the intellectual ancestor of the Hyogo Framework), should also be considered as it may be particularly useful for HIV responses. As a means of reducing the overall impact of disasters, the Strategy identified the need to address disaster risks in the context of sustainable development and to build resilience by strengthening national and local capabilities to manage and reduce risk (UN, 1994). The Strategy called for attention to five main areas:
- governance (organizational, legal and policy frameworks)
- risk identification, assessment, monitoring and early warning

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- knowledge management and education
- reducing underlying risk factors
- preparedness for effective response and recovery.

These areas fit with multisectoral, development-based approaches to HIV and AIDS, particularly the second and fourth components. The risk identification component should cover the need for data about prevalence and vulnerability, answering the question of who will need what services in the event of a disaster. The preparedness component should identify what will be needed during the early phases (e.g., maintaining ART supplies for those enrolled in treatment) and how to re-introduce services as quickly as possible if they have been disrupted. There is considerable evidence from the field that these goals can be achieved in conflict settings (see Chapter 5).

However, the work of a few brave but small-scale projects run by NGOs is no substitute for well-planned and well-implemented national programmes. There is today a great deal of funding available to governments from bilateral and multilateral donors which could be used to extend AIDS treatment and HIV prevention services to refugee and displaced populations; there is also funding available for organizations working in weak states or areas of chronic conflict. The current context also offers good opportunities for relief, development and HIV organizations to work together – preferably in harmony with the coordinating mechanisms already in place in countries – and making best use of the different actors' comparative advantages (as is encouraged by UNAIDS' 'Three Ones' principles: one agreed HIV/AIDS Action Framework that provides the basis for coordinating the work of all partners; one National AIDS Coordinating Authority; and one country-level Monitoring and Evaluation System).

The International Federation, for instance, has huge assets in its well-organized National Societies, which can call upon both highly skilled professionals and large corps of volunteers. While consigning laboratory services and clinical management to collaborating institutions demonstrating sufficient technical preparedness and competence, it is envisaged that the National Society can make a solid contribution in its areas of competence such as community mobilization, treatment literacy, promoting adherence to ART, providing nutritional support through home-based care programmes, and education of PLHIV, family members and communities on how to prevent the spread of HIV (International Federation, 2004). This approach does not reduce the need for the specialist relief services which may need to be mobilized quickly from outside countries when disaster strikes, but it will greatly aid their work when they arrive.

In the end, building national capacity for HIV programming in 'normal times' strengthens responses all along the relief/development continuum – and in both generalized epidemics and those concentrated in marginalized populations. It is a means

of both strengthening resilience and speeding up responses in the early stages of disasters (in the traditional sense) and of tackling head-on the long-term, complex disaster that HIV poses to high-prevalence countries.

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CHAPTER 3

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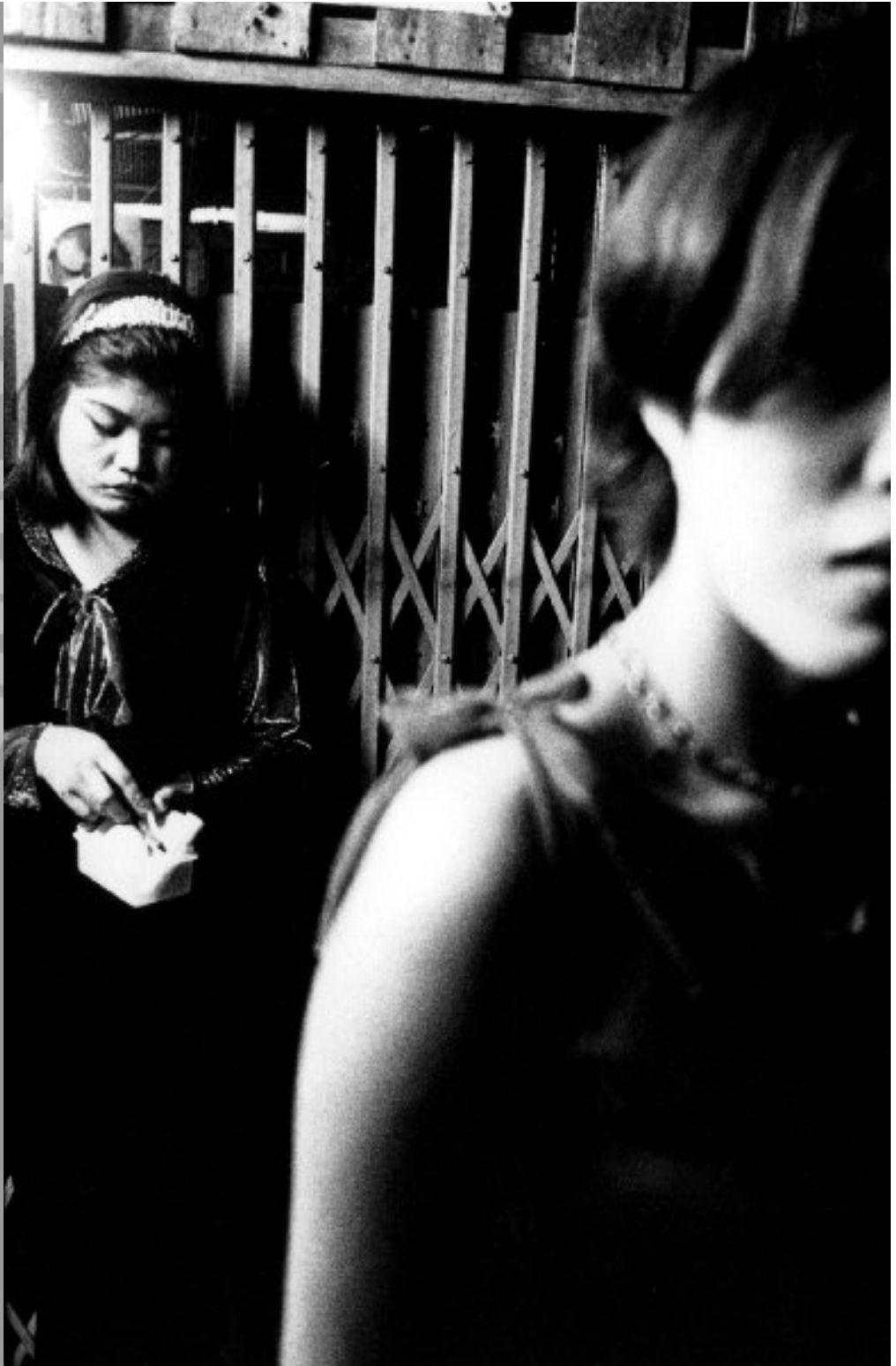
HIV and population mobility: reality and myths

The world's population has never been so mobile. Vast numbers of people today are on the move, both internally and across borders, temporarily, seasonally or permanently for a host of voluntary or involuntary reasons. Some are migrants, intending to take up residence or remain for an extended stay. Many others move back and forth frequently, such as transport workers and traders. The HIV epidemic can spell disaster for both sending and receiving communities, as well as communities along transit routes. In regions which do not yet have generalized epidemics (i.e., where adult HIV prevalence among the general adult population is at least 1 per cent), HIV and AIDS still have severe impacts at individual and family levels.

This chapter explores the linkages between HIV and labour migration and trafficking. Examples from different regions are given; these are not comprehensive, however. Subsequent chapters address forced migration due to conflict (Chapter 5) and natural disasters (Chapter 6).

The International Organization for Migration (IOM) estimates there will be more than 200 million migrants in 2008. Patterns of population movement are so extensive that today most countries are simultaneously, to varying extents, countries of origin, transit and destination (IOM, 2008). Some countries also have large numbers of mobile people within their borders. China's internally mobile population, for example, is estimated at 100–150 million (Tucker et al., 2005).

The pandemic has also generated new forms of migration. These include increased migration from rural to urban areas as a result of a decline in agricultural production; the movement of healthy migrants to take up job vacancies caused by AIDS deaths; the movement of people living with HIV to be closer to healthcare facilities or providers; the return of sick people to rural homes for support; migration for work by other household members when the primary breadwinner falls ill; displacement by people with HIV to avoid stigmatization by their community; and the migration of spouses upon the death of their partner (Crush et al., 2005; IOM, 2005a).

Children may be sent away from households affected by AIDS to receive care elsewhere, to work when household members fall sick or die or to assist ailing relatives (Young and Ansell, 2003). There is also evidence that children are moving large distances, even across borders, without the supervision of a relative or guardian. A study of unaccompanied children migrating to South Africa found that they did so because of a combination of the HIV epidemic (death of parents or caregivers), poverty and the lack of educational opportunities in their country of origin (Save the Children, 2007) (see Box 4.1).

Photo opposite page: Two illegal migrants from Myanmar work as prostitutes in the town of Rangon on the border between Thailand and Myanmar.

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While HIV is often driven by poverty, it is also associated with inequality and economic transition (Piot et al., 2007). Economic growth and trade between neighbouring countries increase mobility, particularly of transport workers, and stimulate the sex industry along transport routes. Migrants are sometimes unfairly stigmatized as spreading HIV, but often the reality is that they move from regions of lower to higher HIV prevalence. In relatively low HIV prevalence countries like Bangladesh, Pakistan and the Philippines, returning migrants are more likely to have HIV than the local population (CARAM Asia, 2007).

About 35 per cent of all documented HIV cases in the Philippines are among returning overseas workers, as were 42 per cent of new HIV cases recorded in 2006 (CARAM Asia, 2007). While a selection bias may be partly responsible for these high numbers (some cases were identified following deportation after the migrant worker tested HIV positive), it appears that a great number of these people were infected in the country where they were working, or in transit.

Box 4.1 The migration, and its effects, of children affected by AIDS

A great deal has been written about children whose parents are ill or who have died, of AIDS or of other causes, and it is frequently mentioned that migration of one sort or another is often involved (see Foster and Williamson, 2000, for a review). The majority of the research has been done in Africa. Migration decisions in families are better seen as a family strategy than as an individual decision (Booysen, 2006), and also in a context in which the migration of children is – and always has been – widespread: "where the importance of social over biological parenting resonates through the literature" (Madhavan 2004).

One of the rare studies anywhere in the world to focus specifically on the migration of children as a result of AIDS, carried out in 2001 in urban and rural communities in Malawi and Lesotho (Ansell and van Blerk, 2004; Young and Ansell, 2003), found that children leave their households for four main reasons, which may be exacerbated by HIV and AIDS:

■ to care for sick relatives
■ because of the death of one or both parents
■ because of increased poverty due to illness/death in the family
■ because of the remarriage of widowed parents.

Children are commonly sent long distances, often between urban and rural areas, on the basis of who is responsible for them (some maternal grandmothers, especially, cared for children because their daughter would have wanted them to, while in other cases care may be given out of obligation), who is able to provide for their needs (not all of those who could meet material needs could also meet emotional needs) and who might usefully employ their capacities (including to assist when relatives fall sick or die). One of the striking results of the study was that the children were generally not aware of the rea-

sons for sickness and death among their family members, nor were they consulted about their subsequent migration. Relatives often made the decision to send a child away after the parent's funeral, and the children felt they had no choice but to accept what their relatives had decided.

Most children inevitably found migration after the death of a parent traumatic. They faced the same challenges as any other child who moves to a new place, such as missing old friends and having to make new ones, changes in school curriculum and teaching methods, possibly a change in language and learning new ways of life. But they had to deal with a host of other difficulties as well, starting with the trauma of losing a parent. Newcomers were often said to be withdrawn, finding it difficult to engage with other children. Many of the children were separated from their former siblings since families try to spread the burden of caring for children, and relations were not necessarily easy with their new siblings. Rivalry, jealousy and tensions between children of the household and children arriving were not uncommon, and new siblings were sometimes reluctant to share either material resources or the emotional attention that is required when a child is coming to terms with the death of a parent.

Children who had been adopted through obligation faced particular difficulties: they were frequently treated differently from other children in the household, or from the way they had been treated at home. Many felt discriminated against in their new family, particularly if resources were scarce. Some were expected to undertake more and different work from that they were used to.

AIDS complicated the adaptation of migrant children in other ways as well. For example, stigma – or the fear of stigma – often made their integration more difficult. Poverty created by extended AIDS care meant that the children often did not have resources to share with potential new friends. Repeated illnesses in their families meant that some children engaged in multiple migrations as they were sent to one caregiver after another. Finally, children's AIDS-related migration can take forms that make it particularly problematic: it is more likely to be unaccompanied, it may happen suddenly, leaving children unprepared and disrupting their education, and it is also more likely to move them to environments in which they are ill prepared for the tasks that will be required of them.

Some of the migrations failed, resulting in renewed migration and trauma. Failures happened either because orphans felt ill-treated in their new families or because of changes in guardians' circumstances. Some of the children were unhappy with the decisions made. Some had engaged in multiple migrations. In extreme cases they left the extended family altogether to form alternative families on the streets, making it increasingly difficult to maintain links with relatives or to return home: "I don't know anybody to visit [at home]" (Young and Ansell, 2003). ∎

A 2007 survey of Albanian, Moroccan and Peruvian migrants in Italy found that they were most vulnerable in their first year in the receiving country. While many of these migrants had heard of HIV through education campaigns in their home countries, they had only superficial knowledge of the modes of transmission and how to protect themselves. Moreover, they wrongly perceived the lack of such education campaigns in Italy, unlike those in their home countries, as an indication that HIV did not exist in Italy (IOM, 2007a).

Not all migrants and mobile people are at equal risk of HIV, and interventions should prioritize those at greatest risk. For instance, behavioural surveillance in Lao People's Democratic Republic (PDR) found that only 6 per cent of mobile male seasonal labourers reported having a commercial sex partner in the previous 12 months, compared to 12 per cent of military personnel, 24 per cent of police and 31 per cent of truck drivers (Family Health International, 2006).

Many of the underlying factors driving mobility (such as an unbalanced distribution of resources, local unemployment, socio-economic instability and political unrest) also increase the vulnerability of mobile populations to HIV infection. Because of their mobility and their status as non-nationals, migrants may fall through the cracks in HIV responses in countries of origin, transit, destination and return (IOM, 2002). In countries such as China and Viet Nam, where freedom of movement is restricted and access to government services is tied to the place of legal residence, irregular internally mobile populations are similarly disadvantaged.

HIV is rarely the most immediate health threat that migrants face. Physical violence, illegal detention in poor conditions, work-related hazards, sexual abuse, mental health issues and infectious diseases such as tuberculosis are often seen as more immediate priorities than HIV. These issues, let alone the complex challenges of HIV, will never be addressed successfully until migrants' rights are respected and protected.

> "Unfortunately, there is a widespread belief that it is migrant workers who carry and transmit the virus. Not surprisingly, therefore, most of the employing nations enforce mandatory testing for HIV and other communicable diseases to ensure that their countries remain free of HIV."
>
> (Wulan and Lingga, 2007)

Migrants living with HIV and those taking anti-retroviral medication face additional challenges. Pre-deployment testing and exclusion of migrants with HIV means some will hide their status and their medications when crossing international boundaries. It is in everyone's interest, not just their own, that migrants taking anti-retroviral medications adhere to these regimes throughout the migration process. The development of drug-resistant strains of HIV is an impending personal and societal disaster which

will be hastened if treatment access is interrupted. However, government health schemes rarely provide anything other than emergency services for undocumented migrants (also referred to as migrants 'in irregular situations'). IOM notes:

> "The health of migrants in an irregular situation, such as undocumented labour migrants and trafficked persons, can be at risk due to poverty, powerlessness, discrimination, and vulnerability to exploitation. Migrants in an irregular situation often lack access to health care and social and legal services in host communities. Even if social and health services are available and affordable, migrants in an irregular situation are often hesitant to use them for fear of being reported to immigration officials, or deported."
>
> (IOM, 2006b)

Internationally funded initiatives, even if in collaboration with the Ministry of Health and local health providers (e.g., PHAMIT: Prevention of HIV/AIDS Among Migrant Workers in Thailand), are time-limited and dependent on ongoing support from the international community.

Labour migration and HIV

As noted in Chapter 2, HIV and AIDS is already beyond the capacity of communities to cope in many parts of sub-Saharan Africa, where mobility associated with mining and transport facilitated the early and rapid spread of HIV (Williams and Gouws, 2001; Crush et al., 2005). Workers in other relevant sectors include commercial farm workers, construction workers, domestic workers, factory workers, entertainers and informal traders.

Gender trends in labour migration

IOM reports that although the proportion of women in global migratory flows has not fluctuated markedly over the past few decades, there are distinct regional trends. Latin America records the highest proportion of women (54 per cent) among international migrants in developing parts of the world. Women represent about 60 per cent of migrants from the Philippines, Sri Lanka and Indonesia. In Oceania, women migrants have outnumbered men since 2000 (IOM, 2008). In recent years nearly three in four Cambodian migrants to Malaysia were female. Most of these women work as domestic workers; some also work as factory workers, shop assistants, plantation workers and construction workers (Lee, 2006).

Women are also on the move within countries. For example, in Viet Nam's burgeoning industrial parks and export processing zones, 63 per cent of the workers are women, as are many of the labourers who work in the border areas with China. The

proportion of female migrants has increased due to a greater demand for female labour in services and industry, and also because of growing social acceptance of women's mobility. The feminization of migration is one of the major recent changes in population movement within Viet Nam (Dang and Luu, 2008). Women's HIV vulnerability is often increased by mobility, and undocumented female migrants are among the most vulnerable to exploitation and abuse (see Box 4.2).

Mine workers

The apartheid system in South Africa established and reinforced patterns of circular migration that persist to this day. Men from rural areas and neighbouring countries were permitted to work in South African mines, but only on annual contracts, without bringing their families and with no right of permanent residency. Large numbers of single men continue to move periodically from their homes to the mines and back again.

> "The high HIV-prevalence countries of southern Africa are bound together by their dependence on mining, especially hard rock mining for gold and other metals in South Africa and Botswana. In the 1980s and 1990s, for example, the South Africa gold mining industry employed half-a-million migrant mineworkers from rural areas in South Africa, and from Botswana, Malawi, Mozambique, Lesotho and Swaziland."
>
> (Williams and Gouws, 2001)

Mine workers in southern Africa are typically young men from rural areas who work in dangerous, stressful conditions and live in single-sex hostels with easy access to sex workers and alcohol. The work is exhausting and dangerous, which also shapes the

Box 4.2 Importance of inclusive, gender-sensitive approaches

Only focusing on 'high-risk groups', such as truck drivers, fails to address the risks to large population groups, including the wives of men who may have multiple sexual partners. In India, Oxfam and the South Orissa Voluntary Action (SOVA) support self-help groups in tribal areas to empower women with greater individual and collective strength by helping them to purchase seed and fertilizer, or manage the government ration scheme. SOVA realized these groups could also be used to disseminate HIV information. Working with the community in this way has helped overcome challenges in accessing truck drivers and has also enabled women to achieve greater autonomy in their sexual relations. Oxfam also reports that sex workers are now much more likely to refuse sex without condoms and that there has been a reduction in HIV-related stigma (Oxfam, 2006). ■

way miners view the risks of HIV compared with the daily odds of being maimed or killed. In 2000, men who moved from Hlabisa in rural South Africa to mines in Carletonville were twice as likely to be HIV-positive (28 per cent) than non-mobile men (14 per cent). Yet in 40 per cent of discordant couples the woman at home was HIV positive, indicating that the wives of mobile men are sexually active in their absence and risk infecting their partners when they return home (Williams and Gouws, 2001).

The lifting of South African apartheid laws in the early 1990s led to increased mobility throughout southern Africa and probably contributed to the further spread of HIV in the region (Lurie et al., 2003). Yet increased mobility does not necessarily increase HIV risk: mine workers who return home four or more times a year appear to be at significantly lower risk of HIV infection, possibly because they have fewer concurrent partners (IOM and UNAIDS, 2003). Structural interventions to reduce mine worker vulnerability to HIV include comprehensive approaches involving family housing for mine workers, extending health, HIV and sexually transmitted infections (STI) services to the sexual partners of mine workers (including sex workers around the mines) and building social capital through support for community associations such as sports clubs and youth groups. Today, improved transport routes and more flexible work arrangements mean that mine workers can return home more often. While this can lessen the pressures for multiple concurrent sexual partners, it also means that the rural areas are far less insulated from HIV and other infectious diseases (Crush et al., 2005).

Truck drivers

Truck drivers and their assistants are also usually sexually active men, living and working in a stressful macho culture and separated from regular partners for extended periods of time. They are particularly vulnerable to HIV infection because of several structural and environmental factors: they often move between regions with different levels of HIV, they usually carry significant sums of cash to meet their travel needs and they often have inadequate access to health services, including to STI treatment (IOM, 2005a). Other factors increasing their vulnerability include spending idle time due to delays in loading and unloading goods, crossing borders or broken bridges and mechanical failures; a lack of suitable accommodation at rest stops; the availability of unregulated sexual services in the 'hot spots' where trucks stop; and the relative poverty of the regions through which the truckers pass.

Studies in West Africa found HIV prevalence in truckers of between 3 and 32 per cent (IOM, 2005b). HIV rates are lower in regions outside sub-Saharan Africa but the potential for disaster exists: in a Bangladesh study 7 per cent of truckers tested positive for syphilis. Other studies indicate that it is possible to protect these mobile populations. In Hong Kong, 90 per cent of truck drivers interviewed reported using

condoms with sex workers. In a Vietnamese study 55–85 per cent of truckers reported always using a condom (IOM, 2005b).

Interventions with truck drivers largely focus on information, education and communication (IEC), peer education and treatment of STIs. However a multisectoral, rights-based approach is needed to address the underlying reasons why these truck drivers remain vulnerable to HIV infection, including regulation of working conditions in the transport sector (ILO, 2005). Some governments are taking steps to integrate these mobile populations into the national response, including addressing the sectoral level. Lesotho and Zambia both make explicit reference to mobile populations, including transport workers, in their national AIDS plans. The South African Department of Transport has had an HIV and AIDS strategic plan since 2001. The Cambodian Ministry of Public Works and Transport adopted a policy mandating HIV education in the transport sector, such as professional training programmes in driving schools, in 2006. However, in the absence of adequate human and financial resources, challenges remain in implementing such policies and plans.

Construction workers

Construction workers are usually (but not always) male, young, single and semi-skilled or unskilled. Most construction workers are inherently mobile: as one project is completed they are laid off and return home or are moved to a new site. Construction workers face many of the same structural and environmental factors that place migrants in other sectors at increased risk of HIV infection. Sites are often located in remote, underdeveloped areas. Foreign construction workers may have difficulty obtaining work visas.

Many workers are undocumented and hence do not have access to government health and STI services, where they exist. Work sites are also dangerous; the workers experience boredom and loneliness, and there is little social cohesion. Subcontracting arrangements common in the construction industry make allocation of responsibility for HIV programmes more difficult because they often require the various subcontractors to indemnify the general contractor for responsibility for workers' health and safety. At the same time, subcontractors may wish to avoid the costs associated with providing HIV programmes and STI prevention and treatment (IOM, 2007b). The typically impoverished local communities surrounding the site are also at risk, as women from these communities may engage in sex with male construction workers for money or other promised rewards. Ethnic minority women have been noted as particularly vulnerable, for example in the border areas between Lao PDR and Viet Nam (Dang and Luu, 2008).

In some countries, HIV levels in the construction sector are high and are believed to contribute significantly to the national epidemic. In 2003, the South African Deputy Minister of Public Works noted that the construction sector had the third highest HIV

incidence of the economic sectors in the country (IOM and UNAIDS, 2003). According to the Asian Development Bank (ADB), rapid growth in the construction sector in Indonesia has caused HIV transmission to increase 'exponentially' since 2000, as migrant workers in the sector are more likely to engage in high-risk sexual behaviour.

In response, some governments require social impact assessments in the planning stage of large infrastructure projects and the inclusion of impact mitigation plans, including HIV mitigation, in the contracting process. As of 2007, the Cambodian Ministry of Public Works and Transport requires new contracts for public infrastructure construction to contain a budget for HIV and STI prevention. An evaluation of recent experience in Asia has found that including general HIV prevention requirements in construction contracts is insufficient. Following a review of its road projects in Yunnan, southern China, the ADB found that "contracts need to clearly define a minimum package of interventions and indicators to measure performance as well as provide tools and resources to help companies implement HIV prevention in the workplace" (ADB, 2007) (see Box 4.3).

Major infrastructure works such as dams can result in the relocation of tens of thousands of people, with consequent health impacts, including HIV and STIs, due to loss of immediate livelihoods, rupture of the social fabric and recourse to transactional sex or sex work. These impacts are in addition to the risks to local communities resulting from the presence of large numbers of construction workers, noted above. In Viet Nam it is anticipated that more than 90,000 people will be relocated by 2009 due

Box 4.3 HIV and infrastructure: the Asian Development Bank's experience in the Greater Mekong subregion

In 2007, the ADB reviewed HIV prevention initiatives in four road construction projects in the Greater Mekong subregion of South-East Asia (ADB, 2007).

The key lessons and recommendations are to:

- develop programme support through capacity-building of the transport and infrastructure sector institutions
- consolidate HIV implementing arrangements
- design self-contained HIV prevention components
- adopt a holistic 'settings' approach rather than focus on target groups

- integrate HIV prevention into the contractors' occupational health and safety programmes
- collaborate with local AIDS authorities
- partner with other specialized agencies for anti-drug and human trafficking activities
- synchronize the implementation schedules of HIV activities to coincide with the programme of construction
- ensure condom availability during and after construction
- incorporate gender. ∎

to the construction of the country's largest hydroelectric dam in a north-western mountain region near the border with Lao PDR. In China, government sources have indicated that as many as 4 million people could be relocated by 2020 as a result of the Three Gorges Dam project.

Health workers

The global scarcity of health workers has been attributed to various factors, including inadequate investment in the health sector, difficult working conditions, high levels of responsibility coupled with inadequate remuneration and lack of occupational status. Although all regions are affected, health worker migration away from severely HIV-affected countries and regions, particularly in southern Africa, is having a devastating effect on the population. Among health workers themselves, there is increased mortality and morbidity, increased absenteeism and reduced productivity. In addition, the clinical and psychosocial care for patients with AIDS impacts heavily on the morale and stress of health professionals. The lack of qualified doctors, pharmacists, nurses and other health workers has created a vicious circle. AIDS has depleted the health workforce and deteriorating conditions force even more health personnel to leave their home countries. As a result, there are not enough trained staff to deal with the existing case load, let alone manage the expanded provision of combination treatments for AIDS (IOM, 2006c).

Practical responses (beyond increased investment in training and working conditions) include reviewing retirement policies, improving management of the existing workforce (including standards of health and safety), protecting migrant health workers from discrimination and social exclusion, facilitating return migration and guest worker schemes (IOM, 2006d).

Sex workers

Sex workers are often highly mobile, and studies show that mobile women may be more likely to engage in sex work. Research in China has found that mobile women (typically those moving from the countryside to urban areas) were more than 80 times more likely to engage in commercial sex than their stay-at-home counterparts. Even when age, education and marital status were taken into account, these women were still more than 15 times likely to engage in sex work (Yang and Xia, 2006). Many women engaging in sex work in China never use condoms (only half on average in one study across 19 provinces) and STIs are common (14 per cent of sex workers surveyed in Guangdong province had syphilis in one study). Predictably, increases in HIV infection have been recorded in sex workers in Yunnan, Guangdong and Guangxi (Tucker et al., 2005).

Government policies can exacerbate or mitigate the potential harms of sex work. In China, police crackdowns and incarceration in re-education centres promote sex worker mobility, distancing them from healthcare services and the stability of local social struc-

tures. Progressive policies have been demonstrated to work, even in countries where sex work remains technically illegal: undocumented Vietnamese sex workers in Cambodia benefit from free STI treatment and that country's 100 per cent condom-use policy in the sex industry. Brothels are allowed to operate without criminal prosecution in return for open access for healthcare workers, regular STI checkups for sex workers and the assurance of condom use in all sexual encounters (Phalla, 2005). In Can Tho in southern Viet Nam, provincial government support for a drop-in centre for mobile sex workers provides an opportunity for mutual support, HIV education and condom distribution (CSEARHAP, 2006). It can be harder to reach women who migrate to study or to work in factories, bars or construction, or as domestics, and sell or barter sex.

Trafficked people

Approximately 800,000 people are trafficked annually across national borders. Millions more are trafficked within their own countries. The majority of trans-national victims are females trafficked into commercial sexual exploitation (US Government, 2007). In addition, some economic migrants including sex workers choose to utilize traffickers as the way to move across borders which exposes them to criminal networks. Structural causes of vulnerability to being trafficked include poverty, limited access to education, lack of legal sanction and enforcement, and social and cultural attitudes and practices that devalue and degrade women and girls (UNAIDS, 2004).

> "We were told that we had to make the customers wear condoms. If they did not, we were fined. If the customer refused to have sex with us because he had to wear a condom, we were fined. Sometimes we would not tell the bar owner the client refused to wear a condom because we did not want to get into trouble and get another fine. We had to pay for all our condoms as well."
>
> (Trafficked sex-trade worker in Moldova, cited by IOM, 2006b)

Children by their illegal squatter home, overshadowed by high-rise apartment buildings in Kowloon, Hong Kong, China.

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A 2006 study of trafficked women in three countries in east and southern Africa found that women were trafficked to the region from as far away as Thailand (IOM, 2006a). The risk of HIV infection was compounded by the sexual violence and psychological trauma these women suffered. A 2007 study of repatriated sex-trafficked Nepalese girls and women found high HIV prevalence (38 per cent). The median age at trafficking was 17 years, and girls trafficked at a younger age were even more likely to be HIV positive. The study noted that the repatriation of girls and women sex-trafficked to India was recognized as a barrier to HIV control in neighbouring low-prevalence countries such as Nepal. Returnees may be ostracized by local communities and re-engage in sex work to survive. The return of sex-trafficked survivors from India is considered a critical factor in the increase in Nepal's HIV prevalence (Silverman et al., 2007). There is also evidence that decriminalization of sex work, combined with such targeted interventions, is an important aspect of empowering sex workers to resist exploitation.

International and regional cooperation is essential to stop trafficking (see Box 4.4 for an example of a project to combat trafficking in Cambodia). Since 2003 the Southern African Counter-Trafficking Assistance Programme (SACTAP) has supported governments and civil society groups to address trafficking in southern Africa while also offering assistance to victims and raising awareness among the general public. Training includes the health implications of trafficking, including STI and HIV. In May 2007 member states of the Southern African Development Community (SADC) met to discuss trafficking issues through the IOM's Migration Dialogue for Southern Africa (MIDSA) process. In South-East Asia six countries agreed in 2004 to cooperate in a rights-based and victim-centred approach: the Coordinated Mekong Ministerial Initiative against Trafficking (COMMIT).

Box 4.4 Cambodia's response to human trafficking

Cambodia is still in the process of rebuilding after long years of turmoil and civil war. Human trafficking adds to the problems of reconstruction. It is a serious global social problem and violates many rights: the right to life, the right to free movement, the right to be free of torture, and others. Trafficking continues despite being a crime, because traffickers make a large profit from it, and have little risk of being caught and punished.

The traffickers may be neighbours, boyfriends, someone met on the street in a strange town, even someone in the family. Many victims are recruited by traffickers with false promises of a good job. They are trafficked across borders into other countries – Malaysia and Thailand, for example. Others come under the control of traffickers when they leave home following domestic violence or rape, or when they are in a foreign country and do not understand either the language or how things work there. Cambodians are also trafficked within their country; for example, girls from rural provinces are sent to the capi-

International Federation
of Red Cross and Red Crescent Societies

tal or to tourist destinations for forced sex work. Victims from other countries, such as Viet Nam, are sometimes exploited in Cambodia, or passed through Cambodia on their way to exploitation in other destinations.

Cambodians are trafficked into so-called '3-D' work which is 'dirty, degrading and dangerous'. They find themselves far from home, with little pay, or as virtual slaves with no pay at all. All contact with their family and friends is cut off. They are abused and mistreated, and some even die. Typically, they are exploited in sex work, begging, domestic service, factory work and agricultural work. Most of the trafficking victims are women and children, although men may also be trafficked; for example, many are forced onto fishing boats and never allowed back onto land. Victims of cross-border trafficking often have no proper documents, and if they escape or are rescued, they may be arrested and imprisoned for irregular migration.

Cambodia has responded to this crisis in many ways. For example, the government of Cambodia has developed a national task force, chaired by the deputy prime minister, and a national plan of action; a new law on suppression of human trafficking and sexual exploitation has just been passed; there are specialist law enforcement efforts; and there are a number of organizations that run shelters and provide services such as vocational training. However, there is still a great need for further programmes to prevent trafficking, as factors such as poverty, illiteracy and joblessness and the lure of better employment opportunities in other places make Cambodians very vulnerable.

The Cambodian Red Cross Society (CRCS), building on its traditional strengths in community service and emergency response, has initiated its own response to human traf-

ficking (RHT) programme, with humanitarian values at the core. Starting in 2006, the programme collected and analysed the available expertise and then held participatory workshops with government agencies, non-governmental organizations (NGOs) and local Red Cross representatives to map the situation and develop responses. In the pilot phase of the programme, three border provinces were selected and Red Cross volunteers were recruited and trained in villages and schools. These volunteers work with their peers and neighbours to provide information about trafficking and safe migration, and how to access the services provided by CRCS and other agencies. The new volunteers also learn about first aid and other Red Cross activities. As part of the wider CRCS network, they are able to help their communities in many ways.

As the programme continues, CRCS has expanded the volunteer networks and begun giving practical assistance to victims of trafficking and their families. This includes providing basic necessities such as food, water and immediate shelter; helping victims to re-establish contact with their families and return home and to access services from others such as shelter, medical care and vocational training. Survivors of trafficking who have returned home, and children whose parents disappeared after migrating, can receive both emergency aid and longer-term assistance. In the communities where the volunteers are active, CRCS also helps victims of rape and domestic violence, since they are especially vulnerable to trafficking recruiters. CRCS is also working with National Societies in neighbouring countries to develop cross-border responses to trafficking, building on the traditional International Red Cross Red Crescent Movement expertise in prison visits and in reuniting families.

The border areas where the CRCS programme is working are 'hot spots' for human trafficking problems. Local people knew that many of their neighbours had disappeared and then later returned with empty pockets and a troubled spirit – or did not return at all. They had even seen public service announcements on TV about human trafficking. But until a CRCS volunteer talked with them personally, one group of neighbours in Banteay Meanchey province whose children went missing under suspicious circumstances did not realize that they could do anything about it. With support from the CRCS, they contacted the specialist human trafficking authorities and soon most of the families had contact with their children. They hope to be reunited soon.

Red Cross youth and the fishing boat victim

With 2008 the new phase of the programme started, and the CRCS Koh Kong province branch saw the benefit of investing in young people. One of the Red Cross youth trained by the RHT programme saw a man looking lost and hungry by a bridge on the border with Thailand. It turned out that the man had been badly abused in Thailand, receiving only 500 baht (US$ 15) a month for hard work on a fishing boat. When he was sick and too weak to work, he was dismissed and tried to go back home. He ran out of money in Koh Kong, and by the time the Red Cross youth saw him he had not eaten for several days. After a quick series of phone calls, the man received emergency food, shelter and basic counselling, and was then helped to return home.

The CRCS works with other agencies on the project to combat trafficking, including the Ministry of Social Affairs, Veterans and Youth Rehabilitation, which is responsible for a mobile team that identifies trafficking victims at major border crossings and also for a variety of other repatriation, rehabilitation and reintegration services; the specialist anti-trafficking police in the Ministry of Interior; the Ministry of Women's Affairs, which conducts public awareness-raising and advocacy and is developing cross-border agreements; IOM, which works in a number of areas including awareness-raising and repatriation; the UN Inter-Agency Project to Combat Trafficking in the Mekong Sub-Region, which serves as an umbrella and support service for all of the efforts against human trafficking, and a number of Cambodian and international NGOs that provide services such as shelter, vocational training, legal aid and human rights advocacy. ∎

Responding to the plight of migrant workers

This section reviews some international, regional and national responses to address HIV in the context of mobility, notes the importance of addressing the underlying causes of vulnerability and proposes some practical steps which can be taken.

International and regional responses

The International Convention on the Protection of the Rights of All Migrant Workers and Their Families (UN, 1990) assures all migrants (including undocumented migrants) access to "any medical care that is urgently required for the preservation of their life or the avoidance of irreparable harm to their health on the basis of equality of treatment with nationals of the State concerned" (article 28). Documented migrants are entitled to the same access to health services as nationals, provided that the requirements for participation in the respective schemes are met (article 45). The convention entered into force in 2003 after ratification by 20 states. Since then, however, fewer than 20 additional countries have ratified it – none of them major recipients of migrant workers. Rather than pushing for universal ratification of this convention, members of the Association of Southeast Asian Nations (ASEAN) have toyed with proposals for a regional mechanism, which is almost certain to provide less protection, if it is ever adopted.

Regional intergovernmental and other stakeholder initiatives, such as the UN Regional Task Force on Mobility and HIV Vulnerability Reduction in Southeast Asia and Southern China (UNRTF), provide an opportunity to share perspectives and experiences, but the policy gap between sending and receiving countries in the wider region on issues such as mandatory HIV testing of migrant workers remains substantial. (By contrast HIV is not a bar to migrants' work or residence in the countries of southern Africa.)

Unfortunately, the response of intergovernmental bodies, development agencies and donors has been at times fragmented and conflicted. In 2006 the Global Fund to Fight AIDS, Tuberculosis and Malaria approved US$ 19 million for a regional response to HIV and mobility in West Africa, yet in 2007 it rejected a similar proposal from ASEAN in South-East Asia (where UNRTF has operated for ten years), with no invitation to revise and resubmit. At the 16th International AIDS Conference in 2006, the ADB supported a statement titled 'Joint Initiative by Development Agencies for the Infrastructure Sectors to Mitigate the Spread of HIV/AIDS' pledging close donor cooperation and partnership. Yet ADB support for the UNRTF-initiated national multisectoral technical working groups on HIV and mobility in South-East Asia has been largely absent. Worse, at the International Congress on AIDS in Asia and the Pacific in August 2007, the ADB floated a proposal to establish a regional network of governments, donors and civil society to address HIV and

mobility; in effect, a parallel mechanism to the existing UNRTF. Regional dialogue on mobility is important, but it should not replace urgent national action to scale up practical interventions with migrants and mobile populations already shown to work (see Box 4.5).

National responses

Some labour-exporting countries (e.g., Cambodia, Indonesia, Philippines, Viet Nam) require that intending migrant workers receive HIV education before departure. Recognizing that such 'pre-departure orientation seminars' (PDOS) can only provide the most basic HIV and other health information, attention has also focused on preparing potential migrants well in advance of their departure.

> "Let's talk about the PDOS. The [HIV/AIDS module] is barely an hour. You wouldn't be interested to listen to it because you're already contemplating on what will happen to you when you are abroad or whatever. You will not absorb it. It will never register in your mind, really."
>
> (Filipino migrant worker who had worked in Saudi Arabia, cited by CARAM Asia, 2005)

In the Philippines, pre-employment orientation seminars explaining the risks of HIV have been held for people considering working overseas. In Myanmar, a community

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Box 4.5 CARAM Asia migrant friendly testing campaign

Although UNAIDS and IOM advise that the exclusion of HIV-positive migrants has no public health benefit (IOM and UNAIDS, 2004), many migrant-receiving countries require an HIV test for a work visa and exclude all HIV-positive migrants. Some insist on a further HIV test on arrival or periodically thereafter.

For would-be migrants, an HIV diagnosis that follows routine medical screening in the last hectic days before planned departure overseas, can be devastating. The consequences for migrants testing positive in receiving countries can be worse, including immediate detention, without any psychological or other support, until deportation. CARAM Asia notes that much can be done now to improve the experience of pre-departure HIV testing for migrants, while advocating for the elimination of discriminatory immigration provisions in the longer term. In 2007 CARAM Asia launched the migrant friendly testing framework. The framework includes standards of informed consent, ensuring provision of pre- and post-test counselling, protecting confidentiality and providing proper referral for those who need support or treatment (CARAM Asia, 2007).

CARAM Asia is the Coordination of Action Research on AIDS and Mobility, an open network of community-based organizations and NGOs. ■

resilience approach pioneered in Mon state since 2006 goes beyond the provision of HIV information through the creation of village mobility working groups and intensive discussion of the risks, including HIV, faced by migrants and their communities (Fletcher, 2007). This approach also has the advantage of reaching intending undocumented migrants, who will be missed by the formal PDOS process. The focus is on the risk to the community, not just the individual, and empowering the community to develop its own responses to the challenges of HIV and AIDS.

Structural factors must be addressed

As noted above, mobility is often driven by the search for economic opportunity. The lack of rural development in many countries has led to mass movement towards the cities. Laws restricting internal freedom of movement have proved ineffective in such circumstances and have often created an underclass of disenfranchised workers without access to health or education services for themselves or their families.

The scale and the gender dimensions of this disaster are now becoming apparent. HIV vulnerability related to mobility is intricately linked to cultural, economic and political factors which must be understood and acknowledged if workable solutions are to be found. For example, the traditional preference for sons in countries such as China and India and the increasing availability of ultrasound technology over the past two decades has facilitated sex-selective abortion and is believed to have resulted in a significant alteration in the demographic sex ratio in these countries. In China there are an estimated 8.5 million more men than women in the generations born between 1980 and 2000. It is anticipated that as these men reach adulthood, many will move from poor rural areas to towns and cities in the east and south of the country in search of jobs and brides. Although poor, they will seek out sexual services (Tucker et al., 2005). However, sex work remains stigmatized and illegal in China, which contributes to an environment conducive to STIs and HIV.

> "Migrants' vulnerability to HIV is based in a complex and closely interwoven web of emotions (particularly fear, shame and love or desire), physical and cultural context, peer and family relationships, gender, economics, expectation, lack of information and habit."
>
> (Fletcher, 2007)

Young women in China are also severely affected by the political and economic shifts affecting that country. The transition to the market economy has weakened institutional support for gender equality, leading to greater sex segregation in the labour market. Female migrants are channelled mainly into low status service and entertainment jobs, perpetuating and reinforcing their subordinate status in cities (Yang and Xia, 2006). Casual sexual relationships or sex work may be their only means of survival, reflecting patterns of transactional sex and sex work in southern

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Africa two decades ago which are believed to have contributed to the HIV epidemic in that region.

> "Internal migrants can become external migrants; external migrant returnees can become internal migrants before returning to their home town or village. The boundaries blur, and therefore so do the vulnerabilities. As with all HIV-related work the factors of timing, emotions, culture, society and context must not be overlooked."
>
> (Fletcher, 2007)

The necessary policy responses are familiar and daunting, in particular the need to move beyond focusing on individual risk behaviour to address the structural and environmental causes of HIV vulnerability. Practical steps include: decriminalize sex work and make it safer; abolish internal residency requirements for access to health services, and provide free and friendly STI and HIV services for all; address the social, cultural, legal and economic factors that lead to sex-selective abortion; enforce prohibitions against gender-based discrimination in employment; invest in rural development to offer young people an alternative to city life; research and publicize migrants' financial contribution to the economy and the other benefits of mobility; engage the media to address negative public perceptions about migrants and mobile populations; and assess the potential economic and social impact of not acting urgently to address HIV vulnerability.

The most effective solutions can only be identified in consultation with affected populations, which presumes they have a place to speak and will be heard. Freedom of speech and association are implicit in the realization of the right to health. The extent to which migrants and mobile populations themselves are engaged in the response to the challenges of HIV and mobility will greatly determine the success of our efforts.

Chapter 4 was written by David Patterson who is a consultant on the legal and policy responses to HIV in developing countries. He also wrote Boxes 4.2, 4.3, 4.5 and contributed to Box 4.4. Box 4.1 was written by Mary Haour-Knipe, consultant on migration, health and HIV issues. Box 4.4 was written by Sun Kanha, RHT Project Coordinator, Cambodian Red Cross Society, and Janet Ashby, consultant in response to human trafficking. Anindita Ramaswamy, a writer based in Mumbai, India, contributed to Chapter 4.

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Office to Monitor and Combat Trafficking in Persons (USA): **www.state.gov/g/tip**

Partnership on HIV/AIDS and Mobile Populations in Southern Africa: **www.iom.org.za/PHAMSA.html**

Prevention of HIV/AIDS Among Migrant Workers in Thailand: **www.phamit.org**

CHAPTER 4

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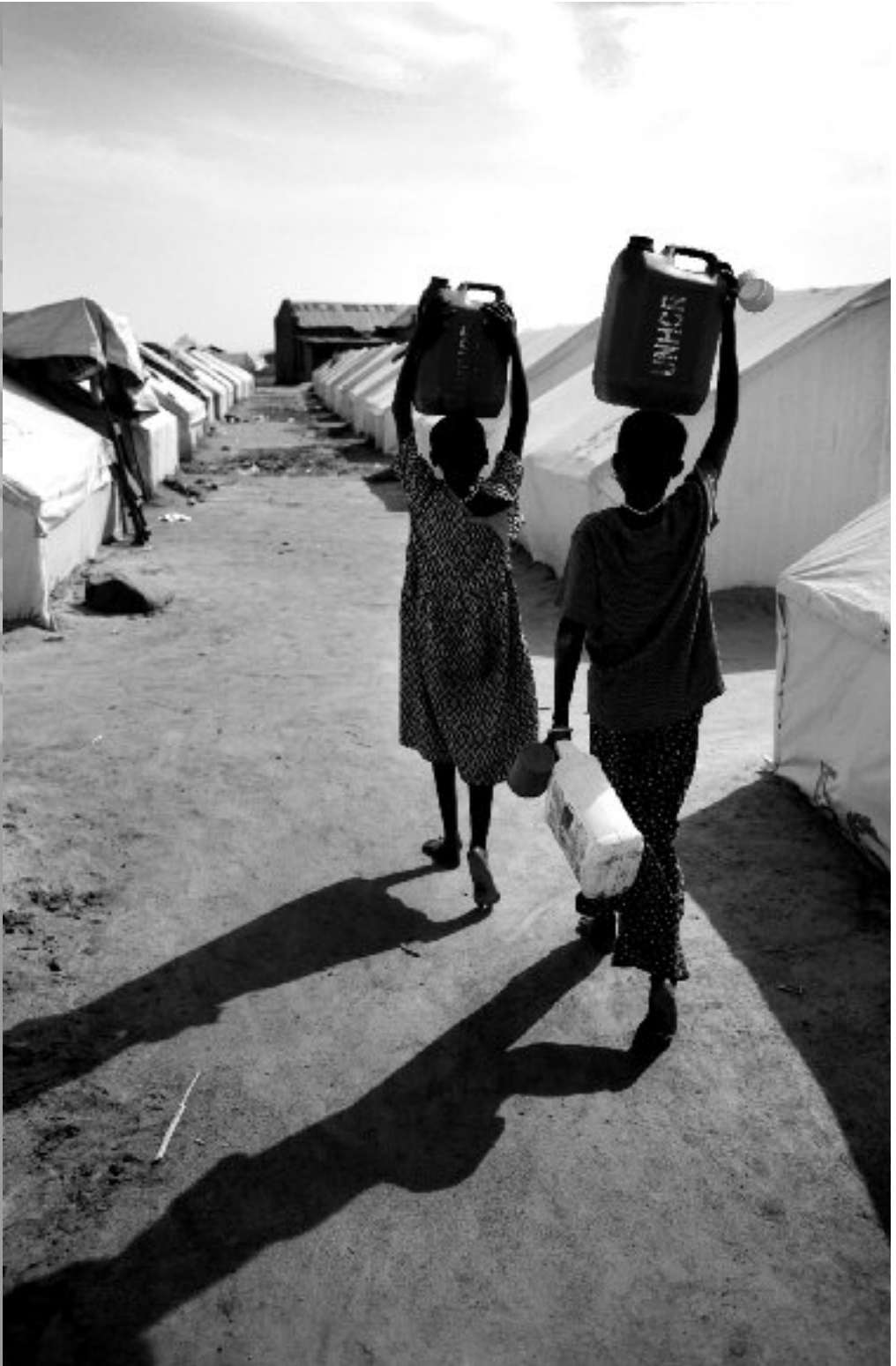
Refugees and the impact of war on HIV

On a recent afternoon in the eastern Rwandan town of Rwamagana, a support group met in a simple church. Its sloping tin roof creaked and groaned in the heat of the sun. Most of the voices inside were women's. They had come to share their experiences of living with HIV. After the meeting, a woman whose shock of black hair was streaked with grey, relayed the feelings of many. "The HIV infection we're facing now is a consequence of the genocide," she said.

For some Rwandans, the linkage between war and HIV is direct. An unknown number of survivors contracted the virus from the brutal, multiple rapes they endured during wartime. Others became vulnerable to infection after the war ripped apart their families and society and they migrated within or outside their country, sometimes trading sex as a means of survival and protection. For some, genocide and displacement may have had little to do with how they became infected. Still, regardless of how the women in the Rwamagana support group acquired HIV, many now struggle with similar problems in the war's long shadow. Those who lost their families to the genocide have no one to help them cope with their diagnosis. "When you're infected you need someone to take care of you," said one group member, "but because of the war, we don't have family."

This lack of support, combined with the psychological reverberations of trauma, including depression, leads some to give up altogether. "They don't want to live," said Beatrice Gasinga, a trauma counsellor and founder of Urunana, a national non-governmental organization (NGO). "They reach the point that they're supposed to take [anti-AIDS] drugs, but they just don't want to do it." When they do seek care, genocide survivors may encounter genocide perpetrators. Living in the same post-war communities, they attend the same health clinics, and participate in the same support groups, including this one. "Some of us killed," said one of the few men participating in the group. He recently stood trial in a local *gacaca* court for his role in the genocide, served time in prison, and acknowledged and apologized for his crimes.

Rwanda is only one of many countries where mass rape, conflict and forced displacement impact the HIV pandemic in multiple, complex ways. Since 1989, at least 122 armed conflicts have taken place worldwide, according to the comprehensive database of the Uppsala Conflict Data Program. As of late 2007, CrisisWatch, a programme of the International Crisis Group, was tracking 58 areas of current and recent conflict. Active areas of conflict included Afghanistan, Iraq, Pakistan, Somalia, Sri Lanka and Sudan. The Geneva Centre for the Democratic Control of Armed Forces documented conflict-related sexual violence in 52 countries over the past 20

Photo opposite page: Lologo transit camp, southern Sudan. Displaced people and refugees are sometimes accused of introducing HIV into host communities, although prevalence rates are often lower in refugee and IDP camps than in neighbouring areas.

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years in Africa, the Americas, Asia, Europe and the Middle East (Bastick, Grimm and Kunz, 2007).

Among countries with high rates of HIV, about half were also affected by major conflict between 2002 and 2005, including eight of the 15 countries with the largest number of people living with HIV (PLHIV), seven of the 15 countries with the largest number of children under 15 years living with HIV and AIDS, and six out of the 15 countries with the largest number of orphans under the age of 17 due to AIDS.

Many of the conflicts led to mass displacement among civilians. In 2006, the plight of some 32.9 million people fell within the protection and assistance activities of the Office of the United Nations High Commissioner for Refugees (UNHCR) (UNHCR, 2007). Roughly a third of them had fled across international borders seeking refuge or asylum from conflict and persecution. Nearly half were uprooted, but remained within their own countries of nationality. Because UNHCR's mandate covers only a subset of all refugees and internally displaced persons (IDPs), the true numbers of those affected by armed conflict and its aftermath are likely to be many millions higher. Internal displacement alone due to conflict and human rights violations affects roughly 24 million people, according to the Internal Displacement Monitoring Centre of the Norwegian Refugee Council. While acute emergencies involving tens of thousands of refugees are most likely to hit the evening news screens, in fact displacement often lasts for many years, even decades. A recent study suggested the average length of displacement was 17 years (UNHCR, 2004). Contrary to popular belief, the majority of all refugees live within host communities, not camps. That means that their exposure to HIV is intimately linked with that of the communities that surround them (UNAIDS and UNHCR, 2007).

What makes conflict-affected populations vulnerable?

Conflict often disrupts educational systems and social programmes, robbing children and adults of opportunities for HIV education. "People in conflict settings are often isolated and don't have the level of awareness [about HIV] that you see in non-conflict-affected populations," said Susan Purdin, senior technical adviser for reproductive health at the International Rescue Committee (IRC). This lack of knowledge puts populations at risk when fleeing from areas of low to high HIV prevalence, or when experiencing the end of conflict, as physically isolated areas open again to commerce and contact with outsiders. It also endangers populations that interact with military forces, including peacekeepers, whose HIV and other sexually transmitted infection (STI) prevalence can be several times higher than that of the general population. For example, there is some evidence that armed conflict and the involvement of soldiers from multiple regions helped carry HIV from town to town in the early stages of the HIV epidemic in Guinea-Bissau, Sudan and Uganda (Spiegel et al., 2007).

Public and private health services, too, take a hit during wartime. Normal supply chains for drugs and medical equipment are disrupted. It becomes more challenging to ensure sterile equipment and a blood supply free from infectious agents such as HIV. Patients and healthcare professionals may be divided by front lines and unable to travel easily to designated facilities. The stress of war, poor nutrition, overcrowded and unsanitary conditions and difficulty accessing needed supplies and medications can exacerbate health conditions, including HIV and AIDS (Fink and Stinson, 2007).

Doctors and nurses, seen as a major resource for warring factions, have been conscripted into service or directly threatened and killed for treating 'enemy' populations in places such as Bosnia, Chechnya and Iraq. Many, understandably, try to move themselves and their families away rather than remain and endure danger and deprivations. This can leave civilians without enough healthcare providers. And when populations flee en masse to safer territory, particularly in poor countries, authorities in their new communities may baulk at making precious health services available and affordable to them. Even in countries where refugees are officially eligible for free healthcare services, such as in Armenia, Azerbaijan and Georgia, they have reported difficulty in obtaining these services; and refugees and asylum seekers in Turkey were found to have poor access to HIV prevention information and condoms (Homans, 2006a, b, c, d). Refugees and IDPs who feel stigmatized or who lack documentation, transportation and financial resources may not even seek healthcare services.

All of these factors mean that at the very time a conflict-affected population needs safe and comprehensive healthcare services the most, it often has difficulty accessing them. Medical workers who remain in practice are overburdened. "Health providers are doing so many other things," said Purdin. HIV prevention, care and treatment too often fall by the wayside.

Vulnerable groups

It is often said that conflict alters the fabric of society. Social norms break down and gender-based violence rises. When livelihoods are lost, both women and men may turn to sex work to survive and support their families. But the vulnerability of particular groups of women, men and children can also take subtler forms. During the Rwandan genocide, hundreds of thousands of mainly Tutsi survivors fled into neighbouring Tanzania. Most of them were women and children. "Men had been killed back in Rwanda," said Carlos Cardenas of Mercy Corps' health unit, who worked in a Tanzanian refugee camp at the time. Although men were few, pregnancy rates paradoxically soared. The reasons were complex and multi-factorial. Most men in the camp were protecting several women. "The only way [the women] had to pay back that protection was with sexual favours," said Cardenas. Moreover, many genocide survivors said they felt the urgent need to repopulate their nation. At the time, aid workers focused their efforts on helping the women through their pregnancies to

healthy deliveries. They later wondered, though, whether the sexual dynamics that developed in the Tanzanian camps had contributed to the spread of HIV.

Women are frequently victims of physical and sexual assault in unstable circumstances. In addition, war-affected women, when ill, may be reluctant to leave their living quarters to seek medical care out of fear of being separated from children or putting them at risk during travel. Men are not typically considered a vulnerable group, although military-aged men are often at risk of being killed by hostile forces or forced into fighting. For cultural reasons, men may also be less willing than women to seek help for physical and especially psychological problems. Tragically children, too, are a vulnerable group in times of conflict and displacement. The United Nations Children's Fund (UNICEF) estimates that half of the people displaced by war are children. In a medical sense, children are more vulnerable than adults to the stresses and deprivations of trauma and displacement. Some, separated from their families, must fend for themselves in child-headed households or are recruited as soldiers. As refugees or IDPs, they may end up living on the streets in urban centres, engaging in sex work to survive. While children orphaned by AIDS are often raised by dedicated members of extended families and communities, some grow up without adequate support and guidance (Fink, 2007). They may be lured into criminal or anti-social activities. Based on the societal instability this may cause, authors such as Garrett (2005) have suggested that the HIV and AIDS pandemic could actually lead to violent conflict, though this remains unsubstantiated. This has not occurred in southern Africa, the region with the highest HIV prevalence in the world, despite early predictions that it might happen.

Again, the threat of HIV for children can come from unanticipated places. In West Africa, an explosive assessment published in 2002 by UNHCR and Save the Children UK alleged that humanitarian assistance providers – including United Nations (UN) peacekeepers, NGO workers and governmental representatives – were involved in sexual violence and exploitation of children (UNHCR and Save the Children UK, 2002). The findings led to an investigation by the UN. While most allegations could not be confirmed or substantiated, and sexual exploitation was found not to be widespread, the incident led to commitments by the UN and humanitarian agencies to implement protective actions and codes of conduct aimed at eliminating sexual exploitation and abuse of children and women (Machel, 1996; UN, 2002).

It is important for aid workers to receive education and training about HIV and AIDS and have access to counselling and condoms. In the past, aid workers have been subject to sexual violence, engaged in risky sexual behaviours, and been exposed to HIV in healthcare settings.

Armed personnel are also at risk of both acquiring and spreading HIV (see Box 5.1). In some countries, HIV prevalence rates among the military are two to five times

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higher than among civilians (Kingma, 1996). The need to provide HIV and AIDS-related training to national uniformed services and personnel of UN agencies and other organizations involved in providing assistance in emergencies, including international peacekeepers, has been highlighted. The UN Security Council passed a resolution on HIV/AIDS and international peacekeeping operations in 2000 underscoring the importance of HIV and AIDS awareness and prevention initiatives among peacekeepers (UN, 2000).

Box 5.1 HIV risks and peacekeeping troops

AIDS and peacekeeping

In 2000, the UN Security Council passed Resolution 1308, in which for the first time AIDS was stated to be a global security risk due to its "deleterious effects on peacekeepers and peacekeeping". Subsequently, UNAIDS and the Department of Peacekeeping Operations (DPKO) entered into a collaborative agreement under which both organizations agreed to inform the Security Council regularly on progress in implementing Resolution 1308 as well as to persuade member states to include a reference to HIV in the preamble of any new Security Council Resolution establishing or expanding mandates of peacekeeping missions.

In addition, DPKO has appointed a full-time AIDS Policy Adviser at their headquarters and established HIV focal points in all the peacekeeping missions. With a contribution from UNAIDS, DPKO also maintains a trust fund to sustain AIDS activities among peacekeepers. With the increasing focus on regional troop and mission management, UNAIDS has also supported African Union (AU) AIDS programmes for their peacekeepers as well as for several African national armed forces from where the AU peacekeepers are drawn.

Key components of peacekeeper AIDS programmes include awareness training, personal risk assessment, behaviour change counselling, provision of condoms, provision of post-exposure prophylaxis kits and voluntary counselling and testing. Missions typically develop peer education programmes, drawing on the UNAIDS peer education kit and AIDS awareness cards which have been translated into several national languages and distributed to over 1 million peacekeepers. While promoting condom use as a lifesaving measure, DPKO and UNAIDS have also ensured that prevention training clearly reinforces code and conduct.

Pre-deployment HIV training tools have been developed and national governments are encouraged to include AIDS in pre-deployment training sessions for their peacekeepers. In collaboration with UN partners in countries where the missions are operating, DPKO AIDS advisers also seek to mainstream HIV prevention into mission mandates and to undertake outreach activities within local communities – for example, training of the Haitian national police, collaboration with the Society for Women and AIDS in Africa in Sierra Leone or peer education among national armed forces in Eritrea. Overall, outreach education among uniformed services personnel and communities has reached many thousands of men and women directly or indirectly. International peacekeepers

have therefore been an important source of support to national AIDS programmes in some countries.

A more recent focus of work within the field of AIDS and peacekeeping is the integration of HIV into disarmament, demobilization and reintegration programmes (DDR). Evidence shows that the immediate post-conflict phase contains high risk of HIV transmission, but is also optimal for interventions (Clingendael Institute, 2005). There are a number of reasons for this: the armed groups participating in DDR often practise risky sexual behaviour. On reintegration they may continue to behave in the same way, especially if they have the money to purchase sex. On the positive side, combatants that undergo DDR programmes often have a certain standing in the communities in which they are being reintegrated and can act as role models. The UN Population Fund, UN Development Programme, DPKO and UNAIDS cooperate closely to use this window of opportunity, where it may be possible to use ex-combatants as a positive role model, while in parallel sensitizing them to their own vulnerability.

HIV risks and peacekeepers

Peacekeeping troops come from over 100 countries; all are affected to varying degrees by the HIV epidemic. On average, every month the UN DPKO employs 90,000 international peacekeepers, including troops, military observers, police units and individual police officers. At the time of writing (January 2008) deployment is currently in 18 peacekeeping and three political missions with almost 80 per cent of troops coming from countries with HIV prevalence rates of less than 1 per cent. The rest of the troops come from higher-prevalence countries such as Nigeria, Senegal and South Africa. International peacekeepers are supported by approximately 14,000 nationally recruited staff.

The standard for deployment, recruitment and retention of peacekeepers has been fitness to perform peacekeeping duties during the term of deployment. Pre-deployment medical examinations are mandatory for all troops and police units and are the responsibility of each troop-contributing country (TCC).

DPKO has adopted the policy that chronic medical conditions – including clinical AIDS – preclude fitness for mission duty. HIV tests on their own are not considered an indication of fitness for deployment (UN, 1999), but an estimated 90 per cent of TCCs have independently introduced pre-deployment HIV testing for peacekeepers. A number of peacekeepers from some countries have nevertheless fallen sick from AIDS, have been repatriated or died on mission, presumably because pre-deployment medical fitness examinations had not been carried out.

Interestingly, deployment seems to increase the risk of HIV infection among peacekeeping troops. Several reports of troops infected while on a peacekeeping mission have been published. An analysis of the Cambodia mission (1992–1993) states that while 21 peacekeepers died due to hostile action, 47 were diagnosed as HIV positive following deployment (AFP, 2001). By February 2007, the mission in Liberia had provided voluntary counselling and testing to almost 8,000 UN military personnel, with 1 per cent testing positive for HIV (Likimani, 2007). Increased infection rates have been reported among Nigerian peacekeepers returning from deployment in neighbouring countries as well as among Indonesian troops returning home in the 1990s.

The risk of peacekeepers contracting HIV during missions has been closely associated with the possibility of their spreading HIV to host communities. However, there is little hard evidence to substantiate such reports. The Cambodian government claimed that the rise of HIV in the country was due to the presence of UN peacekeepers in the early 1990s, and similar concerns regarding peacekeepers have been raised in Timor-Leste and Kosovo. Negotiating peacekeeping missions have in some cases been hampered by national authorities' insistence that only proven HIV-negative civilian and uniformed peacekeepers should be deployed.

The peacekeeping missions in Liberia and Haiti have been most comprehensively surveyed regarding their HIV knowledge, attitudes and practices. Another survey among 667 peacekeepers in Liberia revealed that approximately 25 per cent of those questioned had had sexual intercourse within the mission area, almost one-third had had two or more sexual partners and 21 per cent reported not using condoms despite their availability (Bazergan, 2006). These numbers are similar to those reported about the Eritrea/Ethiopia mission in 2002. A study in Haiti revealed only 6.5 per cent of more than 1,100 people surveyed reported having had sexual relationships while on mission. Some 95.1 per cent of those reporting sex with a casual partner had consistently used condoms (UN, 2007).

There have also been a number of cases where sexual misconduct has been reported and/or alleged among international peacekeepers, and concerns have been raised about an underlying culture of improper sexual attitudes and behaviour in some units. There are very few hard facts, however, and most reports tend to be anecdotal. Apart from the disturbing possibility that deployment as such may have a negative influence on the health of an individual affected by an HIV-related disease, any breach of discipline may jeopardize missions. It is therefore imperative that the UN takes strong action to address issues of conduct and discipline, as well as HIV prevention and awareness and practice with all peacekeepers. The UN Secretary-General has mandated all missions to do so (UN, 2003). ■

An issue of human rights

HIV raged throughout the world for many years before serious international efforts to address the pandemic in conflict and refugee situations emerged. HIV and AIDS were not initially considered appropriate to address in the immediate response to conflicts and other emergencies. Awareness was stirred in the mid-1990s. Graca Machel's study on children and armed conflict emphasized the potential threat that gender-based violence and exploitation posed in the spread of HIV (Machel, 1996). Humanitarian advocates also lobbied for addressing reproductive health concerns, including HIV, in emergencies. A Minimum Initial Service Package, or MISP, was developed by aid agencies for use by aid workers in acute emergencies prior to the introduction of comprehensive services. Still in use today, its guidelines include the distribution and use of standardized kits for safe deliveries, post-rape management and contraception – including the free availability of condoms – and

efforts to ensure that medical equipment and blood for transfusion are free from infectious agents.

The development of the MISP coincided with a shift among mainstream humanitarians and development professionals to embrace a 'rights-based' approach to programming. "Refugees and the conflict-affected have a right to the same kind of services as anybody else; it's just harder to get those services to them," explained Purdin, who among others helped develop the MISP and the widely-adopted *Sphere Humanitarian Charter and Minimum Standards in Disaster Response.* The Sphere standards outline steps humanitarians can take to ensure that minimum human requirements for water, sanitation, food, nutrition, shelter and healthcare are met among disaster-affected populations (Sphere Project, 2004).

The Sphere handbook – first published in the late 1990s and revised in 2004 – is based on principles that have deep roots in international humanitarian law, refugee law and human rights laws and norms. These include the right to life with dignity enshrined in the Universal Declaration on Human Rights and in international human rights covenants, the distinction between combatants and non-combatants enshrined in the Geneva Conventions and other instruments of international humanitarian law, and the principle of non-refoulement (that nations must provide asylum to those who seek it and are seriously threatened at home) derived from the 1951 Convention on the Status of Refugees. Over 140 countries are party to the refugee convention, having committed to providing refugees with the same 'public relief and assistance', including medical care, available to nationals. Human rights law (fully applicable in peacetime and with certain limits during times of national emergency) also commits states to respect the right to health, the right to equality and non-discrimination, the right to privacy, the right to liberty and security of the person, the right to information, the right of participation, the right to work and the right to education, among others.

Acknowledging that refugees have rights implies that providing them with only whatever good-will and charity inspire is not enough. Governments must ensure that those affected by wars and disasters are protected and have access to the means of dignified survival. When governments fail, aid workers are ethically obliged to provide competent assistance.

Sphere incorporates the MISP as one of its standards and, since the 2004 revision of its manual, has included HIV and AIDS as a cross-cutting issue. It identifies people already living with HIV as a vulnerable population requiring particular awareness and attention in emergencies. In addition, the Sphere standard on chronic diseases should apply to HIV and AIDS in high-prevalence settings. It reads, in part, "for populations in which chronic diseases are responsible for a large proportion of mortality, people [should] have access to essential therapies to prevent death" (Sphere Project, 2004).

Additional guidelines specifically dealing with HIV-related rights in conflict, displacement and refugee settings have been produced by the Inter-Agency Standing Committee (IASC), a coordinating body for humanitarian response (IASC, 2003), in a framework for assessment and planning produced and used by UNHCR. UNHCR promotes the non-discriminatory access of IDPs, refugees and others to HIV and AIDS healthcare, information and education, protection against detention, restricted movement or return of IDPs or refugees to their countries of origin based on HIV status, respect for the confidentiality and privacy of health-related information and protection against sexual violence and exploitation (UNHCR, 2006).

According to UNHCR, multisectoral minimum essential HIV and AIDS interventions should be implemented early in a crisis, followed by comprehensive prevention, care and treatment programmes integrated with national programmes. By avoiding the creation of parallel or unequal services, integration reduces costs and also the inequalities that can contribute to tensions and conflict between refugee and host communities. Several regional programmes have been established to address HIV in conflict-affected populations. One is the World Bank-financed Great Lakes Initiative on AIDS (GLIA) in the Great Lakes region of Africa. It supports the refugees, displaced persons and returnees who migrate across the subregion, and promotes collaboration and capacity-strengthening among those who assist them (UNAIDS and UNHCR, 2007).

The GLIA includes key analytical features that should ideally be incorporated into all HIV programmes, including assessment, monitoring and evaluation. As HIV and AIDS interventions in settings of conflict and displacement expand, there is a need to conduct operational research aimed at improving the effectiveness of various programmes.

Countering myths

While an understanding of the rights of conflict-affected populations has been critical to expanding HIV services to them, so, too, has the collection of evidence that overturned long-standing myths. Several years ago, the US State Department provided funding for the development of an HIV programme at UNHCR. Epidemiologist Paul Spiegel of the US Centers for Disease Control and Prevention (CDC) runs the programme. When he arrived, the agency had little information about how prevalent HIV was among the war-affected populations it served. "What I found was nowhere did we have any data to make proper decisions," said Spiegel. "I started to arrange to do some sentinel surveillance work." However Spiegel encountered resistance to his research plan. "People said, 'You can't do that. We know that the HIV prevalence is going to be high, and that's going to increase stigma and discrimination.'" Spiegel persevered, and his research ultimately showed the initial beliefs to be a myth. "What's clear is that conflict in most situations puts a brake on the epidemic." For example,

Angola, Sierra Leone and southern Sudan – all areas that have experienced prolonged conflict – had lower HIV prevalence rates compared with surrounding countries (Spiegel, 2004). Refugee camps in Kenya, Rwanda and Tanzania had lower HIV prevalence rates than did surrounding host communities, whereas in Sudan, displaced and host communities had similar rates of infection (Spiegel, 2004).

More recent analyses, albeit hampered by a shortage of good-quality data, found no evidence to suggest that conflict has increased HIV in affected populations in Burundi, the Democratic Republic of the Congo, Rwanda, Sierra Leone, Somalia, southern Sudan and Uganda – in some situations, prevalence rates actually decreased (Spiegel et al., 2007). The conclusions were in some cases surprising – for example, it had been widely believed that the mass rape that took place during the genocide in Rwanda led to large, population-based increases in HIV prevalence, but the review by Spiegel and colleagues did not find evidence to support this. The same study also considered 12 sets of refugee camps: three-quarters had a lower prevalence of HIV infection, two camps had a similar prevalence and one a higher prevalence than the host communities that surrounded them (Spiegel et al., 2007).

The research highlighted an important point. While conflict can increase HIV risk for all the reasons discussed above, the isolation and decreased mobility associated with conflict-affected areas can actually hinder the spread of HIV. "Since refugees come from those areas, they often have lower HIV prevalence" than the non-refugee populations that surround them, said Spiegel (see Box 5.2). Furthermore, refugees in camps may enjoy better access to HIV prevention programmes and messages that can help them avoid risk behaviours. These findings, published in peer-reviewed medical journals including *The Lancet*, have bolstered efforts to reduce stigma and misconceptions about refugees. They provide evidence that can and should be used to convince policymakers to end official discrimination against refugees.

Box 5.2 Angolan refugees leaving Zambia: taking home 'the weapon of prevention'

During the decades of civil war in neighbouring Angola, Zambia was home to thousands of Angolan refugees. Zambia's HIV prevalence rate is significantly higher than Angola: 17 per cent compared with 4 per cent (UNAIDS, 2007).

Angola's war-induced isolation has helped slow HIV infection rates and the challenge now is to keep the country's relatively low prevalence in check.

The situation poses an acute problem: will peace and the reopening of the country, including the return of many refugees from neighbouring countries, mean a jump in HIV prevalence levels?

The problem is aggravated by the very limited knowledge about HIV, its transmission and prevention among the Angolan population.

In Zambia the International Organization for Migration (IOM), in partnership with UNHCR, has developed and implemented a wide range of programmes targeting Angolan refugees as well as the surrounding Zambian communities in Mayukwayukwa camp, in the western part of Zambia.

The programme's activities aim to increase the general awareness levels on HIV and AIDS, increase the vocational and life skills of refugees and implement HIV prevention activities in the areas in Angola to which refugees are returning.

Equipped with these skills, refugees will be better able to support and protect themselves once they have returned to the communities they were forced to abandon in Angola.

Also, most importantly, the refugees are encouraged to pass on their knowledge to their home communities in Angola.

The younger refugees – both boys and girls – are encouraged to participate in a football league, where safe sex and HIV and AIDS are discussed before and after matches.

Farming skills are peppered with lessons in nutrition and general health, while literacy training and health workshops help build awareness of HIV and other diseases. Condoms are readily available and freely distributed.

"We believe the messages about HIV will flow into the community here, and back into Angola when they repatriate. If myths about the disease can pass from person to person, why not the truth?" said HIV coordinator Chola Musonda.

When Lucas Savier, 43 years old and a married father of two, fled Angola for Zambia in 2000, he knew nothing about HIV, except that it was a disease that could kill. An eager student at health classes in Mayukwayukwa camp, he now teaches others.

"Prevention is very important, you should not be doing unprotected sex," Savier said. "You should not use the same razor blades as other people, but HIV can't be caught from drinking from the same glass or from hugging somebody. It's crazy what some people think."

"The refugees have dealt with the problem by acknowledging it," said an IOM representative. "When they go back to Angola, prevention will be the weapon they take with them." ■

Treating patients affected by conflict

A different myth took longer to dispel: that it was impossible to treat refugees, IDPs or those living in conflict-affected areas with life-extending anti-retroviral treatment (ART). Refugees and IDPs were thought to be too mobile for treatment, and when it came to individuals who remained in troubled areas, "there was concern that there would be ongoing conflict that would make it difficult for people to follow up on their treatment," said Leslie Shanks, head of the public health department of Médecins sans Frontières (MSF) in Amsterdam, the Netherlands. MSF doctors and nurses in the field were seeing patients sicken and die from AIDS, and they put pressure on the organization to do something. "The doctors and nurses knew that in the West, treatment was available, and they pushed very hard to make that available to the patients where we were," Shanks said. "We didn't want to ignore the medical needs of people in front of us because of potential barriers and risks in the future. We decided to come up with a way to deliver HIV care to people in these situations rather than accept the naysayers who said it was impossible."

The methods that MSF developed include providing patients with the information and resources – including supplies of ART – they needed to cope with conflict-related disruptions in health services, or even the need to flee across borders to escape outbreaks of violence. Once educated about dangerous practices such as sharing medications and splitting doses in half to keep supplies from running out (stopping ART completely is safer), patients are provided with several weeks' stock of medications to keep at home in case of emergency. Emergency stocks are also kept securely in local clinics and, in certain contexts, spread out throughout urban areas in the homes of key MSF staff members. Patients are informed of the various sites where medicines are available when free movement is dangerous or restricted. They are also given copies of their treatment cards, containing information about their disease and medications, which they can present to other practitioners if necessary.

In 2004, these types of preparations were put to the test. One of MSF's first HIV programmes in an unstable, conflict-affected area – Bukavu, Democratic Republic of the Congo – shut down temporarily when the city fell under attack. "The patients really understood how important it was for them not to interrupt their drug supply," Shanks said. They made use of their emergency stocks. "During that time, they were able to keep going on their treatment." Many Congolese crossed the border to Rwanda, becoming refugees. Those on ART sought and obtained treatment at another MSF clinic there.

Now, MSF provides a wide range of HIV prevention, care and treatment services in various humanitarian settings. Programmes include the treatment of STIs, condom provision, prevention of mother-to-child transmission and assistance to support groups run by PLHIV.

MSF's success in Bukavu helped silence the 'naysayers'. Opposition to treating refugees and other conflict-affected individuals further dissolved in the face of the larger activist movement to expand treatment access in low-income countries. The June 2001 UN General Assembly Special Session (UNGASS) on HIV included conflict-affected populations in its Declaration of Commitment on HIV/AIDS, stating (perhaps a bit too definitively) that "conflicts and disasters contribute to the spread of HIV/AIDS" (UN, 2001). The declaration called on governments and international assistance agencies to include HIV and AIDS awareness, prevention, care and treatment within emergency response strategies.

Despite these commitments and declarations, Spiegel and others have published research showing that many developing countries with AIDS programmes have been excluding refugees from their HIV/AIDS National Strategic Plans and funding applications (UNHCR, 2007). This poses an obvious threat to national prevention and care efforts, because refugees and host populations interact daily. In response, UNHCR has produced a series of policy documents on providing ART for refugees, and the agency advocates for governments to include refugees in their treatment plans. Thanks to the research of Spiegel and colleagues showing that refugees most often have lower HIV prevalence than host populations, the advocacy has become somewhat easier. "The data we received helped us to say they're not going to overwhelm you, it's not about millions of HIV-positive people," he said.

Integrating HIV and AIDS interventions with refugees and surrounding host populations can improve services for both communities. UNHCR has helped countries such as the Democratic Republic of the Congo to integrate refugees into national HIV and AIDS funding proposals. In addition, UNHCR sometimes pays governments on a fee-for-service basis to offer medical care to refugees, which can be more cost-effective than creating separate, camp-based health systems. Such arrangements have been put into place, for example, in South Africa and Zambia. Refugees are now accessing HIV services in those countries as well as in Kenya, Rwanda, Thailand and Uganda, among many others. For the past several years, the President's Emergency Plan for AIDS Relief (PEPFAR) has also made US funds available for the treatment of refugees.

Challenging conditions

As humanitarian agencies increase the provision of ART and other HIV-related services, they confront challenges in each phase of the cycle of conflict – from violence to displacement to asylum to return. "Each of them has their own risks and solutions, all context-specific," said Spiegel. "It makes it extremely challenging to meet all the needs of refugees and those surrounding them."

Typical challenges of dealing with HIV in low-income countries are often magnified by conflict. As described above, shortages of medical workers and barriers to access are

common, and whatever medical infrastructure is present must deal with many competing health problems. Isolation and insecurity complicate the delivery of necessary supplies and equipment. For individual patients, competing survival needs and experiences of violence, personal trauma and the deaths of key support figures can decrease willingness to seek services and care or to sustain needed treatment. Aid workers, too, are often targeted by militants in wartime, in violation of international humanitarian law, and it can be difficult to recruit qualified staff to work in insecure and austere conditions (see Box 5.3).

Box 5.3 Providing ART for refugees and returnees

Challenges to providing services for people with HIV and AIDS remain even when conflict is over and rebuilding is taking place. The International Rescue Committee's successful ART programme in Kakuma refugee camp is a case in point. Kakuma camp was set up in the northern Kenyan desert in 1992 when a large number of refugees fled war in neighbouring southern Sudan. The camp grew to become one of the largest in the world as conflict sent residents of numerous other African countries to Kenya for asylum.

The IRC has provided health services in Kakuma refugee camp in Kenya since 1992. It now runs an HIV programme that includes a full range of prevention services and clinical and psychosocial care. IRC's camp clinic treats more than 100 people with ART, working with local organizations to provide these services to both refugees and the adjacent host community (Purdin et al., forthcoming).

Many of those treated in the camp clinic are refugees from south Sudan. The end of hostilities opened up the possibility for them to return home. However, a recent evaluation by IRC found that extremely limited HIV and AIDS-related services are available for returnee, IDP and host populations in south Sudan. Perhaps because of the area's many years of isolation, there remains persistent stigma around HIV, denial that the infection exists in the community and misconceptions about the best way to deal with the threat of infection. While HIV prevention education, condom availability and voluntary counselling and testing (VCT) services (IRC runs the VCT programme in the state hospital) are now robust, there is little in the way of support or treatment for those who test positive. Facing stigma, they are often lost to follow-up. Pregnant mothers with HIV have no access to Nevarapine to reduce transmission of the virus to their babies – supplies of the drug have run out and have not been replenished.

IRC aims at improving access to care for people living with HIV and AIDS in the region, but it faces many obstacles, from degraded roads and communications systems that make it extremely challenging to establish robust drug supply chain logistics, to poor local drug management and storage. The NGO has also been so far unable to find a donor willing to fund ART and a staff nurse to provide services to those who test positive at VCT centres.

So what is IRC's advice to its ART patients from south Sudan in Kakuma refugee camp? Stay put, for now. "The best plan is to allow people who are on anti-retrovirals to stay in their country of asylum where they have access [to the drugs], until access improves at home and they can return," said Purdin.

Funding is also a limiting factor. During wartime, governments may divert healthcare funds to serve the military. Many NGOs rely on donor agencies for funding, and monies are typically granted in short, six-monthly or year-long cycles during acute crises. This makes it difficult to develop the kinds of community-based programmes needed to change HIV risk behaviours and reduce stigma (particularly in situations where major cultural and language differences between humanitarian staff and beneficiaries must be bridged). For many NGOs, the choice to launch a particular programme is also influenced by whether the donor "has the money or wants us to do it," said Mercy Corps' Cardenas. "We're so donor-driven."

Refugees are more difficult to reach when they live in urban settings than in refugee camps. "Many urban refugees aren't registered with us or with governments, so they don't have the means to access care," said Spiegel. Refugees may not realize they have a right to access healthcare; they may be fearful of doing so and they are often wrongly denied services. Language and cultural differences can also present difficulties obtaining healthcare in countries of asylum. There is a need to do more "advocating with governments to ensure [that refugees and asylum seekers are] part of existing systems and not being left alone, so vulnerable, dying of AIDS before they come see us," said Spiegel.

A vision of the future

Several years ago, a Burundian family with several members on ART fled to Tanzania, becoming refugees. They appeared at a medical NGO in need of medicines. At the time, the Tanzanian government had no policy for providing ART to refugees. The family's treatment was continued ad hoc while UNHCR officials worked with the government, offering support if the country would allow refugees to access ART in government facilities.

Some experts believe that the humanitarian community is poorly prepared to deal with conflicts or emergencies that occur in areas of high HIV prevalence and treatment access. Emergencies that send hundreds or thousands of ART patients, rather than just a single family, fleeing from where they currently obtain medicines and services are "going to happen more and more as anti-retroviral therapy becomes more widespread," said Spiegel. The violence that erupted after Kenya's contested presidential elections in December 2007 put these fears to the test (see Box 5.4). MSF and Kenya Red Cross Society workers canvassed IDP camps to locate patients on ART,

and a free help hotline was established. However, some clinic patients were lost to follow-up, IDPs who forcibly or willingly relocated to rural areas with host populations were difficult to reach, and camp residents with AIDS reported difficulty accessing ancillary services including adequate nutrition.

Clearly, more work needs to be done to prepare for and respond to the HIV pandemic in emergencies. "There has been good progress on HIV, however there are still many gaps in terms of ensuring people have access to the whole treatment packages," said MSF's Shanks. That includes treatment and prophylaxis for opportunistic infections.

Box 5.4 Providing ART and healthcare for HIV-positive people during the Kenyan emergency

On 27 December 2007, disputed presidential elections unleashed an explosion of frustration and violence in Kenya. The violence quickly degenerated into bedlam and bloodshed between ethnic groups, and up to 1,000 people are estimated to have been killed, and 300,000 displaced. Many Kenyans, including employees of organizations responding to AIDS, had travelled to their rural homes for holidays and/or to participate in the elections and were therefore caught up in the violence. The main areas affected by the unrest were the slum areas of Nairobi, Eldoret and Burnt Forest in Rift Valley Province, and Kisumu in Nyanza Province. Coast Province, including the main town of Mombasa, and Western Province have also been affected by violence, looting, burning of homes and reported incidences of rape. The situation is also having a regional impact with an estimated 5,400 people displaced into Uganda.

The national prevalence of HIV was estimated to have dropped to 5.1 per cent (4.6–5.8) in 2006 from a high of 10 per cent in the late 1990s. The government of Kenya estimates that 55,000–100,000 Kenyans were newly infected with HIV in 2006, which indicates a significant drop from previous estimates. The government further estimated that

35,000 deaths were prevented due to successes reported by ART programmes (UCO, 2008). The displacement caused by the post-election violence threatened to erode these gains. The disruption to ART for thousands of patients was particularly worrying as it puts patients at risk of developing resistance to the drugs. Displacement also interrupts steady access to nutritious foods, which also affects the patient's ability to respond well to ART.

At the time of the violence, the Ministry of Health estimated that 15,000 displaced Kenyans were HIV positive out of whom 6,750 were in need of ART and 2,550 were beneficiaries of ART programmes while in their communities.

The response
The Ministry of Health (MoH) has moved quickly to provide guidelines to health workers for the clinical management of disruptions to ART. Guidance has also been provided to patients who are on ART programmes to report to the nearest government health centre for further management.

Across the country, NGOs developed new ways to trace HIV patients. MSF set up a toll-free national hotline, launched on 21 January. "The hotline will run for six weeks and will

be advertised in the national English and Kiswahili newspapers," said MSF's Anouk Delafortrie, who is coordinating the project. "We are asking patients to call for advice about the closest centre if they have had to relocate, and letting them know what their options are if they are no longer near an MSF health facility" (PLUSNEWS, 2008).

"When the unrest broke out after the election, many of our patients were displaced, so we have set up this mobile clinic in Jamhuri Park [in Nairobi, where 2,400 IDPs are living] to try and trace them and alert them to our presence – since we have been here, about 50 of our own patients have come to refill their ARV [anti-retroviral] prescriptions," said Mohamed Hamid, coordinator of the mobile clinic. "We are not turning away patients from other health providers – if they have their medical records with them then we are providing them with drugs" (PLUSNEWS, 2008).

The MoH and several other health NGOs have also set up satellite centres at Jamhuri Park and in IDP camps in the Rift Valley to trace their patients, with particular emphasis placed on tracing those on ARVs and tuberculosis (TB) medication.

Other agencies, like the Kenya Red Cross Society and CARE International, have been involved in ensuring the basic needs of these and other displaced people are met, distributing food and non-food items, including mosquito nets, and supplying water and sanitation facilities in camps. Medicines alone are not enough to maintain the health status of those with chronic illnesses.

The quick response of the MoH and NGOs to ensure continuity of access to ART, and attend to the basics that maintain health, serves as an example for future emergencies.

Looking forward

The response of the Kenyan government and NGOs to the unexpected violence was commendable, and highlighted the importance of preparedness. UNAIDS, the Kenya Red Cross Society, the World Health Organization and others underlined the importance of rapid assessment and establishment of the magnitude of the problem in terms of interruptions to treatment, including:

- Developing a contingency plan for managing treatment continuity/interruption among those on ART
- Ensuring availability of testing and post-exposure prophylaxis (PEP) kits in all the areas, along with the necessary psychosocial support
- Developing a comprehensive HIV information kit (including condoms and guidance on managing ART interruption) to accompany all response efforts, especially among the displaced
- Ensuring appropriate relief food baskets and special protection from the weather elements for the chronically ill
- Treatment of opportunisitc infections (especially TB) and STIs. ■

Keeping HIV from falling off the agenda of humanitarian responders is always a challenge when so many other urgent priorities exist. "The really acute post-conflict settings are not getting the amount of attention they need to address HIV and a lot of other things like health system development and re-development," said Purdin of the IRC. "In the poorest settings with the most devastation from conflict, the problems are very deep and the support for programming isn't sufficient."

There have also been some steps backwards. As part of UN reform, the structure of humanitarian response has changed, and aid workers from various sectors, including health, now coordinate within a 'cluster' system. Advocates have had to work hard to keep access to HIV services in the forefront of the response to complex humanitarian emergencies. "It's really frustrating to have to keep fighting the battles," said Purdin.

Opportunities

While the challenges and risks related to HIV in conflict and displacement settings are great, so, too, are the opportunities to improve healthcare and protect populations. Conflicts can draw humanitarian agencies into remote, low-income settings, where healthcare services were poor even before the conflict. Thus, the presence of the agencies and their financial, technical and logistical resources during or after a conflict presents an opportunity to provide certain populations with HIV prevention, care and treatment services that had previously been absent or too costly for most people, particularly the marginalized, to afford.

The provision of HIV-related services can be easier in refugee camps. The population within them is well defined and easy to access. In fact, research has suggested that refugees returning to their homes post-conflict, because of their exposure to HIV prevention programmes, are sometimes more knowledgeable about HIV and engage in fewer risky behaviours than those who had not been displaced (Spiegel and Nankoe, 2004).

Conclusion and recommendations

In conclusion, the relationships between HIV, conflict and displacement are complex and contextualized. Research suggests that populations isolated by conflicts in recent decades often have lower than expected rates of HIV infection, probably due to fewer opportunities to come into contact with the virus. On the other hand, all steps in the cycle of conflict, displacement and return can increase vulnerability to HIV. The weakening of societal cohesion and social norms open the way for sexual violence and exploitation. Trauma and loss of livelihoods may lead some to engage in higher-risk sexual activities including sex work. The degradation of educational, health and social services also hinders protection. War-affected populations may also assume more risk of contracting HIV when interacting with higher prevalence populations such as some armed forces or host communities in countries of asylum.

Therefore:
- ■ It is important to prioritize basic HIV prevention and related interventions from the earliest days of a crisis and build towards a comprehensive, integrated package

of prevention, treatment, care and support services for refugees, IDPs and host populations. When planning and providing services, attention should be paid to the views of PLHIV and the special needs of youth and survivors of gender-based violence.

- Ultimately, comprehensive HIV interventions for refugees and conflict-affected populations are similar to those in other settings, with particular attention paid to vulnerability reduction (including food security), the provision of culturally and linguistically appropriate services and support for demobilized soldiers and survivors of sexual and gender-based violence. Prevention activities should centre on changing risk behaviours, facilitating access to condoms, advocating against gender-based violence (and making healthcare services available for its survivors), ensuring the safety of medical equipment, medical supplies and blood for transfusion, and making sure post-exposure HIV prophylaxis, HIV counselling and testing, prevention of mother-to-child transmission and STI management services are available.
- HIV care, treatment and support should ideally be similarly comprehensive and continuous, encompassing not only ART, but also prophylaxis and treatment for opportunistic infections, psychosocial, nutritional and economic support (including to orphans and vulnerable children) and palliative care.
- Achieving sustainable success requires that agencies also engage in capacity-building activities, such as recruiting and educating healthcare professionals, when possible from the affected community, and strengthening physical infrastructure, supply chains and laboratory services.

All of this can be a tall order in the context of an emergency or post-emergency situation. Still, with recent advances in knowledge, the widespread recognition of the right of refugees to a full range of HIV services and the expansion of funding sources, the opportunities for addressing HIV among the war-affected and displaced have never been better. The remaining challenge is to turn these opportunities into effective actions, overcoming the many logistical, operational and attitudinal obstacles involved in addressing HIV among those devastated by conflict and displacement.

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International Crisis Group: **www.crisisgroup.org**

International Rescue Committee: **www.theirc.org**

Médecins sans Frontières (Doctors Without Borders) (MSF): **www.msf.org**

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Save the Children International: **www.savethechildren.net/alliance/index.html**

UNAIDS: **www.unaids.org**

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Uppsala Conflict Data Program: **www.pcr.uu.se/database**

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Natural disasters: the complex links with HIV

When Jane Machira went to Uganda's Soroti province in the wake of massive flooding in October 2007, she found herself "shocked and upset" by the situation of people living with HIV (PLHIV). As Christian Aid's HIV officer in East Africa, she wanted to check on the mobile clinics run by partner organization Youth With A Mission (YWAM), whose clientele includes many HIV-positive people and their families. The conditions she found were harsh, as people told her of crops swept away by the flood waters and the contamination of all sources of clean drinking water by collapsed pit latrines, rotten food and the bodies of dead animals. In places where roads were severely affected, many PLHIV had been unable to reach hospitals to get their vital anti-retroviral drugs, while local clinics had run out of medications to treat opportunistic infections. In an online appeal, Jane commented:

> "I was utterly saddened to see Grace Okello's farm totally flooded and water logged. Her harvest was completely destroyed and her home ruined. Grace, who takes care of eight orphans, was just about to harvest her groundnuts (the seeds had been provided by YWAM) when the floods struck. Nothing was left. Without food, people living with HIV cannot fight the HIV virus or protect themselves from opportunistic infections. With the loss of crops and destruction of farms, the price of food has risen sharply and Grace, like many others, cannot afford to buy food from the markets.

> "My heart wept when I saw that Grace, along with many other families, had lost everything. I also cried because it is work undone. Uganda has been a success story in the way it has sought to tackle HIV… Now, for people like Grace who have addressed one crisis in their lives, I see another one emerging. Without food, shelter and support, because of the rains I don't know how she will cope."

> (Christian Aid, 2007)

Devastating events

Natural disasters, such as the massive flooding described in Uganda, comprise some of the most devastating events in human history. In a matter of hours, and sometimes even of minutes, an earthquake or hurricane can kill tens of thousands, and undo decades of economic development. History records many natural disasters of huge amplitude, from the earthquake in 1138 that killed almost a quarter of a million people in Syria to China's Yellow River floods that killed over a million people in 1887

and 1931. Many more disasters of smaller amplitude are recorded throughout history, and continue to strike almost every week of the year in one location or another.

Natural disasters are often divided into two categories of 'climatic' and 'geological' events, although these are not strict scientific definitions (other terminology includes 'hydrometeorological' and 'geophysical' disasters). Climatic disasters are weather-related and include floods, cyclones, storms, drought and wildfires. Geological disasters include earthquakes, tsunamis and volcanic eruptions. Somewhere in the middle are avalanches, landslides and mudslides, which may be related to a mixture of climatic and geological factors.

The Global Resource Information Database maintained by the United Nations Environment Programme (UNEP) states that 118 million people are exposed each year to major earthquakes (i.e., above 5.5 on the Richter scale), 343.6 million to tropical cyclones, 521 million are exposed to floods and 130 million to meteorological drought. Another 2.3 million people are exposed annually to landslides.

Fast-moving epidemics of highly infectious diseases are also included in the list of natural disasters. The so-called Black Plague, caused by the *Yersinia pestisis* bacterium, is thought to have killed around 75 million people in Asia and Europe during a decade in the mid-1300s. More recently, an epidemic of influenza killed almost 50 million people in the single year of 1918. Today, HIV constitutes a unique disaster which currently kills millions of people each year (see Chapters 1 and 2 for epidemiological information) and is having a serious impact on human development in the hardest-hit countries.

HIV and 2007's 'crop' of natural disasters

The year 2007 will be remembered as a particularly bad year for floods and forest fires, although other types of disasters were registered in different parts of the world. Africa saw no less than 23 countries affected by some of the biggest floods in decades. In Asia, tens of millions were affected by floods in Bangladesh, India and Nepal, while Cyclone Sidr on 15 November had a massive impact on coastal Bangladesh. Extreme rains affected 1.5 million people in the Caribbean, Central America and Mexico; at their height, four-fifths of the Mexican state of Tabasco were submerged.

The year also saw severe 'cold snaps' in Argentina, Bangladesh, Nepal and Peru. Latin America was struck by Category 5 Hurricanes Felix and Dean, as well as a number of tropical storms, while Australia, Greece and the US state of California experienced severe wildfires or drought.

On the geological front, major earthquakes were registered in Peru, Sumatra (Indonesia) and the Solomon Islands, where the earthquake was accompanied by a tsunami.

However, the Peru earthquake, in which more than 500 people died, was the only geological event among the 15 'Flash Appeals' issued by the United Nations (UN) in 2007. Most other major seismic events in 2007 occurred in the ocean, far away from population centres. Figure 6.1 shows the major disasters in 2007 as listed by OCHA, the UN's Office for the Coordination of Humanitarian Affairs.

It is impossible to make any direct link between HIV mortality and the natural disasters occuring in 2007, but there is no doubt that such events had negative impacts on millions of people living with or affected by HIV. Of the 15 disasters resulting in Flash Appeals in 2007, nine occurred in countries with generalized epidemics, i.e., where over 1 per cent of the adult population is HIV positive (the nine include the disasters that struck the Caribbean and West African regions, which both contain several countries with generalized epidemics).

In practical terms, this means that hundreds of thousands of people living with HIV would have been affected in one or more ways, and general populations exposed to increased risk of infection. Such impacts and risk factors include interrupted care and treatment for AIDS or opportunistic infections, reduced or lost access to medical interventions to prevent mother-to-child transmission, shortages or lack of condoms and other prevention-related supplies and disruption of prevention programming and reproductive health services (see Box 6.1).

Specific impacts on HIV-positive people

When natural disasters strike, HIV-positive people suffer the same negative impacts as everyone else – but certain problems affect them even more, or in particularly severe ways. Everyone is hurt when a disaster disrupts the supply of medications, but for someone on anti-retrovirals, any disruption of the medical regime is likely to cause resistance to treatment. Scarcity of food is hard on everyone, but for someone living with HIV, malnutrition is likely to speed up the progression of the infection.

Similarly, disruption of water supplies poses a huge problem for someone with advanced HIV for a variety of reasons. Clean water for food preparation is essential to minimize the risk of intestinal infections, to which PLHIV are especially vulnerable, and to make food easier to eat for those suffering from mouth ulcers or thrush. Since HIV-positive people suffer frequent attacks of diarrhoea, extra drinking water is needed to avoid dehydration, as well as to swallow medicines. Susceptibility to skin infections means frequent bathing is necessary.

In advanced AIDS care, clothing, beds and patients themselves need to be washed frequently, and toilets need to be flushed more often. Where 'nutrition gardens' have been planted to provide an additional source of healthy food for HIV-positive people, irrigation is essential.

Figure 6.1
Natural disasters 2007 (Summary of contributions in US dollars)
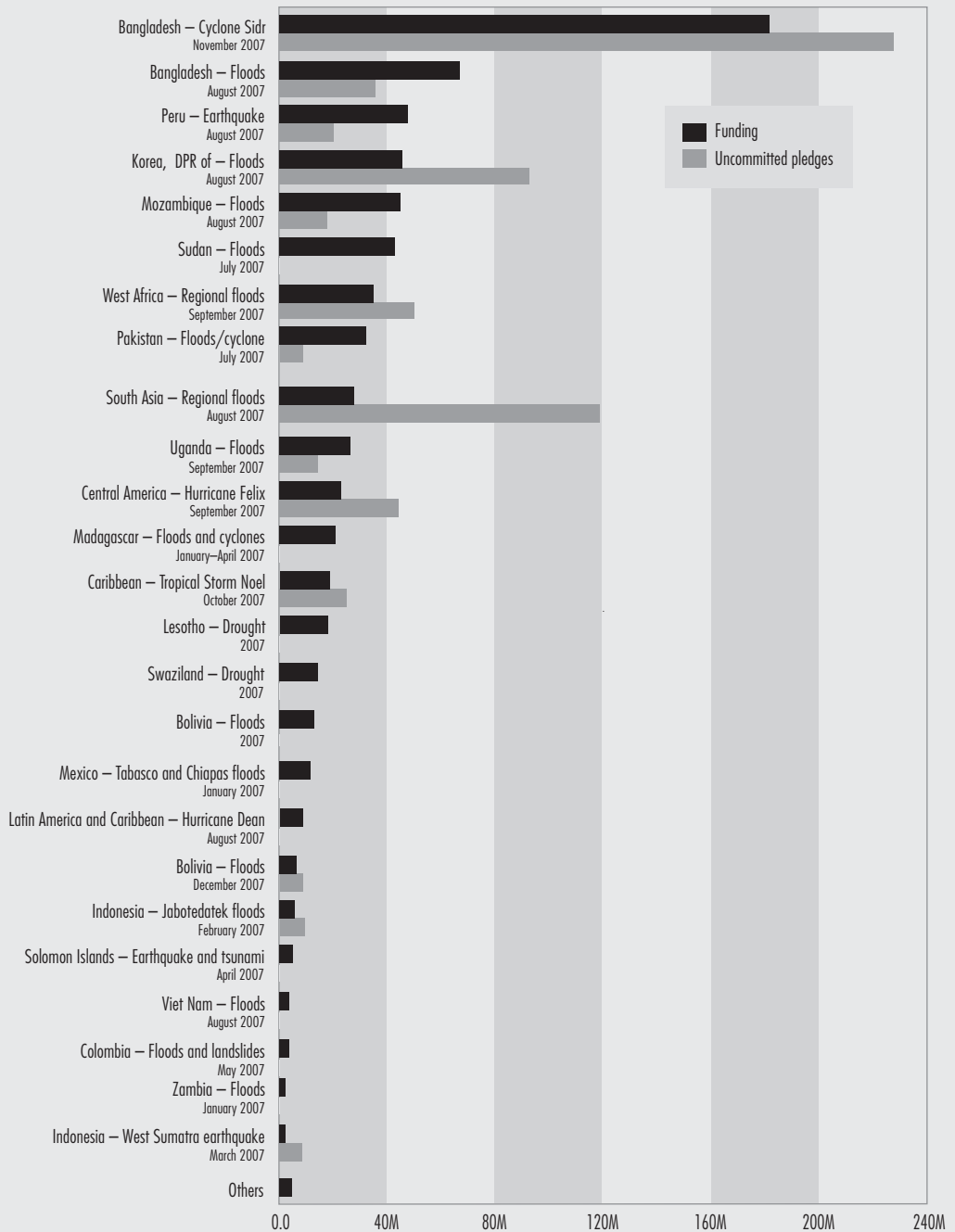
Source: ReliefWeb/Financial Tracking Service Note that a 'pledge' is a non-binding announcement of an intended contribution by the donor, while a 'commitment' indicates a contractual obligation between the donor and recipient. An 'uncommitted pledge' indicates the balance of original pledges not yet paid or bound into a contract.

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Box 6.1 Was 2007 a 'blip' or portent of the future?

The types and impacts of major disasters vary greatly from year to year, and to say that 2007 was a bad year for floods and fires does not make it unusual (except of course for the millions of victims). There were no major geological events – at least, not affecting heavily populated areas – on the scale of the previous two years. The worst-affected countries were, typically, developing countries; with the exception of the forest fires affecting parts of Australia, Greece and the US, the industrialized nations suffered relatively little. There was no repeat of Europe's heatwave in 2003 that killed thousands – mostly elderly people – or the unusually high number of tropical cyclones that battered Japan in 2004.

However, analysis does suggest some patterns. In recent decades, the incidence of heatwaves has increased considerably: there were 29 in the ten-year period 1987–1996, compared to 76 in the period 1997–2006 (EM-DAT, 2006). An even greater increase has been recorded in cold snaps, although there is some question of whether this is a result of better reporting (Oxfam, 2007). In general, it appears that although some regions such as the Mediterranean basin, southern Europe and southern Africa are growing drier overall, the general trend is for increasing humidity (which, under certain conditions can actually intensify heatwaves) and greater frequency of extreme rain events.

In the long-term view, there is increasing concern that climate change, and particularly global warming, may result in an increasingly harsh environment for some already vulnerable populations. The UNDP *Human Development Report* for 2007 speculated about the possible effects over the coming century if an overall warming of 2 degrees Centigrade occurs (UNDP, 2007). The scenario is a nightmare of dying tropical rainforests, loss of biodiversity as oceans heat up and shrinking icesheets and glaciers.

As this report makes clear, natural disasters have severe impacts on HIV-positive people living in affected areas. An increase in climatic disasters would increase both the numbers of individuals suffering these impacts each year and their severity. Moreover, the shape of the global epidemic could be affected if climate change causes significant population movement between areas with significantly different HIV prevalence levels (see Chapter 4 for a discussion of HIV and mobility).

It is impossible to fully predict the magnitude of impending climate change, nor if current assumptions about impacts will be borne out. Nonetheless, such predictive exercises are of great value in that they permit societies to (a) change their behaviours insofar as these have an impact on climate change, and (b) organize themselves to deal with disasters if and when they strike. In the words of Sálvano Briceño, Director of the UN International Strategy for Disaster Reduction:

"The problem today is that around the world vulnerability to disasters continues to increase, a situation that will worsen with climate change. So we need to take action now to reduce the risks of devastating impacts on people and their livelihoods. Disaster risk reduction is not an option, it is an urgent priority" (UN, 2007). ∎

Impacts on risk behaviour

Although AIDS advocates frequently refer to the potential of increased risk behaviour, sexual and gender-based violence and other problems that might increase the incidence of HIV transmission in disaster situations, there appears to have been little research to actually assess the extent of this risk (with the exception of rape in certain conflicts). A recent document devoted to women in disaster situations, Oxfam's *The tsunami's impact on women*, found more questions than answers:

> "How safe are women in crowded camps and settlements, when they are so outnumbered by men in several of the countries in question? Will widows in India have access to land once owned by their husbands? Will younger women enter into marriages with much older men, as already seems to be happening in some locations? And will this carry risks in terms of compromising their education and reproductive health? In the fishing communities of South India, what rights will surviving women enjoy under new arrangements and programmes? In whose names will newly built houses be registered? Will men take on new domestic roles, or will women's workloads increase?"
>
> (Oxfam, 2005)

Other questions might be asked that relate more directly to HIV. For example, do natural disasters break down family structures or change sexual networking in ways that might increase HIV transmission in places where prevalence is significant? Again, there is little information available.

What is certain is that some components of HIV prevention can be halted in their tracks. For example, supplies of condoms can be disrupted, sometimes for long periods of time, which can certainly put people at risk if they have unprotected sex. Similarly, HIV prevention activities such as counselling and testing and behaviour change communications – everything from school programmes to mass media campaigns – are generally put on hold while priority medical interventions are emphasized. While this is understandable and even necessary at a time when basic survival needs have to be prioritized, it is important that such services be resumed as soon as possible. A different form of risk is faced by HIV-positive mothers who give birth during emergencies, since they are not likely to have access to medical interventions that reduce the risk of mother-to-child transmission of HIV.

Key populations at higher risk

With most discussions of HIV and disasters focused on general populations, little attention has been paid to so-called populations at higher risk – injecting drug users, male prisoners, sex workers and men who have sex with men (MSM) – when disas-

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ters strike areas with concentrated epidemics (defined as HIV prevalence of over 5 per cent in a specified sub-population).

Some research has been undertaken to study HIV-related risk behaviours of drug users in disaster situations. In 2003, a rapid assessment of drug users was carried out in the wake of the earthquake in Bam, Iran. The earthquake was a major event that killed an estimated 35,000 residents of the city, which in recent years has had a significant drug use problem. The study found that about half of drug-dependent interviewees had suffered withdrawal symptoms as it became difficult to optain opium. Behaviour changed somewhat as oral intake of opium replaced smoking, neither of which puts the user at high risk of HIV infection. However, a newspaper report three years later suggested that heroin injection had increased in the city and surrounding areas, and that a small but growing number of HIV infections had been recorded in the city (Tait, 2006). Although there is no evidence that the new infections are related to the earthquake, the report quoted a heroin addict who, when asked about the risk of AIDS, replied, "Those using needles don't care if they are shared or dirty. They just see a needle and want to get high. My life is already destroyed."

Given the potential for fast-spreading epidemics demonstrated among injecting drug users in other parts of the world, such data constitute an 'alarm bell' that should be heeded.

Little research or journalistic information appears to be available about HIV-related risk to (or services for) sex workers or MSM during disasters. Even in documents devoted to women in disaster situations, such as the Oxfam document mentioned above, there is no mention of sex workers except for concern that women whose livelihoods are disrupted by the disaster might have to resort to sex work for economic reasons.

Slow-onset disasters in areas of high HIV prevalence

For some of the world's population, the greatest danger is less from unpredictable climatic or geological events of short duration than from 'slow-onset disasters' in which natural phenomena interact with population growth, unsustainable production systems and ill-targeted development practices (although these can contribute to and amplify such natural disasters). To a large extent, the most vulnerable populations are rural ones, although environmental degradation can have disastrous impacts on urban and peri-urban populations as well. Again, some of the populations most vulnerable to these factors live in countries with general HIV epidemics in sub-Saharan Africa and the Caribbean.

A vivid example of chronic vulnerability that is at least partly due to human activity can be seen in the rural populations in the Horn of Africa. In 2000, a UN Inter-

Agency Task Force on long-term food security and development in the region noted that poverty itself was one of the main causes of environmental degradation, as the growing population is forced to cultivate increasingly marginal, unproductive land. Soil fertility is falling as land once left fallow is farmed continously, steeper slopes are being cultivated and ill-conceived development projects to encourage livestock-raising in hitherto unused rangeland have actually increased the vulnerability of pastoral farmers to drought – at a time when hard-pressed governments are less inclined to bring health, education and water services to such areas. Less than 10 per cent of cultivated or cultivatable land is irrigated in the region (in Asia the figure is 37 per cent) and evidence-based approaches to agriculture in drought-prone areas (drought-resistant crops, better tillage systems and improved water 'harvesting') have not been applied on any significant scale. The result in many areas is chronic food insecurity.

In the first half of the current decade, it was postulated that sub-Saharan Africa faced a 'new variant famine' – an acute food crisis different to other such crises because of the cumulative impacts of HIV and AIDS on rural houscholds and food production systems. In this hypothesis, the epidemic increases rural populations' susceptibility to events such as flooding or droughts and reduces their resilience when such shocks occur. This raised considerable controversy: the hypothesis was treated as fact by some, particularly people concerned about an impending famine in the Southern African Development Community (SADC) countries at the time, which threatened an estimated 15 million people in the region. The hypothesis also found a number of critics, some of whom objected that it was unsupported by data. Others – donors and non-governmental organizations (NGOs) among them – suggested that the 'new variant famine' allowed advocates to use AIDS as a means of encouraging food aid to countries where agricultural production was actually sufficient, while obscuring the contribution of political factors to food insecurity.

As it turned out, the massive tragedy expected to afflict the SADC countries did not occur, at least in terms of the feared high levels of starvation and acute malnutrition. This was partly because of a massive humanitarian response and partly because of what Paul Harvey, of the Overseas Development Institute's Humanitarian Policy Group, refers to as "the usual underestimation of the resilience of people's survival strategies". Harvey hastened to add that "this does not disprove the hypothesis or refute the possibility that an HIV/AIDS epidemic may lead to heightened mortality in acute crises: it simply suggests that this did not happen in southern Africa in 2002-2003... Disentangling the relative importance of HIV/AIDS compared to bad governance or bad weather is and will remain difficult" (Harvey, 2004).

Three years later, a summary of SADC National Vulnerability Assessment Committee reports noted that, although 2006 had been good in terms of both rainfall and agricultural production, about 3.1 million people remained vulnerable to food inse-

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curity in the region. This "confirms the fact that vulnerability to food insecurity in the region is chronic in nature and is largely an outcome of growing poverty, HIV and AIDS, and weak governance, commonly referred by the UN in the region as the 'Triple Threat' " (SADC, 2006). The report noted that all SADC countries, with the exception of Swaziland and Zimbabwe, had registered growth of more than 3 per cent in gross domestic product between 2000 and 2005, but stated:

> "The growth of the economies however, has not meant reduction in the percentage of people living below the poverty datum line however; the percentage of people living below the poverty datum line remains high. At least two-thirds of the poor households (those living on less than a dollar per day) are in rural areas and derive their livelihood from agriculture."
>
> (SADC, 2006)

Health status in the region continued to be of concern "with populations suffering from frequent bouts of diarrhoea, endemic malaria, cholera outbreaks, tuberculosis and the highest prevalence of HIV and AIDS in the world" (SADC, 2006).

The international community's response to the 2003 crisis was primarily one of food aid, and there was considerable discussion in its aftermath as to whether valuable opportunities for lasting benefits to the region were missed.

Few efforts were made to strengthen national health systems or to address long-standing problems of water and sanitation (as noted above, access to clean supplies of water is of heightened significance to people living with HIV and AIDS). This, it can be argued, reflects the downside of humanitarian reponses in locations where extensive risks are chronic: the immediate crisis may be averted or mitigated, but the underlying problems remain.

In a thought-provoking essay on the future of food aid, Daniel Maxwell suggests that approaches to such slow disasters need to be very different from those caused by major 'events':

> "Programmatically, between 'relief' and 'development' there is an emergent grey area around social protection and safety nets, and around the reduction and mitigation of disaster risk. In some contexts, notably Ethiopia, donors and national governments have put enormous effort into separating chronically vulnerable groups from disaster-affected groups—dealing with the former as a safety net issue and the latter as a humanitarian response issue... While these categories might seem similar in terms of the interventions required, the causal factors underlying the problems being addressed are different. The safety-net category is relatively predictable, permitting donors to allocate resources without waiting for assessments and appeals. This reduces considerably the level of unpredictability in allocations and pipelines—and should also make an appropriate humanitarian response quicker."
>
> (Maxwell, 2007)

Natural disasters in areas of low HIV prevalence

As shown in Figure 6.1, many natural disasters occur in regions where HIV prevalence is relatively low in the general population. An example can be seen in the tsunami of 26 December 2004, which had a devastating impact on several Asian countries. Over 232,000 people were killed or missing, millions lost their homes and local and national economies were severely affected. At the same time, a surge of humanitarian assistance was mobilized, with unprecedented amounts of unrestricted cash donations from individual citizens in industrialized countries.

Of the countries affected, only Thailand has a generalized epidemic (estimated adult prevalence 1.4 per cent), and it has well-organized prevention and treatment services for people living with HIV. Some of the other countries have concentrated epidemics among certain sub-populations. For the most part, however, the areas hit by the tsunami had low levels of HIV prevalence, and relief efforts concentrated on other priorities. In the hard-hit Indonesian island of Sumatra, for example, HIV-related efforts were initially restricted to promoting the consistent application of universal precautions in health settings. Mindful of the risk of HIV arriving in the area with external responders, training workshops were provided for the approximately 45,000 uniformed personnel involved in providing humanitarian assistance.

Over the following weeks and months, health services were restored in the coastal areas of the affected countries. The disaster gave rise to a considerable amount of activity

aimed at strengthening emergency systems in the region. However, unlike in the case of Hurricane Katrina (see Box 6.2), little research appears to have been done about HIV-positive people in the tsunami. One of the few projects to do so was a joint effort by the Asia Pacific Network of People Living with HIV (APN+) and the International Federation of Red Cross and Red Crescent Societies (International Federation), which used a peer-based survey to investigate the immediate and longer-term impacts on HIV-positive people in affected areas in India, Indonesia, Sri Lanka and Thailand. The project staff found it relatively difficult to find subjects to interview, noting that the HIV-population is relatively 'invisible' in many countries and that local-level organizations of HIV-positive people do not exist in all areas. The project report found that:

> "HIV-positive people faced increased challenges due to the Tsunami such as illness, unemployment, poverty, psychological trauma and discrimination. While many tens of thousands of non-positive people also faced these challenges, positive people were placed at increased risk due to the double impact of HIV and the Tsunami on their physical and mental health, and the isolation and discrimination they often felt from their own families and communities… We found that many of our survey respondents believed they faced HIV related discrimination, and whether this was actual or perceived, it affected their access to services."
>
> (APN+ and International Federation, 2007)

Box 6.2 Hurricane Katrina, a disaster under the microscope

While the greatest amount of media attention was captured by Hurricane Katrina, it is sometimes forgotten that the 2005 hurricane season buffeted the Caribbean and Central America with no less than 27 named storms (UNDP, 2007). The impacts of some of these storms were significant. For example, Hurricane Stan in October killed over 1,600 people in Guatemala's Central Highlands, most of them Mayan people from the country's aboriginal majority (Simms et al., 2006).

However, the fact that Katrina hit a major city in the United States, and the controversies that arose as a result of official emergency responses, meant that the late August hurricane is possibly the most reported and analysed climatic disaster in history. This is

borne out by some of the scientific literature that has emerged since the hurricane. A quick perusal of titles in a medical database finds that there has been research on topics as varied as:

- symptoms of post-traumatic stress disorder in New Orleans workers
- trauma, poverty and health among hurricane survivors from the Vietnamese-American community
- symptoms of depression and post-traumatic stress disorder among hospital outpatients
- skin disorders among construction workers following Hurricane Katrina and Hurricane Rita.

Moreover, there has been unprecedented research into HIV-related aspects of this hurri-

cane, which occurred in a part of the United States with relatively high prevalence among specific groups such as injecting drug users, MSM and parts of the black population (these are not mutually exclusive groups, there is a considerable overlap). Unlike most parts of the world, there was a fairly clear picture of the numbers involved: about 21,000 HIV-positive people were estimated to be living in the three affected states, including almost 7,400 in the New Orleans metropolitan area. Also unlike other parts of the world, many of these people were receiving HIV-related services, even the poorest. Since much of US health-care is delivered through private systems, it is difficult to know what happened to many of the better-off people. However, a good deal is known about government services. As one report noted soon after the hurricane:

"Prior to Hurricane Katrina, many low-income people with HIV/AIDS in Alabama, Louisiana, and Mississippi relied on their state's Medicaid program for medications and other services or its AIDS Drug Assistance Program (ADAP) for medications if they had no other source of care or coverage. For example, in June 2004, Alabama served 1,220 ADAP clients, Louisiana served 1,654, and Mississippi served 769. These individuals may now be faced with trying to access ADAP services in other parts of their home state or in other states; a similar challenge is facing Medicaid beneficiaries with HIV/AIDS who may have relocated to other states as well" (Kaiser Family Foundation, 2005).

Information was soon available about how the disaster had affected public health services. It took only a short time for basic outpatient primary care services to be re-established for HIV outpatients outside the city, but access to anti-retroviral treatment was disrupted for months. The largest HIV care provider, the Medical Center of Louisiana at New Orleans, was able to help patients obtain medications by mid-October and opened a temporary HIV clinic in the first week of November. A study reported: "Six months following the hurricane, microbiologic studies are still unable to be performed in clinics and uninsured patients must travel at least 70 miles for subspecialty care" (Clark et al., 2006). The longer-term aftermath of the disaster brought further challenges. For example, the dispersal of survivors to other locations meant that the local services faced a reduced patient base and remaining patients were served by fewer healthcare professionals and facilities (Louisiana State University Health Science Center, 2006). ■

One interesting fact to emerge from the study was that the influx of medical services in the wake of the disaster and of people seeking medical assistance led to an increase in the number of people who learned their HIV-status. The study noted that "many positive people interviewed as part of this Project, particularly in Tamil Nadu State in India, became aware of their positive HIV status only after the Tsunami due to medical care provided to them for various health problems often linked to the effect of the Tsunami". It added, "Hopefully many of these positive will now be able to [be] more proactive in terms of their own health needs and be active in terms of their level of involvement in their local positive organisations". The report made a number of recommendations, chief among which was the need for more involvement of representative organizations of HIV-positive [people] in emergency planning and for more

peer-based support services "whether in disaster situations or general life" (APN+ and International Federation, 2007). (See Box 6.3 for a review of the work of Islamic Relief, other Muslim organizations and people living with HIV, in natural disasters and other humanitarian situations.)

Box 6.3 When faith leaders and people living with HIV come together

Fatima* does not know how she contracted HIV. The young mother from East Africa only found out that she was HIV positive when she moved to another country and had to undergo a compulsory medical examination. The diagnosis came as a shock, but what was more terrifying was the reaction of the community in her new home country.

Like many other people living with HIV, Fatima experienced stigma, discrimination and hostility from those she was supposed to feel closest to. She felt that she had nowhere to turn.

Like many other communities, Muslim communities often associate HIV with 'sinful' practices. A consequence is that Muslim organizations have been conspicuously absent from the international HIV discourse. It is rarely a consideration for Muslim organizations involved in disaster relief.

Islamic Relief realized that the absence of Muslims from HIV-related work was a challenge that needed to be tackled urgently. Islamic Relief is a relief and development organization that works in over 25 countries worldwide and has its headquarters in the United Kingdom. It traditionally had no HIV-related programmes, but it noticed that the epidemic was having an increasing effect on its operations.

Islamic Relief organized five days of consultations on Islam and HIV/AIDS in Johannesburg at the end of 2007. The consultations were based on expertise and experience from over 50 countries, related by over 200 Islamic scholars, people living with HIV, HIV practitioners and medical doctors.

Within Muslim communities, stories such as Fatima's are often met with calls for compassion and moral messages. However, these consultations showed that such responses were often too simplistic to tackle the problem effectively, especially in the context of natural disasters. One of the participating scholars gave an example: "We discussed the issue of children who have lost their parents in a disaster, and are vulnerable to homelessness and HIV. The traditional Islamic answer that orphans should be fostered by their immediate relatives would not suffice, as this often proves to be practically impossible.

"Simply encouraging these children to 'avoid sin' will not help either. Many children who have lost their parents in a disaster have no support structures, are vulnerable to sexual abuse, and may turn to commercial sex in exchange for food or shelter in order to survive. Moral messages mean little to children living in such circumstances. So what can we do? We would not stop talking about dozens of issues such as this one until we felt we had found a meaningful way forward."

The consultations on Islam and HIV/AIDS were designed to tackle difficult and often controversial problems. There were discussions on topics ranging from sex work, injecting drug users and methods of prevention in the context of war, natural disasters and other

causes of social disintegration, as well as on issues such as mandatory testing, inheritance rights and care for vulnerable children. The outcomes of these discussions will help Muslim organizations to make meaningful decisions regarding HIV in disaster contexts in the future.

Because discussions took place in small and diverse groups, people were forced to acknowledge different experiences and to challenge their own assumptions. It led to significant attitude shifts in many participants. Impressed by their own ability to change attitudes, the HIV-positive Muslims who attended the consultations established a worldwide positive network in which the members provide support to each other and push HIV higher up the policy and action agendas in the Muslim world. Similarly, the Muslim organizations that funded the consultations (Al Eslah Society, Islamic Development Bank, Islamic Relief Association, Kuwaiti Ministry of Awqaf, Qatar

Charity and the Qatar Red Crescent Society) noticed that implementing organizations had the impression that Muslim donors would not be willing to fund their HIV-related operations. In response, these donor agencies jointly established an inter-agency HIV fund. These consultations are not the first time that Islam and HIV have been discussed, but mark a significant change in emphasis away from the traditional discussion topics of condoms and 'sin' to focusing on the wider realities of the pandemic. It is also the first time that such consultations were managed and funded by Muslim organizations. Over the next few years a consortium of Muslim organizations will continue to build on the success of these consultations (see www.islamandhivaids.org).

Although this will not change the discrimination or suffering that people such as Fatima have already experienced, it may help to ease the pain of those who will come after her. ■

* Not her real name

Rhetoric versus risk

Concerns that HIV advocacy can sometimes distort humanitarian aid efforts are relatively common though difficult to substantiate. However, there are plenty of examples where the rhetoric of HIV vulnerability is used without reference to real infection levels or observed risk behaviours. An early example can be seen in the aftermath of Hurricane Mitch, which struck Latin America and the Caribbean in October 1998. Mitch caused up to 18,000 deaths in the region, affected an estimated 560,000 people and inflicted an estimated US$ 5 billion in damage.

In addition to these impacts, research showed that Mitch caused serious health consequences for some of its victims. A study in three hurricane-affected areas of Honduras found that nine months after the hurricane, small children from resettled families were significantly underweight, compared to their pre-hurricane status. In neighbouring Nicaragua, a six-fold increase in cholera was linked to flooding due to the hurricane. However, although Honduras already had one of the highest levels of HIV prevalence in the region (an estimated 1.5 per cent of the adult population, the majority among males in most-at-risk groups), no research to date indicates that Mitch contributed to increased cases of HIV infection in the country, nor even in the

local areas most affected by the hurricane. Disruption to HIV-related health services was minimal: in fact, the country had few services for the small numbers of people diagnosed as HIV positive, and these were by and large concentrated in the capital and other areas relatively unaffected by the hurricane. (The situation is considerably different today, with subsidized treatment programmes covering many people who need anti-retroviral drugs.)

Nonetheless, in the following year, a seminar in London considered an emotively titled report called *The silent emergency: HIV/AIDS in conflicts and disasters* (UK Consortium on AIDS & International Development, 2002). In the report, a chapter on Hurricane Mitch listed a variety of HIV-related impacts imputed to the hurricane in Honduras. These included entirely undocumented claims such as "a 30-50% under-reporting of HIV/AIDS cases", an increase in "girls involved in/at risk of sexual exploitation", and an "increase in domestic violence and sexual violence". Bafflingly, the report also lamented that there had been "no modification in sexual health behaviour", due, apparently to the fact that Mitch "was not perceived as a threat to HIV/AIDS". It also complained that most international NGOs did not do more about HIV, "with many initially ceasing sexually transmitted infections (STI) and HIV prevention in favour of providing food, shelter and medical care". (One wonders what the reaction might have been at the time if these NGOs had ignored the need for food, shelter and medical care, and instead carried on their condom distribution activities.)

Almost a decade later, the language of theoretical HIV vulnerability (as opposed to real infection levels or observed risk behaviours) still emerges in official communications about disasters, sometimes a long time after the fact. A 2007 UN publication devoted to HIV in Asia bizarrely chose to devote its section on Indonesia to the population of Banda Aceh on the island of Sumatra – ignoring other parts of Indonesia which have serious concentrated epidemics. A UNAIDS official responsible for HIV prevention stated unequivocally that camps for internally displaced persons "breed high-risk behaviour" – a claim that is not only insulting to tsunami victims but, as in the case of Hurricane Mitch, is not supported by any evidence. The publication further commented that displaced women "face social instability, poverty and powerlessness – conditions that could heighten their vulnerability to another possible tsunami that could sweep the nation: HIV/AIDS" (UN OCHA/IRIN, 2007). Quite apart from the condescending attitude to women implicit in this statement, the idea that Indonesia faces a tsunami-like HIV epidemic flies in the face of all epidemiological evidence.

The way ahead: integrating HIV in responses to natural disasters

A review of agency and journalistic reports suggests that some of the lessons described above are achieving widespread acceptance, with the result that there are

increasing numbers of pragmatic, well-targeted responses to the needs of HIV-positive people when natural disasters strike. Some of these feature cooperation between government health services, international donors and NGOs. For example, soon after a powerful earthquake struck Peru in August 2007, the Ministry of Health sent two medical teams to visit affected areas with the mission of verifying health conditions of HIV-positive people and people living with multi-drug resistant tuberculosis, and to meet with sex workers. The teams brought with them anti-retroviral medicines and condoms to make up for short supplies. The initiative was supported by the Global Fund to Fight AIDS, Tuberculosis and Malaria through CARE Peru, whose national coordinator commented, "Our primary goal is to help ensure that patients continue to take their medications so that the micro-organisms don't become resistant to the point that the anti-retroviral medicines no longer have therapeutic value" (CARE, 2007).

It is a commonplace of HIV programming that political leadership and support are essential if interventions are to be succesful. This appears to be equally true in efforts to keep HIV high on the list of priorities in disaster responses and to ensure that responses are truly multisectoral. A good example of both leadership and multisectoral approaches can be seen in Mozambique after Cyclone Flavio battered several provinces in late February 2007, and was followed by serious flooding. On 5 April the National AIDS Council convoked a high-level meeting in Chimoio (the capital of Manica province) under the banner of "HIV/AIDS and disaster: a double emergency"; chaired by the prime minister, the meeting was attended by several ministers, senior civil servants, provincial governors and representatives of municipalities. The meeting launched an emergency programme to support HIV/AIDS projects in the flood- and cyclone-affected areas, and ended with the governors signing a joint document detailing five priority areas for action: coordination; home-based care and treatment; nutrition for people living with HIV and AIDS; child protection; and prevention among children and young people. The meeting coincided with other meetings to coordinate resettlement plans for the affected areas, which involved the National Institute of Disaster Management and UN representatives.

Preparation for natural disasters is, of course, essential both in making emergency responses more effective and in strengthening the resilience of populations to cope when disaster strikes. A variety of activities are necessary to prepare for natural disasters, as is stressed by the Hyogo Framework and other international guidelines (see Chapter 3). Again, a review of news and agency reports suggests these guidelines are being taken on board.

An important trend in preparedness management in areas of high HIV prevalence is the adoption of integrated approaches which feature a mixture of classical development projects, emergency planning and HIV prevention. A good example can be seen in the countries surrounding Lake Victoria in eastern Africa, where an integrated pro-

gramme has been implemented by the International Federation with funding from the Swedish International Development Agency. The Lake Victoria Programme involves five countries – Burundi, Kenya, Rwanda, Tanzania and Uganda – each of which is either on the lake or tied to it by the Kagera River. The area faces a variety of problems including deterioration of water quality in the lake, occasional flooding, soil loss and deforestation (which contribute to the flooding) and high levels of HIV infection – up to 35 per cent prevalence in some places. The programme therefore includes a range of activities. Some projects focus on income generation to alleviate chronic under-employment, including environment-focused activities such as tree planting to fight soil loss and to mitigate the impacts of human-caused deforestation. Water control is an important part of the programme, with a great emphasis on community-built ditches and canals to take water overflow and avert flooding. Specific emergency preparation is included such as training of Red Cross lifesaving action teams, capable of intervening in case of disasters such as floods, but also fishing and other boating accidents. Finally, many of the interventions are health related, including hygiene and sanitation projects, and HIV prevention efforts appropriate to the generalized epidemics present in these countries (International Federation and Swedish Red Cross, 2007).

In areas where slow-onset disasters or chronic food insecurity coincide with high HIV prevalence, a broad development orientation now informs most guidelines for humanitarian assistance. For example, *Food Assistance Programming in the Context of HIV*, a recent high-level document jointly produced by the US Agency for International Development, the Academy for Educational Development and the World Food Programme (WFP) advises:

> "Developing food-assisted livelihood programs in the context of HIV does not mean altering activities to serve only PLHIV and affected households. In fact, implementers must keep the project's primary purpose (e.g., creating programmatically sound food security and livelihood strategies that benefit food-insecure populations) foremost in their minds."
>
> (FANTA Project and WFP, 2007)

Overall, the best approaches to HIV in the context of natural disasters is consistent with guidelines for all forms of disaster. Better emergency responses must be planned which take into account the specific epidemiological situation in the disaster area, strengthening existing institutions' ability to withstand the disaster event and restore much needed health services as quickly as possible. At the same time, the development-related aspects of HIV responses must be taken into account, particularly in areas of chronic risk, addressing the epidemic's contribution to weakening societies and economies and to undermining their ability to respond to disasters. As Paul Harvey puts it, "HIV/AIDS is a long-term crisis. Humanitarian aid has a role to play, but

agencies should recognise that it is only part of a wider response, and should be clear about what it can and cannot achieve."

Chapter 6 was written by Andrew Wilson, a freelance writer and editor specializing in public health issues. He also contributed Boxes 6.1 and 6.2. Box 6.3 was contributed by Willem van Eekelen, Head of the Policy and Research Unit for Islamic Relief Worldwide.

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CHAPTER 6

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HIV and AIDS funding: where does the money go?

Estimated annual spending on the response to AIDS in low- and middle-income countries grew from less than US$ 300 million in 1996 to US$ 1.6 billion in 2001 and then to US$ 10 billion in 2007. UNAIDS estimates that reaching the goal of universal access to HIV prevention, treatment, care and support by 2010 will require steep annual growth until the total reaches US$ 40 billion in 2010. From 70 to 80 per cent of that will be required in low- and lower-middle-income countries heavily burdened by HIV and AIDS and heavily dependent on financial assistance from donor countries (UNAIDS, 2007a).

Raising so much additional money from donor countries will not be easy. Starting with a UN General Assembly resolution in 1970, their governments have repeatedly promised to increase official development assistance (ODA) until it reaches 0.7 per cent of their gross national product (GNP) but only a few have honoured that promise. The rest have fallen far short, so there has always been a wide gap between what donor countries provide and what low- and lower-middle-income countries need to finance their progress towards an acceptable level of socio-economic development. Other international sources – foundations, non-governmental organizations (NGOs) and private businesses – have never come close to closing that gap, though some have been very generous.

Equally, there was already concern about the disproportionate share of all ODA going to only one disease when, in November 2007, UNAIDS released sharply lower estimates of HIV and AIDS prevalence and showed that the disproportion was even greater than thought. Actual spending falls far short of required spending on the full range of disease and injury in low- and lower-middle-income countries, and not nearly enough is spent on building capacity into their entire healthcare systems (MacKellar, 2005; Kates et al., 2007a).

The best hope may lie in making better use of whatever money may be available. The fact is that much – perhaps most – of the money supposedly spent on the response to HIV in low- and middle-income countries never actually reaches those countries or else, once there, is wasted on inefficient bureaucratic procedures and on programmes and projects that fail to deliver services to the people most in need of those services (UNAIDS, 2006a). Streamlining the flow of money from its source to the front line, and then spending it on interventions that work, could go a long way towards achieving the goal of universal access. Showing donors that their money is being put to good use and achieving results might convince them they should give more.

Photo opposite page: In Guinea, a health educator at a prenatal clinic encourages pregnant women to have regular HIV tests.

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Total spending on the response to AIDS

Through the UNAIDS Global Resource Tracking Consortium, a number of international and regional organizations are collaborating on gathering the baseline data for making estimates and projections of annual spending on HIV. The data come from a variety of sources but particularly from national governments, and they are often expressed in terms of budgetary intentions rather than actual expenditures and with little detail about government sources and allocations of money. Since 2005, the Consortium has been supplementing this budgetary data with National AIDS Spending Assessments.

The Organisation for Economic Co-operation and Development (OECD) tracks commitments and actual disbursements (which often lag far behind commitments) by donor governments. Their data can be cross-checked using data from recipient country governments, but the use of different categories and reporting periods means that fully accurate cross-checking is often impossible. Details typically lacking in national budgets include domestic household spending and contributions made by international, national and local foundations, civil society organizations and private businesses. Various members of the Consortium attempt to track contributions by some of those but there are major gaps.

Based on the best data available, total spending on the response to AIDS in low- and middle-income countries was US$ 8.9 billion in 2006. (Since it benefits high-income countries, too, spending on HIV vaccine and other biomedical research and development is not included in this figure.) Of that total, 44 per cent came from donor governments while the rest came in small part from other international sources but in large part from domestic sources (Kates et al., 2007b).

Domestic household overspending

A harsh reality is that the poorest people in the poorest countries are often obliged to cover the highest percentage of all HIV-related health and social costs from their own pockets. There are typically insufficient hospitals, clinics, laboratories and pharmacies in their countries, while those that exist are often understaffed, under-equipped and undersupplied (see Box 7.1). These facilities are often obliged to ask patients and their families to pay fees or to provide their own medicines, meals, clothing and bedding and attend to laundry, bathing and grooming. Equally, individuals and their families must often cover the costs of home-based care, plus support for orphans and other vulnerable children, by out-of-pocket spending.

In high- and upper-middle-income countries, government health and social security programmes often cover 80–95 per cent of the costs of HIV-related health and social care. In low- and lower-middle-income countries, combined government and inter-

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CHAPTER 7

Box 7.1 Task shifting: a human resource response to the HIV and AIDS disaster

The world is faced with a chronic shortage of health workers, particularly in sub-Saharan Africa where the World Health Organization (WHO) estimates a shortfall of 820,000 health workers (WHO, 2006a). Not only are sub-Saharan countries not training enough workers, but many highly trained workers are emigrating to meet the demand for health workers in developed countries; this is happening at the same time as the HIV and AIDS epidemic is creating huge increases in demands for health services. About 95 per cent of people with HIV and AIDS live in developing countries and nearly two-thirds of them, some 22.5 million people, are in sub-Saharan Africa (UNAIDS, 2007b).

The 2006 global commitment to scale up HIV services – with the aim of universal access to treatment for all those who need it by 2010 – has created new urgency for intensifying global action to strengthen the health workforce (WHO, 2006a). In May 2006, a WHO-organized international consultation developed a proposal for an AIDS and health workforce plan dubbed "Treat, Train, Retain" (WHO, 2006b). A crucial component of the training strategy is task shifting – that is, the rational delegation of tasks, where appropriate, to less specialized health workers in order to expand the health workforce for increased service delivery. It includes both a redistribution of tasks among existing health workers and, where necessary, the creation of new cadres to extend the workforce capacity by performing clearly delineated tasks. WHO is in the process of producing guidelines and recommendations for countries considering the adoption or expansion of task shifting for the delivery of HIV and AIDS services, and believes it provides a realistic possibility of expanding the health workforce fast enough to meet the urgent need for HIV services (WHO, 2007).

Task shifting is already being implemented in countries that face acute health workforce shortages at the same time as high HIV burdens. For example, in Malawi, non-physician clinicians and nurses prescribe anti-retroviral treatment (ART) among other services, and the scope of practice of some cadres of community health workers has been extended to allow them to perform HIV counselling and testing. Outcomes have been good in terms of significant increases in the number of people receiving ART and high levels of service-user satisfaction (Ministry of Health, Malawi, 2005). The WHO-commissioned study on task shifting reports good health outcomes, rapid increases in access to HIV services and a high level of patient satisfaction. These findings are consistent with other studies on the effectiveness of task shifting for the delivery of health services, including HIV services (WHO, 2007).

The past few years have seen improved access to anti-retroviral drugs in several African countries, bringing new challenges to community-based HIV interventions such as home-based care. In 2006, the International Federation, in partnership with WHO and the Southern Africa AIDS Information Dissemination Service, developed an HIV prevention, treatment, care and support training kit for community home-based care volunteers. With the involvement of the Zimbabwean Ministry of Health, Hospaz (the Zimbabwe Association of Hospices), Connect (a Zimbabwean training organization in family therapy and systemic counseling) and The Centre (an organization for people living with HIV), training

was launched for Zimbabwe Red Cross Society care facilitators and trainers. The toolkit comprises eight modules and provides a wide spectrum of information covering topics on basic HIV and AIDS, treatment literacy, adherence, palliative care, care for carers, treatment preparedness, counselling, nutrition and positive living. With training, volunteers involved in home-based care programmes can now meet the additional challenges they face in providing treatment-related information and follow-up to people living with HIV, along with the involvement of affected families to ensure successful treatment (International Federation, 2006).

In Malawi, Red Crossers trained using the toolkit explained:

"Our experience of the manual is that it is a very good and effective tool for skills transfer because it is centred on practical work. The manual is full of practical scenes that volunteers encounter in the community as they attend to home-based clients and the chronically ill. The manual uses five to 15 minutes' mini lectures then participants go to groups for group work that require them to demonstrate the transfer of skills to the client and guardians, then the class critiques the scene and offers constructive support on how to improve."

While the training described exemplifies adult learning methodology, this may imply a significant shift in methods currently in use to train health workers.

Task shifting is not without other challenges. The *Community Home-based Care in Resource-Limited Settings: A Framework for Action* (WHO, 2002) document proposes a health team mix of professional and para-professionals, and a mix of paid health staff and volunteers to provide care. However, the correct mix of people needed to provide universal access to HIV prevention, treatment, care and support is not clear or uniform across countries. The WHO draft task-shifting guidelines point to the fact that community health workers tasked with more than a certain number of hours per week should be paid. The question of what represents adequate remuneration remains controversial, and there is a paucity of evidence to indicate what combinations of incentives, including financial and non-financial incentives, are sufficient to motivate and retain community health workers.

The provision of community home-based care provides a special challenge to volunteer organizations like Red Cross Red Crescent Societies; volunteers often discover that the number of hours they work escalates as clients become more ill or leave orphans behind. Their workload becomes unsustainable since it is not providing their livelihood and is often contrary to a Red Cross or Red Crescent Society's policy on the number of hours a volunteer should work in a week. The International Federation in southern Africa has learned that community home-based care volunteers 'burn out' over time or can no longer sustain their workload, so continual recruitment and training of volunteers is necessary. Groups engaged in responding to the crises of human resources in health, including the International Federation, need to define a reasonable role for the volunteer in the provision of care and consider what, in the long run, might be more efficiently provided by paid community health workers. ■

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national donor contributions may cover as little as 25 per cent of the costs. Moreover, wide disparities between countries may have more to do with domestic government and donor government policy than with overall national wealth. One analysis found that out-of-pocket spending accounts for 45 per cent of all HIV-related health and social care in Kenya but only 9.4 per cent in Ghana (UNAIDS, 2006a).

In low- and lower-middle-income countries, a large majority of people are too poor to pay any more than they already pay out of their own pockets. In countries heavily burdened by HIV and AIDS, many people are already being driven deeper into poverty by loss of income and increasing expense due to illness and death. Poor people are often criticized for buying fake or quack medicines and for turning to traditional healers, but those may be the only medicines and healers available or the only ones they can afford (though such medicines are sometimes more expensive than conventional medicine). Certainly, the very poor cannot afford to pay for their own anti-retroviral treatment (ART) even when it is available, especially since access to it often involves travel and long stays far from home and work.

Domestic government constraints and waste

National AIDS spending estimates commissioned by UNAIDS have found no obvious correlation between countries' per capita spending on HIV and AIDS, their gross national products and the severity and nature of their epidemics (UNAIDS, 2006a). Some middle-income countries do not qualify for financial assistance from donors and could well afford to be spending more of their own money on HIV. They are not doing so despite the presence of epidemics among certain groups that are now breaking out into the general population. Some low- and lower-middle-income countries cannot afford to spend more of their own money but are not attracting their fair share of financial assistance from donors because they do not happen to be among the 'donor darlings' favoured, for example, by the United States President's Emergency Plan for AIDS Relief (PEPFAR).

While lack of domestic and donor government spending on HIV may be a major problem, domestic governments' misspending of their own and donors' money appears to be an even bigger problem. A number of studies commissioned by the World Bank and other agencies have found that few national AIDS plans are based on sound evidence. As a result, much of the available money is wasted on interventions that do not address the real needs of the people actually living with HIV or at highest risk of infection (Mullen, 2005).

Waste occurs because national AIDS planning, budgeting and implementation fail to:
- **Put people living with HIV and those most at risk of infection at the very centre of the response to HIV.** The whole response should revolve around their needs. Their representatives – chosen by them and accountable to them – should

be at the table first, last and always whenever needs are being assessed, plans and budgets are being formulated and revised, programme and project proposals are being considered, funding decisions are being made, and monitoring and evaluation of results are taking place (see Box 7.2).

- **Build on the strengths of existing service providers.** No matter who owns, operates or funds them, the hospitals, clinics, laboratories, pharmacies and social service agencies that already provide health and social services should also be at the centre of the response to HIV. Determining how to scale up access to HIV prevention, treatment, care and support can be done largely through discussion and negotiation involving them and the people living with HIV and those most at risk of infection.

- **Build on the strengths of the country's own experts and research institutions.** Country- and community-based experience, including life experience from birth, is often a significant part of the expertise relevant to understanding and addressing difficult health and social problems, especially ones involving anything as politically, socially and culturally sensitive as people's sexual behaviour. As a general rule, international experts and research institutions will contribute more if they work in partnership with country- and community-based experts and institutions and engage in two-way transfers of knowledge and skills.

- **Keep building up a body of ever more comprehensive, reliable and up-to-date evidence.** A sound response to HIV is one firmly based on the following types of evidence, much of it country-specific:

  - **Biomedical evidence.** Biomedical scientists are constantly discovering new information about HIV, new mutations of the virus, factors that contribute to transmission, how transmission can be prevented, how opportunistic infections can be prevented and treated, and so on.

  - **Serological and behavioural evidence.** Sentinel surveys at antenatal clinics and other selected sites can track trends in an epidemic. However, periodic population-wide serological and behavioural surveys are necessary in order to identify groups within the population that may be at risk and the factors putting them at risk. In addition, there should be special surveys covering groups that may be hard to identify and question in population-wide surveys, including injecting drug users, men who have sex with men, migrant workers, people displaced by disasters, trafficked people and sex workers.

  - **Evidence about legal, political, cultural, social, economic and other factors.** In many countries, injecting drug use and male-to-male sex are common in prisons. In some countries, doctors are rough and disrespectful of women and girls and especially of those who are poor or come from certain castes or racial and ethnic groups. Systematic study of these and other phenomena – lack of human rights legislation and enforcement – can identify factors that put people at risk of infection and deny them access to appropriate HIV prevention, treatment, care and support.

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- **Evidence about service providers and their needs for capacity-building.** When there is money available, more than enough organizations will step forward to claim their share by saying they represent or serve people living with HIV or at high risk of infection. Any such claims should be subject to scrutiny by the legitimate in-country representatives of at-risk groups and by known and established in-country service providers with solid records of achievement. Once the appropriate service providers have been identified, then their needs for capacity-building should be specified. They may, for example, need to build relations with organizations representing marginalized groups and learn how to meet these groups' unique needs for services.

- **Economize wherever possible and insist on evidence-based, results-driven programmes and projects without wavering.** Building on the strengths

Box 7.2 Cameroon's unwed young mothers provide effective, low-cost and sustainable HIV prevention to girls

Under the Federal Ministry for Economic Cooperation and Development, Germany's five development cooperation organizations aim to support effective, low-cost and sustainable responses to HIV. In Cameroon, one such response began in 2000 after a study found that the country's adolescent girls were following worldwide trends, i.e., towards sex before marriage, early sexual initiation and multiple sexual partners. This puts them at high risk of getting pregnant, being removed from schools, having unsafe abortions, being forced into early marriage and acquiring sexually transmitted infections including HIV. Gender inequality adds to their vulnerability.

By comparison to their countrymen, Cameroon's women are considerably poorer, less educated, less informed about sex and less likely to do what is necessary to prevent pregnancy and infection. On average, they are much younger than their male partners and are often subject to coercion and violence by men.

Born and raised in Cameroon, Flavien Ndonko studied anthropology in Germany and then returned to work with the Germano-Cameroon HIV and AIDS Programme. He understood the cultural background to the study's findings. A girl's 'innocence' is so valued that, when she reaches puberty, her female relatives sometimes 'iron' her breasts to make her unattractive. This extremely painful procedure involves binding a girl's breasts with heated towels then pounding and rolling them flat with stones, wooden pestles or coconut shells. It leaves permanent tissue damage and, sooner or later, may lead to infection, cysts, cancer and the need for breast removal. Whether or not her breasts have been 'ironed', if a girl gets pregnant she is likely to be shunned by her peers and the rest of her community. Her own family may cast her out.

Nadège's story

Nadège was 16 and still at school when her parents sent her to a close family friend and neighbour for tutoring. He made sexual advances and she was, by her own description, "so naïve" and afraid that she could not

resist or tell anyone. When she missed her periods, she told only him. He gave her drugs to induce abortion but they did not work. When her parents noticed she was pregnant, they told her uncle and he beat her so severely that she ran away from home. When she tried to return, her parents took her to a distant crossroads and threw ashes on her to show, in the way of their village, that she was effectively dead and could never come home again. She could not return to school because her uncle would no longer sponsor her.

While cultural traditions may be hard on girls, they can also suggest ways of bridging the gap between the old way of life and the modern one. In Cameroon, a girl's auntie used to be her trusted confidante, teacher and counsellor in sexual matters, which were considered too embarrassing to be discussed with her parents or any other adult. Urbanization, modern transportation and communications, the globalization of youth culture and disparities between rich and poor have undermined that tradition. Now, aunties often live far away but, even if nearby, are no longer equipped with the knowledge or personal experience to help girls cope with the pressures, temptations and risks of modern life.

Ndonko and his colleagues based the Aunties' Programme on that old tradition. It aims to restore self-respect and confidence to unwed young mothers and provide them with the knowledge, skills and mutual support they need to conserve their own sexual and reproductive health and otherwise take care of themselves and their babies. It also aims to turn them into surrogate aunties, with useful roles in their families and communities. Like traditional aunties, these new aunties speak from their own experience as girls who have 'made mistakes' and suffered the consequences. They do not presume to judge or moralize when engaging other girls in frank discussion about their personal lives.

Launched in 2001, the Aunties' Programme has been established in more than 140 villages and urban neighbourhoods and it continues to grow. Its introduction into each new place starts with requests for permission and support from that place's government, health and education authorities. Programme staff make sure these authorities know the budget is small and that success will depend on their donations of space and staff (e.g., doctors to talk about HIV and how to prevent it) for training courses and meetings.

A team – headed by a social worker or social scientist but consisting largely of aunties trained and experienced in other communities – then begins to identify and interview unwed young mothers. Each one is asked to urge any others they know to come forward for interviews. The interviews are aimed at collecting information on their health and sexual histories, informing them about the Aunties' Programme and inviting them to attend a basic training course to be held in their village or neighbourhood soon afterwards. The three-day course provides the new recruits with knowledge and skills to avoid sexually transmitted infections and unwanted pregnancy and to qualify as aunties.

On the last day, the new aunties are given models of a constitution, electoral code and set of rules for a local Aunties' Association. They are urged to take time to study, discuss and revise these until they are ready to vote on versions for their own association and then nominate and elect their officers. The aim is to empower them but, since they are inexperienced at democratic governance, programme staff remain on call for advice and conflict resolution until they are ready to manage on their own.

Each Aunties' Association serves as a mutual support group but each auntie is also encouraged to engage other girls – for example, in her family, neighbourhood, church or mosque – in conversation about sex and HIV. Those who demonstrate their skill at relating to groups of girls are provided with a set of tools for organizing and delivering a series of presentations in schools, with each presentation focusing on one subject (e.g., puberty); the series adds up to a course on sexual and reproductive health and HIV. As they gain more experience, roughly one in ten aunties attends an additional five-day course in counselling adolescent girls and boys, individually and in couples, and helping them solve problems such as what to do when your partner refuses to use a condom.

There are now more than 140 local Aunties' Associations and 7,000 trained aunties. Five hundred are skilled and experienced at sex education in schools and, working in pairs, they can reach up to 48,000 students a year. Seven hundred are trained counsellors and, collectively, they can counsel around 10,500 adolescents each year.

The programme covers some out-of-pocket expenses (e.g., for baby sitters and travel) and pays the occasional honorarium for special assignments but, in general, the aunties work as volunteers and the programme costs are very low. For example, the cost of basic training varies from €2 to €20 (US$ 3–30) per new recruit and the cost of counsellor training varies from €170 to €250 (US$ 258–380) and may be lower in future, as previously trained aunties who have returned to school, achieved their 'A levels' and gone on to university take over from independent consultants.

The programme is constantly improving its monitoring and evaluation procedures. Questionnaires administered before and after training courses and school presentations, and then repeated months later, indicate a high level of success, considering how difficult it is to change people's behaviour. Recent results show that, before basic training, only 26 per cent of unwed young mothers use condoms on a regular basis but after training, 47 per cent do.

Before basic training, only 39 per cent know their HIV status but after training 48 per cent do and during training as counsellors around 90 per cent do. (Basic training takes place within their own communities but counsellor training takes place elsewhere, where they are more willing to take up offers of testing because they are more confident that no one they know will learn the results.) After becoming aunties, one-fifth return to school and two-thirds take other action (e.g., becoming apprentices or starting a small business) to improve their financial situation.

The results achieved by the aunties' school presentations are sometimes dramatic. In one school, 30 girls dropped out due to pregnancy in the year *before* a series of aunties' presentations and none dropped out the year *after*. Anecdotal evidence suggests that counselling is also effective. It most often focuses on the correct use and benefits of condoms but frequently focuses on morning-after pills, safe and early termination of pregnancy and sexual harassment and rape. Some Aunties' Associations have laid charges against male offenders and have reduced the incidence of sexual violence in their communities by letting potential offenders know there is a good chance they will be named and shamed or prosecuted.

In 2005, Cameroon's local Aunties' Associations established the National Network of Aunties' Associations (RENATA) and it has

mounted campaigns to ban breast 'ironing', gender inequality and sexual exploitation and abuse of girls. RENATA has done much to improve the self-respect and confidence of all aunties. Auntie Madeleine Songo puts it this way: "After I was on television my family and the neighbours went crazy. Everybody wanted to talk to me, to listen to me." ■

of existing country- and community-based human resources and infrastructure is the best way of making good use of whatever financial resources may be available and also of leaving a legacy of sustainable health and social service provision that addresses not only HIV and AIDS but the full range of disease and injury. When so little money is available, it should be focused on efforts to accelerate access to HIV-related services as quickly as possible. While politicians have critical roles to play in providing leadership, legislation and overall HIV policies and budgets, the administration of policies and budgets should always be done at arm's length from politicians so they cannot divert money to their own pet programmes and projects or to those favoured by their supporters.

■ **Include the response to HIV and AIDS in humanitarian situations.** A recent study by UNAIDS and the Office of the UN High Commissioner for Refugees (UNHCR) looked at 28 countries spread through all regions of Africa where conflict and natural disasters have displaced millions of people and brought them into contact with host populations, soldiers and aid workers (UNAIDS and UNHCR, 2005). All but three of the countries had national AIDS plans, but a third of the plans made no mention of refugees and more than half made no mention of activities for addressing their needs. These omissions reflected the failure to look for international financial assistance for such activities. In their joint publication, *Strategies to support the HIV-related needs of refugees and host populations*, UNAIDS and UNHCR recommend that humanitarian organizations join with national AIDS authorities, the Global Fund to Fight AIDS, Tuberculosis and Malaria and the World Bank's Multi-Country AIDS Program for Africa (MAP) in taking responsibility for ensuring that the needs of people in emergency situations are taken into account when proposals for funding are developed and approved. They also recommend that humanitarian funding be combined with other funding in those parts of national AIDS budgets that address HIV and AIDS in emergency situations (UNAIDS and UNHCR, 2005).

Civil society's contributions

Most high-income countries deliver significant portions of their health, education, social and other community services through financial agreements with civil society

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organizations, including faith-based ones. A recent analysis of data from eight high-income countries found that these organizations contribute added value (not counting government contributions to their budgets) averaging 22 per cent of their health sector economies, 20 per cent of their education sector economies and 19 per cent of their social services sector economies (Salamon et al., 2007).

In 2006, the 22 high-income countries that are members of the OECD's Development Assistant Committee (DAC) channelled US$ 5.4 billion or 5.2 per cent of all of their ODA through international, national and community-based civil society organizations (OECD, 2007c).

Many of these organizations were able to collect money from other external sources and most added considerable value of their own, including donations of money, time, energy, skills, working spaces, equipment and supplies by their own members and volunteers.

At present, there is insufficient data and analysis on which to base even the most approximate estimates of the sources of money flowing through each of the three levels (international, national and community-based) of civil society organizations engaged in the response to HIV, globally or country-by-country.

Nor is it possible to estimate roughly in financial terms how much value they add through their own contributions. The evidence suggests, however, that the value they add is very considerable (see Box 7.3).

For example, the Christian Health Associations of Africa collaborate with ministries of health on providing 40 per cent of national health care in Kenya and Lesotho, 45 per cent in Zimbabwe, 47 per cent in Liberia and 48 per cent in Tanzania (Dimmock, 2005).

In 2004, the treatment rights group Sidaction surveyed 274 community-based organizations in 45 African countries and found that 68 were prescribing ART, 133 were providing medical follow-up, 156 psychosocial follow-up, 159 education and information on managing the side effects and 141 treatments for opportunistic infections (Sidaction, 2005).

Many civil society organizations are concerned that too often they are not invited to participate in international and national mechanisms where decisions are made about where and how to spend money on HIV. They believe that their financial invisibility may be a reason for this and are collaborating through the International Council of AIDS Service Organizations (ICASO), the International HIV/AIDS Alliance and the UNAIDS Global Resource Tracking Consortium to rectify this situation.

Box 7.3 The importance of community-based organizations: the example of the Treatment Action Campaign's work in Khayelitsha, South Africa

By late 2004, Andile Madondile had been very sick for many months. He suffered from constant diarrhoea, debilitating headaches, shingles and numerous other conditions. He had lost weight and was extremely weak. Yet although he knew something was terribly wrong, the thought that he had HIV – which was confirmed when he finally decided to get tested at a clinic in Khayelitsha, the township in Cape Town, South Africa, where he lives – was terrifying. HIV was not only a death sentence, he believed, but would forever mark him as a person to be shunned and isolated in his community. Was it worth knowing the truth and the subsequent likelihood of experiencing emotionally draining stigmatization? Or better to continue on in ignorance, even if that meant risking almost certain death?

Now 30 years old, Madondile chose the former option, which is why he is still alive more than three years later. It has not been an easy time for him nonetheless. At the time he tested positive, he was living with family members including his mother and some siblings. Confirming his worst fears about HIV-related stigma, several important people in his life reacted quite negatively to the news. He said his partner, with whom he had a daughter (then 3 years old), "ran away". His brother and sister refused to share utensils with him and recoiled from touching him or even being near him. He eventually moved to live by himself elsewhere in Khayelitsha.

Madondile said two developments helped him survive such trauma: his health improved dramatically after he began taking ART in March 2005, and shortly thereafter he joined the local branch of the Treatment Action Campaign (TAC), a South African NGO that offers a wide range of HIV prevention and care services in addition to playing a leading advocacy role on behalf of people affected by HIV. Madondile credits the support and encouragement he has received from TAC with helping him regain confidence, stay healthy and eliminate the shame and despair that followed his HIV diagnosis.

TAC is one of the most well known of the civil society organizations (CSOs) that are directly engaged in responding to the HIV epidemic in South Africa. It is the world's largest in terms of absolute numbers of HIV-positive members. Unlike TAC, which has branches around the country, the majority of CSOs are not only much smaller and localized, but also operate on shoestring budgets (if they have any formal budget at all). Accurate estimates of the total number of community-based groups are difficult to obtain because they vary so greatly. Groups of all shapes, sizes and focus areas are formed and become inactive on a regular basis. At one extreme, some are entirely composed of volunteers, raise no money and do not register with authorities.

Regardless of their size and scope, CSOs provide a variety of HIV-related education, prevention and care services that resource-strapped and overwhelmed governments are unable or unwilling to offer. In many settings, especially isolated rural areas, HIV-affected individuals and families must turn to small community-based groups for even the most basic assistance because public sector health and social services are inadequate, inconvenient to access or simply unavailable.

Results from a 2005 survey of community-based groups in South Africa indicated that the HIV-related care and support services most

commonly offered by such groups included "counselling, emotional care, support for [people living with HIV], promoting community care, support groups, and support to families and caregivers". A smaller number of CSOs were able to "provide more specialised care and support functions such as nutrition support, support to orphans and vulnerable children, home-based care, and income-generation projects" (CADRE, 2005).

According to Mandla Majola, the district coordinator of TAC's Khayelitsha branch, the organization's current activities at the grassroots level include organizing and hosting support groups for HIV-positive individuals and their families, distributing condoms and prevention information, raising awareness about, and seeking care for, victims of gender-based violence and working closely with smaller CSOs in the township that focus specifically on issues such as home-based care and services for AIDS orphans.

TAC's Khayelitsha branch has just five full-time staff members. That it still manages to reach thousands of people points to one of TAC's greatest strengths: nearly all of its activities, from outreach to advocacy to peer education, are undertaken by a small army of volunteers.

Madondile is just one of the more than 1,000 TAC volunteers in Khayelitsha alone. Most, like him, are HIV positive themselves and open about their status. Such openness is not required, but it is encouraged as part of the organization's broad and ongoing campaign to reduce HIV-related stigma. TAC is famous for another high-profile effort: encouraging as many people as possible, HIV-positive or not, to wear t-shirts proclaiming 'HIV-positive' in huge letters. Thousands of 'normal' South Africans at the community level sport them regularly and prominent individu-

als around the world, from former President Nelson Mandela to singer Annie Lennox, have made a point of being photographed wearing one.

Another TAC volunteer, 43-year-old Michael Hamnca, said the climate of openness is crucial to helping connect people in need with the services available to them. He said he and his colleagues often go to clinics, wearing their 'HIV-positive' t-shirts if possible, and hand out information about ART, opportunistic infections and tuberculosis to people waiting to see doctors and nurses. They present themselves as HIV positive and mention where, when and how to find support groups for a wide range of HIV-related issues. Both Hamnca and Madondile said that when talking to members of the community, they often stress how important the 'TAC family' has been at points in their lives when they felt lonely, isolated and oppressed because of their HIV status.

One thousand volunteers may sound like a lot, but the massive need in Khayelitsha for services offered by TAC and other CSOs is likely to continue expanding. In January 2008, some 700,000 people were thought to be living in the township, one of the poorest and most resource-constrained parts of the Cape Town metropolitan area. Every year tens of thousands move there from even poorer areas of Eastern Cape province in search of jobs and social assistance.

Majola, the TAC branch director, said recent surveys indicate that perhaps 17 per cent of Khayelitsha residents are HIV positive, a prevalence rate that mirrors the national one but is twice that of Western Cape province of which Cape Town is the capital. The majority of those already infected are not aware of the fact, he added, and awareness of prevention measures is low even as HIV-related stigma remains high.

It is individuals such as Andile Madondile and Michael Hamnca who are at the forefront of efforts to improve such indicators. Madondile said his first success occurred close to home. A few months after leaving home and joining TAC, he reached out to his brother and sister and spent weeks talking about HIV with them. He said that they now accept him again and will touch him without fear. The same tactic worked with the mother of his daughter; they were reunited within a year. The family now includes another child, born in 2006. "When people understand how to protect themselves and others, they have no fear," he said. ∎

The generosity of foundations and corporations

Funders Concerned About AIDS (FCAA) was founded in 1987 with the aim of mobilizing philanthropy in the United States to respond to AIDS domestically and internationally. By 2000, small and large foundations and corporations were committing more than US$ 300 million a year. From 2005 to 2006, their commitments jumped sharply from US$ 354 million to US$ 979 million while their actual disbursements rose from US$ 346 million to US$ 504 million. This sharp increase was largely driven by the Bill & Melinda Gates Foundation, which accounted for 38 per cent of all commitments in 2005 but 75 per cent of all commitments in 2006. The top ten funders accounted for 90 per cent of all commitments in 2006 (Funders Concerned About AIDS, 2007).

From 2005 to 2006, the proportion of all commitments going to the international response increased from US$ 233 million (66 per cent) to US$ 882 million (90 per cent). Even more impressive was the fact that, while in 2005 53 per cent of all commitments to the international response went to organizations based in North America, only 15 per cent did so in 2006 (see Figure 7.1 for details). Much of the foundation money went towards strengthening the civil society response and increasing the availability and uptake of HIV testing and treatment.

The European HIV/AIDS Funders Group acknowledges that European foundations and corporations have, collectively, been less generous than those in the United States. One of the problems is lack of transparency, making it hard to get information on foundation and corporate giving in many European countries. The group is working with the UNAIDS Resource Tracking Consortium in order to provide a more comprehensive picture of what sums European philanthropy contributes to the AIDS response in low- and middle-income countries. At the same time, the group believes there is significant capacity for these contributions to increase. Based on the best available data, European foundations and corporations made actual disbursements in 2005 of US$ 101.2 million to the international AIDS response. Of that, 92 per cent came from the top 15 donors and 25 per cent came from the top donor, Wellcome Trust (European HIV/AIDS Funders Group, 2006).

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Donor government spending

The perpetually broken promise of more development assistance

The world's major donor countries are the 22 member countries of OECD's DAC; they give the name 'official development assistance' to their own and other countries' financial and technical assistance to low- and middle-income countries. The European Commission has its own DAC membership and also contributes to ODA, though its contributions originate with the 27 countries of the European Union of which 15 are DAC member countries.

From 2001 to 2005, gross ODA grew by 120 per cent from US$ 55 billion to US$ 122 billion. Debt relief – which costs donor countries little because it involves forgiving loans to low-income countries that are already in arrears or unserviceable – accounted for 35 per cent of the growth; aid to war-torn Iraq and Afghanistan accounted for 34 per cent and emergency assistance due to unusual emergencies accounted for another 18 per cent. If debt relief, aid to Iraq and Afghanistan and unusual emergency aid are excluded, nominal ODA increased by only 33 per cent and

Figure 7.1

Geographical distribution of funding commitments made by foundations and corporations in the United States to the international response to AIDS in 2006

Asia and Pacific
23%

USA and Canada for International
15%

Caribbean
1%

Latin America
4%

Western and Central Europe
1%

Eastern and Central Asia
4%

Sub-Saharan Africa
52%

Middle East
0%

North Africa
0%
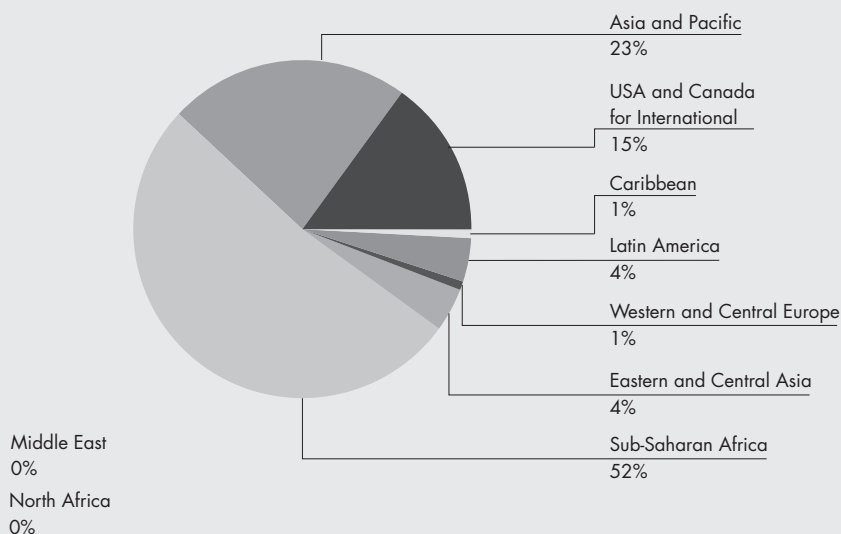
Source: Funders Concerned about AIDS, 2007

most of that increase was offset by currency revaluation and deflation (Kates et al., 2007a).

With less debt relief in 2006, gross ODA fell by 5.1 per cent to US$ 116 billion. Part of this sum came from non-DAC-member countries (e.g., non-OECD Asian and Middle Eastern countries and non-DAC members of the OECD) but the bulk came from DAC member countries. Net ODA from DAC member countries was US$ 104.4 billion (Figure 7.2a). Figure 7.2b shows the amount contributed by each and translates it into a percentage of the country's gross national income (GNI) (OECD, 2007b and 2007c).

Figure 7.2a
Net ODA by DAC member countries in 2006

Net ODA in 2006 – amounts

	US$ billion
Total DAC	104.42
New Zealand	0.26
Luxembourg	0.29
Portugal	0.40
Greece	0.42
Finland	0.83
Ireland	1.02
Austria	1.50
Switzerland	1.65
Belgium	1.98
Australia	2.12
Denmark	2.24
Norway	2.95
Italy	3.64
Canada	3.68
Spain	3.81
Sweden	3.95
Netherlands	5.45
Germany	10.43
France	10.60
Japan	11.19
United Kingdom	12.46
United States	23.53

Source: OECD, *Final ODA Flows in 2006*, 10 December 2007

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Figure 7.2b
Net ODA in 2006 as a percentage of DAC member countries' GNI

Net ODA in 2006 – as a percentage of GNI

UN target

Average country
effort 0.46

Total DAC	0.31
Greece	0.17
United States	0.18
Italy	0.20
Portugal	0.21
Japan	0.25
New Zealand	0.27
Canada	0.29
Australia	0.30
Spain	0.32
Germany	0.36
Switzerland	0.39
Finland	0.40
France	0.47
Austria	0.47
Belgium	0.50
United Kingdom	0.51
Ireland	0.54
Denmark	0.80
Netherlands	0.81
Luxembourg	0.89
Norway	0.89
Sweden	1.02

0.0   0.1   0.2   0.3   0.4   0.5   0.6   0.7   0.8   0.9   1.0   1.1
As % of GNI

Source: OECD, *Final ODA Flows in 2006*, 10 December 2007

An increasing share going to HIV

Between 2002 and 2006, DAC member countries' commitments and actual disbursements for HIV both increased more than threefold in nominal terms. From 2005 to 2006, their contributions to ODA fell by 5.1 per cent but their commitments to HIV grew by 28 per cent to US$ 5.6 billion and their actual disbursements to HIV grew by 11 per cent to US$ 3.9 million. That represented 44 per cent of the total amount (US$ 8.9 billion) spent on the response to AIDS in low- and middle-income countries in 2006.

Of the US$ 3.9 billion, the United States contributed 40.8 per cent, the United Kingdom 20.0 per cent and the Netherlands 8.9 per cent. Calculated as a percentage of

their GNI, the five top donors were, in order, the Netherlands, Sweden, Ireland, the United Kingdom and the United States. Figure 7.3 shows the shares each donor country contributed as a percentage of total spending on the response to HIV (Kates et al., 2007b).

Figure 7.3

DAC member countries' share of total 2006 spending on the response to AIDS in low- and middle-income countries

USA
17.9%

Canada
0.7%

Italy
0.1%

Ireland
1%

Netherlands
3.9%

Sweden
2%

Germany
1.9%

European Community
1.9%

Japan
1.2%

Other governments
2.1%

UK
8.8%

France
2.3%

10.9% Non-G8 donor governments and European Community (EC)

32.9% G8 donor governments and EC

56.2% All others sources, including multilateral, domestic from low- and middle-income country governments, private and household expenditures (out-of-pocket), international foundations and international NGOs

Source: Kates et al., 2007b.

Allocations to multilateral institutions

When the Global Fund to Fight AIDS, Tuberculosis and Malaria was launched in January 2002, the hope was that much of its money would come from foundations, businesses and other non-governmental sources. In fact, the Global Fund has been largely dependent on donor country governments. Over the six years from its launch to the end of 2007, it received US$ 17.9 billion in pledges and US$ 9.2 billion in actual contributions of which 95.5 per cent came from donor countries. During that time, it approved almost US$ 10 billion in grants and disbursed US$ 7.7 billion to grant

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recipients. Of its grants, 90 per cent went to low- and lower-middle-income countries and 58 per cent to HIV work (Global Fund, 2007).

Of the US$ 3.9 billion of ODA from DAC member countries that was disbursed to AIDS in 2006, US$ 0.943 billion (24 per cent) went to the Global Fund specifically to finance grants for AIDS. See Figure 7.4 for the shares contributed by each country.

Figure 7.4

DAC member countries 2006 contributions to the Global Fund to finance grants for programmes and projects addressing AIDS

US$ 0.943 billion

Country	Share
USA	28.5%
Ireland	1.6%
Netherlands	4.7%
Sweden	5.1%
Germany	5.4%
European Community	7.2%
Japan	8.0%
Other governments	10.2%
UK	11.6%
France	17.7%
Italy	0%
Canada	0%

Source: Kates et al., 2007b.
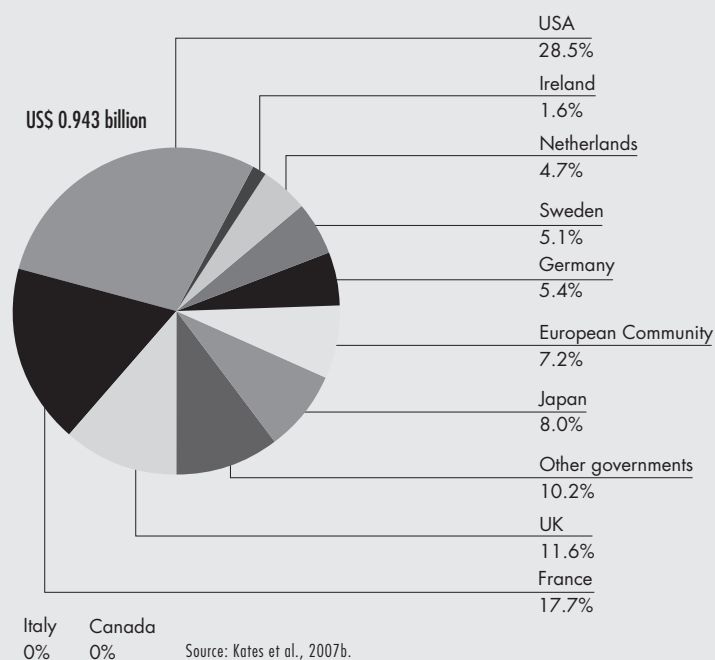
Approximately one-third of the US$ 3.9 billion went to UNAIDS and its ten co-sponsors. Their two-year budget for 2006–2007 was US$ 2.6 billion and, of the ten co-sponsors, the four given the largest shares were the World Bank (32 per cent), UNICEF (18 per cent), the World Health Organization (13 per cent) and the World Food Programme (8.4 per cent) (UNAIDS, 2006b).

Next to the Global Fund, the World Bank is the world's largest multilateral donor to HIV work in low- and middle-income countries, through its Multi-Country HIV/AIDS Program for Africa, MAP for the Caribbean and other development programmes. Since 2002, it has committed around US$ 1.9 billion in grants, low-inter-

est loans and credits to HIV work and has disbursed around US$ 1 billion of that amount (World Bank, 2007).

Bilateral spending on HIV

On average, DAC member countries allocate far more of their ODA to bilateral spending than to multilateral institutions so that bilateral spending has been anywhere from two to four times more important than multilateral spending each year since 2000. The urgent need to respond to HIV and the existence of UNAIDS and the Global Fund have meant that, on average, DAC member countries have allocated comparatively more ODA for HIV to multilateral institutions than to bilateral financial and technical assistance. However, practice varies widely from one DAC member country to another.

The United States, in particular, has a strong preference for bilateral spending of all ODA, including ODA for HIV. In 2006, it committed more than US$ 3 billion to spending on the response to HIV in low- and middle-income countries and disbursed around US$ 1.6 billion. While it made a large contribution to the Global Fund, it disbursed around US$ 1.3 billion through the President's Emergency Plan for AIDS Relief so that its bilateral disbursements far exceeded the Global Fund's disbursements for HIV and also accounted for more than half of all bilateral spending on HIV (Kates et al., 2007b; PEPFAR, 2007).

How effective is donor government spending?

A number of organizations monitor and critically evaluate the spending of ODA in general and of ODA for HIV in particular. The UN Development Programme's *Human Development Report 2005* focused on aid effectiveness and found much room for improvement. The same was true of a 2006 OECD survey to assess how far bilateral agencies and multilateral institutions had to go before they lived up to the principles in the Paris Declaration on Aid Effectiveness (UNDP, 2005; OECD, 2007a). A few of the many other recent assessments have come from ActionAID (ActionAid, 2007), the Center for Global Development HIV/AIDS Monitor (Bernstein et al., 2007; Ootaman, Bernstein and Rosenzweig, 2007), the Centre for AIDS Development and Research Evaluation (Birdsall and Kelly, 2007), the International Gay and Lesbian Rights Association (Johnson, 2007), Oxfam (Oxfam International, 2007) and Save the Children (Foster, 2005).

Opportunities for action

The discussion and the recent assessments mentioned above point to a number of opportunities for action by donor governments and the other international, national and local partners in the response to HIV and AIDS. They include:

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- **Stop tying aid.** Tied aid occurs when grants, credits and loans are given on condition that recipient countries use the money to purchase supplies and services from donor countries or their friends, or when the direct offer consists of supplies or services, in lieu of money. It may help donor countries build or maintain historic ties, trade relations and political alliances and, also, provide jobs for their own nationals and subsidies for their own industries, universities, civil society organizations and consulting firms. However, it deprives recipient countries of much of the value of aid when supplies and services from donor countries are not what they really need, are more expensive or less appropriate than those they might find on the open market, or might be provided by their own industries, universities, civil society organizations and consulting firms and leave legacies of improved capacity. Since its inception in 1961, the OECD's DAC has been urging its member countries to untie ODA and, in 2001, it recommended rapid progress toward that goal. Its 2006 progress report found that 16 of the 22 member countries had untied 80 to 100 per cent of ODA to the least developed countries, while Canada, Austria and Germany had untied more than 60 per cent but that Greece, New Zealand and the United States lagged far behind. Around 97 per cent of ODA from the United States to the least developed countries – including ODA channelled through PEPFAR – is tied aid. Largely due to tying by the United States, 58 per cent of all ODA to the least developed countries continues to be tied aid and only 27 per cent of ODA-related contracts for those countries go to in-country suppliers (OECD, 2006).

- **Stop earmarking aid.** Aid is said to be earmarked when grants, credits and loans are given on condition that they are spent for specific purposes that may not be of highest priority to recipient countries. The earmarking of ODA for HIV has become a matter of some controversy, since it has resulted in some countries spending far more on HIV than they do on other health conditions that impact more heavily on their populations. It has also resulted in some comparatively well-off countries getting large amounts of ODA for HIV, while poorer countries go without ODA to meet their urgent needs for healthcare. Between 2001 and 2005, the increase in ODA going to health kept pace with the increase in total ODA but the percentage going to HIV increased while the percentage going to some other critical areas of health decreased. By 2005, the five largest shares of ODA for health were large-system water supply and sanitation (19 per cent), HIV/AIDS and other sexually transmitted disease (16 per cent), health policy and management (11 per cent), infectious disease control (10 per cent), and basic healthcare (9 per cent). Spending on health training and personnel development had declined by 36 per cent to US$ 0.1 billion, or around 0.6 per cent of all ODA for health in 2005. Not nearly enough was was being spent on recruiting, training and retaining health workers, on building, equipping and supplying hospitals, clinics, laboratories and pharmacies, or on establishing national health insurance schemes (MacKellar, 2005; Kates et al., 2007a).

- **Simplify, harmonize and coordinate procedures.** Ashraf Ghani, Afghanistan's former finance minister and now Chancellor of Kabul University and Chairman of the Institute for State Effectiveness, estimates that US$ 5 billion of ODA is spent on technical assistance to help countries apply for, administer and account for grants, loans and credits (Ghani et al., 2007). The main reason for this is that bilateral, multilateral and other international donors do not harmonize and coordinate their procedures but, instead, have many separate procedures, many of them complicated and requiring frequent donor missions to countries. In 2005, for example, donors sent 791 missions to Viet Nam and only 76 of these were coordinated to serve the purposes of more than one donor (OECD, 2007b). These missions used up millions of the dollars counted as ODA for Viet Nam, and not just in salaries, fees and travel expenses for the donors' representatives and their consultants. Existing and potential Vietnamese recipients were obliged to prepare for these missions and to spend valuable time showing foreign delegations around and explaining their programmes and projects.

- **Provide sustained and predictable aid.** Donors' policies often limit them to providing fixed-term financial and technical support and often mostly to programmes and projects in which their own suppliers are directly involved. What low- and middle-income governments and their health, education and social service providers really need is sustained and predictable financing that increases over time plus, in some cases, technical support from the best available suppliers and preferably from suppliers within their own countries or regions (UNAIDS, 2006a).

- **Insist on responsible financial management.** Most low- and middle-income country governments and their service providers meet public expenditure management standards but some do not. When they do not, it is a disservice to the people of those countries to allow money to be mismanaged. It is also a disservice to the people of those countries to allow foreign governments and corporations to encourage and sustain corrupt practices by offering or tolerating bribes and kick-backs.

- **Apply the principles in the Paris Declaration on Aid Effectiveness.** Made in 2005, the declaration calls for country-led cooperative development processes in which all local, national and international partners collaborate on the mobilization of resources in a coordinated, efficient, effective and sustainable manner. It recognizes low- and middle-income countries' rights to self-government but their need for assistance in building their capacities for effective and responsible self-government (OECD, 2005).

- **Insist on an evidence-based, results-driven response to HIV.** Earlier in this chapter, under the heading 'Domestic government constraints and waste', a list is presented of things national governments and their partners should do but often fail to do when planning, budgeting and implementing responses to HIV. This list indicates the main things that need to be done to ensure that a response to HIV is based on the best possible evidence and achieves the best possible results.

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Chapter 7 was written by Stuart Adams, an independent consultant, who has been doing applied social, health and cultural research, planning and writing for three decades. In recent years, his work has focused mainly on the impacts of and response to the AIDS epidemic in low- and middle-income countries. He also wrote Box 7.2. Box 7.1 was written by Pat McLaughlin, Director of Technical Management at the American Red Cross. Box 7.3 was written by Jeff Hoover, who is a freelance researcher, editor and writer based in New York, USA and Cape Town, South Africa.

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Disclaimer

The data and opinions expressed in these annexes do not necessarily represent the official policy of the International Federation of Red Cross and Red Crescent Societies or of individual National Red Cross or Red Crescent Societies. For further information regarding the figures, data and analysis provided in Annexes I and II, please contact the Centre for Research on the Epidemiology of Disasters (CRED), UN International Strategy for Disaster Reduction (UNISDR) and the US Committee for Refugees and Immigrants (USCRI).

ANNEXES

Disaster data

According to the Centre for Research on the Epidemiology of Disasters (CRED), 405 natural disasters were reported worldwide in 2007, as opposed to 423 in 2006. Although the number of people reported killed (16,679) was the lowest for a decade (and was much lower than 2004, when reported deaths reached 242,000, mainly due to the Indian Ocean tsunami), the number of people reported affected by disasters in 2007 rose to 201 million, a 40 per cent increase compared to the previous year.

By contrast, in 2007, the number of technological disasters and their impact were the lowest for a decade. A total of 252 technological disasters were reported; the death toll decreased to 6,488; and the number of people reported affected (47,000) showed a significant decrease of 70 per cent compared to 2006.

The combined total of 23,167 people killed by natural and technological disasters in 2007 was the lowest of the decade, far below the decade's average of 113,000. Natural disasters accounted for 71 per cent of the fatalities. The deadliest disaster last year was Cyclone Sidr, in Bangladesh, which resulted in the deaths of 4,234 people.

Natural disasters were responsible for the overwhelming majority of the 281 million people reported to be have been affected by all disasters in 2007.

During 2007, 18 disasters (nine floods, four windstorms, four drought or food insecurity events and one wildfire) affected more than 1 million people each. With the exception of three droughts in Africa, all of these disasters occurred in Asia. Among these, one flood affected over 100 million people in China and two others affected more than 10 million in India and Bangladesh.

The cost of damage inflicted by natural disasters last year was estimated at nearly US$ 63.5 billion – 34 per cent below the decade's average. Of the costs reported, windstorms accounted for almost 40 per cent of the total and floods for more than a quarter. The damages from the Niigata earthquake (US$ 12.5 billion) represented almost one-fifth of all reported damages. Fourteen disasters accounted for more than US$ 1 billion in damages.

EM-DAT: a specialized disaster database

Tables 1–13 on natural and technological disasters and their human impact over the past decade were drawn and documented from CRED's EM-DAT. Established in 1993 as a non-profit institution, CRED is based at the School of Public Health of the Catholic University of Louvain in Belgium and became a World Health Organization

(WHO) collaborating centre in 1980. Although CRED's main focus is on public health, the centre also studies the socio-economic and long-term effects of large-scale disasters.

Since 1988, with the sponsorship of the United States Agency for International Development's Office of Foreign Disaster Assistance (OFDA), CRED has maintained EM-DAT, a worldwide database on disasters. It contains essential core data on the occurrence and effects of more than 17,000 disasters in the world from 1900 to the present. The database is compiled from various sources, including United Nations (UN) agencies, non-governmental organizations (NGOs), insurance companies, research institutes and press agencies.

Priority is given to data from UN agencies, followed by OFDA, governments and the International Federation. This prioritization is not a reflection of the quality or value of the data but the recognition that most reporting sources do not cover all disasters or may have political limitations that could affect the figures. The entries are constantly reviewed for redundancies, inconsistencies and the completion of missing data. CRED consolidates and updates data on a daily basis. A further check is made at monthly intervals. Revisions are made annually at the end of the calendar year.

The database's main objectives are to assist humanitarian action at both national and international levels; to rationalize decision-making for disaster preparedness; and to provide an objective basis for vulnerability assessment and priority setting.

Data definitions and methodology

CRED defines a disaster as "a situation or event, which overwhelms local capacity, necessitating a request to national or international level for external assistance (definition considered in EM-DAT); an unforeseen and often sudden event that causes great damage, destruction and human suffering".

For a disaster to be entered into the database, at least one of the following criteria must be fulfilled:
  - ten or more people reported killed
  - 100 people or more reported affected
  - declaration of a state of emergency
  - call for international assistance.

The number of people killed includes people confirmed as dead and those missing and presumed dead. People affected are those requiring immediate assistance during a period of emergency (i.e., requiring basic survival needs such as food, water, shelter, sanitation and immediate medical assistance). People reported injured or homeless are aggregated with those reported affected to produce a 'total number of people affected'.

The economic impact of a disaster usually consists of direct consequences on the local economy (e.g., damage to infrastructure, crops, housing) and indirect consequences (e.g., loss of revenues, unemployment, market destabilization). In EM-DAT, the registered figure corresponds to the damage value at the moment of the event and usually only to the direct damage, expressed in US dollars (2007 prices).

EM-DAT distinguishes two generic categories for disasters (natural and technological), divided into 15 main categories, themselves covering more than 50 sub-categories. For the production of the tables, natural disasters are split into two specific groups:

■ **hydrometeorological disasters:** avalanches/landslides, droughts/famines, extreme temperatures, floods, forest/scrub fires, windstorms and other disasters, such as insect infestations and wave surges

■ **geophysical disasters:** earthquakes, tsunamis and volcanic eruptions.

The technological disasters comprise three groups:

■ **industrial accidents:** chemical spills; collapse of industrial infrastructure; explosions; fires; gas leaks; poisoning; radiation

■ **transport accidents:** transport by air, rail, road or water

■ **miscellaneous accidents:** collapse of domestic/non-industrial structures; fires.

In Tables 1–13, 'disasters' refer to disasters with a natural or a technological trigger only, and do not include wars, conflict-related famines, diseases or epidemics.

The classification of countries as 'high', 'medium' or 'low' human development is based on the 2007 Human Development Index (HDI) of the United Nations Development Programme. For a small number of countries not appearing in the HDI, the World Bank's classification of economies by the countries' level of income is used ('high', 'middle' and 'low').

In both EM-DAT and the tables in this annex, data are considered at country level for many reasons, including the fact that it is at this level that they are reported most of the time; and also due to issues regarding possible aggregation and disaggregation of data. For droughts or food insecurity, which are often multi-year disasters, their impact over time is taken into account.

Bearing in mind that data on deaths and economic damage from drought are infrequently reported, CRED has adopted the following rules as regards data for drought:

■ The total number of deaths reported for a drought is divided by the number of years for which the drought persists. The resulting number is registered for each year of the drought's duration

■ The same calculation is done for reported economic damages

■ For the total number of people reported to be affected, CRED considers that the same number is affected each year that the disaster persists.

Some disasters begin at the end of a year and may last some weeks or months into the following year. In such cases, CRED has adopted the following rules:

■ As regards numbers of people reported affected, the total number is recorded for both the start year and the end year

■ For the numbers of people reported to be killed, CRED distinguishes between disasters which are of sudden onset (earthquakes, flash floods, landslides, etc.) and of slow onset (wildfires, some floods, extreme temperatures, etc.) as follows:

■ sudden-onset disasters: all those killed are registered according to the start year of the disaster

■ slow-onset disasters: the total of all those killed is divided by two and a half and this figure is attributed to each year of persistence

■ Reported economic damages are always attributed to the end year of the disaster. This is because damage is related to both the strength of a disaster and its duration.

By using these rules, some data bias correction is attempted. However, they are far from perfect and CRED will try to improve them, as well as the database as a whole, in the future.

Caveats

Key problems with disaster data include the lack of standardized collection methodologies and definitions. The original information, collected from a variety of public sources, is not specifically gathered for statistical purposes. So, even when the compilation applies strict definitions for disaster events and parameters, the original suppliers of information may not. Moreover, data are not always complete for each disaster. The quality of completion may vary according to the type of disaster (for example, the number of people affected by transport accidents is rarely reported) or its country of occurrence.

Data on deaths are usually available because they are an immediate proxy for the severity of the disaster. However, the numbers put forward immediately after a disaster may sometimes be seriously revised, occasionally several months later.

Data on the numbers of people affected by a disaster can provide some of the most potentially useful figures, for planning both disaster preparedness and response, but they are sometimes poorly reported. Moreover, the definition of people affected remains open to interpretation, political or otherwise. Even in the absence of manipulation, data may be extrapolated from old census information, with assumptions being made about percentages of an area's population affected.

Data can also be skewed because of the rationale behind data gathering. Reinsurance companies, for instance, systematically gather data on disaster occurrence in order to assess insurance risk, but with a priority in areas of the world where disaster insurance is widespread. Their data may therefore miss out poor, disaster-affected regions where insurance is unaffordable or unavailable.

For natural disasters over the past decade, data on deaths are missing for around one-tenth of reported disasters; data on people affected are missing for around one-fifth of disasters; and data on economic damages are missing for 85 per cent of disasters. The figures should therefore be regarded as indicative. Relative changes and trends are more useful to look at than absolute, isolated figures.

Dates can be a source of ambiguity. For example, a declared date for a famine is both necessary and meaningless – a famine does not occur on a single day. In such cases, the date the appropriate body declares the beginning and/or end of an official emergency has been used. Changes in national boundaries cause ambiguities in the data and may make long-term trend analysis more complicated.

However, in some cases, available data may differ greatly according to sources, be more or less documented estimations and/or subject to controversies. In these cases, CRED always compiles all available data or analysis to try to make its own documented estimation, which can be revised when more accurate data are provided. The famine/food insecurity in the Democratic People's Republic of Korea can be regarded as a case study. The government of the Democratic People's Republic of Korea announced 220,000 deaths from famine for the years 1995–1998. However, this number was contested by some NGOs, which gave numbers as high as 3.5 million. CRED's estimation, based on reliable documented sources, put the figures at 610,000 deaths for the period of famine/food insecurity which was considered to last from 1995 to 2002.

Information systems have improved vastly in the last 25 years and statistical data are now more easily available, intensified by an increasing sensitivity to disaster occurrence and consequences. Nevertheless there are still discrepancies. An analysis of quality and accuracy of disaster data, performed by CRED in 2002, showed that occasionally, for the same disaster, differences of more than 20 per cent may exist between the quantitative data reported by the three major databases – EM-DAT (CRED), NatCat (Munich Re) and Sigma (Swiss Re).

Despite efforts to verify and review data, the quality of disaster databases can only be as good as the reporting system. This, combined with the different aims of three major disaster databases (risk and economic risk analysis for reinsurance companies, development agenda for CRED) may explain differences between data provided for some disasters. However, in spite of these differences, the overall trends indicated by the three databases remain similar.

The lack of systematization and standardization of data collection is a major weakness when it comes to long-term planning. Fortunately, due to increased pressure for accountability from various sources, many donors and development agencies have started giving attention to data collection and its methodologies.

Part of the solution to this data problem lies in retrospective analysis. Data are most often publicly quoted and reported during a disaster event, but it is only long after the event, once the relief operation is over, that estimates of damage and death can be verified. Some data gatherers, like CRED, revisit the data; this accounts for retrospective annual disaster figures changing one, two and sometimes even three years after the event.

US Committee for Refugees and Immigrants

The US Committee for Refugees and Immigrants (USCRI) is the successor to the merged non-governmental organizations Immigration and Refugee Services of America and US Committee for Refugees. USCRI resettles refugees, reports on the situation of refugees and asylum seekers abroad, and encourages the public, policy-makers and the international community to respond effectively to their needs and to honour their rights under the 1951 Convention relating to the Status of Refugees.

USCRI travels to the scene of refugee situations to gather testimony from uprooted people, to assess their enjoyment of legal rights and to gauge governmental, civil and international responses. The Committee also works with more than 40 NGO research partners in refugee-hosting countries to gather information and to conduct advocacy. USCRI conducts public briefings to present its findings and recommendations, testifies before the US Congress, communicates concerns directly to governments and provides first-hand assessments to the media. USCRI publishes the annual *World Refugee Survey*, the monthly e-mail 'Bulletin of the Campaign to End Refugee Warehousing' and various issue papers.

USCRI provided the data in Tables 14–16. The quality of the data in these tables is affected by the less-than-ideal conditions often associated with flight. Unsettled conditions, the biases of governments and opposition groups and the need to use humanitarian aid planning estimates can each contribute to inaccuracies. The estimates reproduced in these tables were provisional as at March 2008.

Table 14 lists refugees and asylum seekers by country/territory of origin, while Table 15 lists them by host country/territory. Refugees are people who are outside their home country and who are unable or unwilling to return to that country because they fear persecution or armed conflict. But most refugees never receive formal status determinations. Asylum seekers are people who claim and, prima facie, appear to be

refugees. While not all asylum seekers are refugees, they are in need of international protection at least until it is clear that they are not refugees. USCRI also includes people granted various subsidiary forms of protection if based on factors related to the refugee definition, as distinct from, for example, protection granted because of natural disaster.

Table 16 concerns internally displaced people (IDPs). Like refugees and asylum seekers, IDPs have fled their homes, but remain in their home country. No universally accepted definition of IDPs exists, nor is it clear when their situation ceases to be of concern. USCRI generally considers people who are uprooted within their country because of armed conflict or persecution – and who would thus be refugees if they were to cross an international border – to be internally displaced. Others employ broader definitions, however, sometimes including people uprooted by natural or human-made disasters or other causes not directly related to human rights. IDPs often live in war-torn areas and are neither registered nor counted in any systematic way. Estimates of the size of IDP populations are frequently prone to great margins of error.

Philippe Hoyois, Senior Research Fellow with CRED; Regina Below, Manager of CRED's EM-DAT disaster database; and Debarati Guha-Sapir, Director of CRED prepared the sections on natural and technological disasters. For further information, please contact: Centre for Research on the Epidemiology of Disasters (CRED), School of Public Health, Catholic University of Louvain, 30.94, Clos Chapelle-aux-Champs, 1200 Brussels, Belgium; tel. +32 2 764 3327; fax: +32 2 764 3441; e-mail: cred@esp.ucl.ac.be; web site: www.em-dat.net.

The section on refugees, asylum seekers and IDPs was prepared by the US Committee for Refugees and Immigrants, 1717 Massachusetts Avenue NW, Suite 200, Washington DC 20036, USA (www.refugees.org).

Table 1 Total number of reported disasters,[1] by continent and by year (1998 to 2007)

	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	Total
Africa	80	143	202	185	196	169	164	171	199	176	1,685
Americas	126	138	152	134	157	126	138	138	103	128	1,340
Asia	222	240	303	295	306	293	319	359	304	241	2,882
Europe	76	91	130	96	114	97	98	127	97	102	1,028
Oceania	17	15	13	18	18	20	22	16	18	10	167
High human development[2]	182	191	250	200	224	198	208	214	176	183	2,026
Medium human development	291	364	426	403	460	415	442	478	420	369	4,068
Low human development	48	72	124	125	107	92	91	119	125	105	1,008
Total	**521**	**627**	**800**	**728**	**791**	**705**	**741**	**811**	**721**	**657**	**7,102**

Source: EM-DAT, CRED, University of Louvain, Belgium

[1] In Tables 1–13, 'disasters' refer to those with a natural and/or technological trigger only, and do not include wars, conflict-related famines, diseases or epidemics.

[2] See note on UNDP's Human Development Index country status in the section on disaster definitions in the introduction to this annex.

With 657 disasters in 2007 the number of disasters was the lowest since 1999.

In 2007, 37 per cent of all disasters occurred in Asia. While it remains the continent the most affected by disaster, the number of disasters in 2007 was below the average for the decade (40 per cent).

In 2007, the number of disasters for Oceania was the lowest of the decade.

Table 2 Total number of people reported killed, by continent and by year (1998 to 2007)

	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	Total
Africa	3,321	2,706	5,428	4,536	7,638	6,160	4,246	3,213	5,775	3,388	46,411
Americas	22,003	33,994	2,071	3,077	2,110	2,083	8,429	5,437	1,557	2,812	83,573
Asia	105,510	98,299	88,058	105,960	89,316	39,027	238,404	90,765	20,651	15,025	891,015
Europe	1,543	19,503	1,622	2,338	1,822	73,380	1,259	1,035	5,795	1,689	109,986
Oceania	2,245	116	205	9	91	64	35	46	24	253	3,088
High human development[1]	3,782	6,142	3,311	3,404	3,275	74,664	2,734	3,937	6,165	2,797	110,211
Medium human development	45,061	70,652	13,911	33,215	14,588	43,734	247,527	93,507	23,880	17,272	603,347
Low human development	85,779	77,824	80,162	79,301	83,114	2,316	2,112	3,052	3,757	3,098	420,515
Total	**134,622**	**154,618**	**97,384**	**115,920**	**100,977**	**120,714**	**252,373**	**100,496**	**33,802**	**23,167**	**1,134,073**

Source: EM-DAT, CRED, University of Louvain, Belgium

[1] See note on UNDP's Human Development Index country status in the section on disaster definitions in the introduction to this annex.

The number of people reported killed in 2007 was the lowest of the decade.

In 2007, 65 per cent of people killed by disasters lived in Asia, below the decade's average of 79 per cent.

In Oceania, the number of people killed was the second highest of the decade.

Compared to the disasters that occurred in the previous decade, 2007 did not witness major disasters such as the famine in the Democratic People's Republic of Korea, from 1995 to 2002 (more than 600,000 deaths);* the Indian Ocean tsunami, December 2004 (226,408 deaths); the South Asia earthquake, 2005 (74,647 deaths); the heatwave in Europe, 2003 (more than 70,000 deaths); floods in Venezuela, 1999 (30,000 deaths); the major earthquakes in: Islamic Republic of Iran, 2003 (Bam: 26,796 deaths); India, 2001 (Gujarat: 20,005 deaths); Turkey, 1999 (Izmit: 17,127 deaths); and Hurricane Mitch in Central America, 1998 (18,791 deaths).

*The estimates provided are disputed. See 'Caveats' on page 196 for further information.

Table 3 Total number of people reported affected, by continent and by year (1998 to 2007), in thousands

	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	Total[2]
Africa	10,852	32,636	41,102	46,145	44,001	29,213	36,902	22,856	19,465	12,359	295,531
Americas	16,682	17,027	979	10,913	2,519	3,995	9,703	8,308	1,450	7,645	79,223
Asia	331,451	238,741	206,644	186,203	663,073	235,024	132,292	129,716	119,085	179,509	2,421,737
Europe	3,489	6,311	2,929	787	1,493	1,547	538	527	260	1,639	19,519
Oceania	824	151	7	31	41	38	119	28	38	152	1,431
High human development[1]	*12,993*	*19,351*	*1,555*	*8,942*	*2,912*	*2,850*	*6,741*	*7,364*	*858*	*5,990*	*69,555*
Medium human development	*336,819*	*259,687*	*225,823*	*212,443*	*687,589*	*248,058*	*155,865*	*136,039*	*119,474*	*187,005*	*2,568,802*
Low human development	*13,487*	*15,827*	*24,284*	*22,695*	*20,626*	*18,909*	*16,948*	*18,033*	*19,966*	*8,308*	*179,083*
Total	**363,299**	**294,865**	**251,662**	**244,080**	**711,127**	**269,816**	**179,554**	**161,436**	**140,298**	**201,303**	**2,817,440**

Source: EM-DAT, CRED, University of Louvain, Belgium

[1] See note on UNDP's Human Development Index country status in the section on disaster definitions in the introduction to this annex.

[2] Since slow-onset disasters can affect the same people for a number of years, it is best to use figures on total numbers affected to calculate annual averages over a decade rather than as absolute totals.

On the basis of available data, an average of more than 280 million people were affected annually by disasters from 1998 to 2007; 86 per cent of them in Asia.

In the Americas and Europe, the number of people affected in 2007 was respectively five and six times higher than in 2006, a year that witnessed a particularly low number of affected people in these two continents.

In 2007, the number of people affected living in countries of low human development was the lowest of the decade. In countries of high human development, the number of people affected in 2007 was almost seven times higher than in 2006.

Over the decade, 6 per cent of those affected lived in countries of low human development.

Table 4 Total amount of disaster estimated damage, by continent and by year (1998 to 2007) in millions of US$ (2007 prices)

	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	Total
Africa	311	772	1,202	778	422	6,239	1,844	89	235	584	12,476
Americas	40,556	28,384	7,355	15,457	14,548	24,244	70,904	182,148	6,839	12,938	403,374
Asia	60,755	42,085	26,202	15,161	10,690	31,719	72,802	28,996	25,869	29,634	343,914
Europe	7,493	69,229	21,432	2,314	33,476	21,522	2,002	17,103	2,531	18,582	195,685
Oceania	584	2,547	645	673	2,514	668	606	233	1,322	1,738	11,530
High human development[1]	42,482	86,395	40,870	19,080	50,932	57,747	122,559	198,869	12,680	49,421	681,035
Medium human development	65,072	56,599	8,211	15,238	10,659	26,641	25,020	29,688	24,114	14,056	275,299
Low human development	2,145	24	7,755	66	58	3	580	12	3	0	10,645
Total	**109,699**	**143,018**	**56,836**	**34,384**	**61,649**	**84,391**	**148,159**	**228,569**	**36,797**	**63,477**	**966,980**

Source: EM-DAT, CRED, University of Louvain, Belgium

[1] See note on UNDP's Human Development Index country status in the section on disaster definitions in the introduction to this annex.

As mentioned in the introduction, damage assessment is frequently unreliable. Even for the existing data, the methodologies are not standardized and the financial coverage can vary significantly. Depending on where the disaster occurs and who reports it, estimations may vary from zero to billions of US dollars.

Amount of damage reported in 2007 was higher than in 2006 but remains largely below the decade's average.

In 2007, Asia accounted for 47 per cent of damage, more than its 36 per cent average for the decade. Inversely, in the Americas, the amount of damage was the third lowest of the decade.

High human development countries contributed to 77 per cent of damage in 2007, slightly more than the 70 per cent average for the entire decade.

ANNEX 1

Table 5 Total number of reported disasters, by type of phenomenon and by year (1998 to 2007)

	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	Total
Avalanches/Landslides	22	16	29	21	19	21	16	12	19	10	185
Droughts/Food insecurity	31	30	43	44	39	23	19	27	18	13	287
Earthquakes/Tsunamis	30	33	31	25	37	40	43	25	24	20	308
Extreme temperatures	12	7	31	23	15	26	19	29	32	24	218
Floods	95	112	155	160	173	160	133	196	233	209	1,626
Forest/scrub fires	18	22	30	14	22	14	8	13	9	18	168
Volcanic eruptions	4	5	5	6	7	2	5	8	12	6	60
Windstorms	88	97	104	108	119	85	127	130	76	103	1,037
Other natural disasters [1]	1	2	4	2	ndr	ndr	12	ndr	ndr	2	23
Subtotal hydro-meteorological disasters	*267*	*286*	*396*	*372*	*387*	*329*	*334*	*407*	*387*	*379*	*3,544*
Subtotal geophysical disasters	*34*	*38*	*36*	*31*	*44*	*42*	*48*	*33*	*36*	*26*	*368*
Total natural disasters	**301**	**324**	**432**	**403**	**431**	**371**	**382**	**440**	**423**	**405**	**3,912**
Industrial accidents	43	37	51	54	48	52	81	76	61	46	549
Miscellaneous accidents	29	52	58	50	52	45	62	66	32	39	485
Transport accidents	148	214	259	221	260	237	216	229	205	167	2,156
Total technological disasters	**220**	**303**	**368**	**325**	**360**	**334**	**359**	**371**	**298**	**252**	**3,190**
Total	**521**	**627**	**800**	**728**	**791**	**705**	**741**	**811**	**721**	**657**	**7,102**

Source: EM-DAT, CRED, University of Louvain, Belgium

[1] Insect infestations and waves/surges.
Note: ndr signifies 'no disaster reported'. For more information, see section on caveats in introductory text.
In 2007, the most frequent types of disasters reported were floods (32 per cent), more than their average of 23 per cent for the decade. Inversely, transport accidents (25 per cent) were below their average for the decade (30 per cent). Windstorms were 1 per cent above their decade's average of 15 per cent. In Africa, the number of floods (62) was greater than the decade's average (38). Such phenomena were also observed in Asia and in the Americas but in lower proportions.

Table 6 Total number of people reported killed, by type of phenomenon and by year (1998 to 2007)

	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	Total
Avalanches/Landslides	1,141	363	1,023	725	1,145	706	357	646	1,647	264	8,017
Droughts/Food insecurity	76,300	76,360	76,415	76,492	76,902	38	80	102	60	134	382,883
Earthquakes/Tsunamis	9,573	21,869	216	21,348	1,634	29,617	227,317	76,241	6,692	706	395,213
Extreme temperatures	3,269	739	941	1,787	3,019	74,748	556	805	5,196	1,011	92,071
Floods	10,665	34,370	6,019	5,075	4,259	3,780	7,074	5,748	5,898	8,420	91,308
Forest/scrub fires	150	70	47	33	6	47	14	49	13	151	580
Volcanic eruptions	0	0	0	0	200	0	2	3	5	11	221
Windstorms	24,935	12,141	1,366	1,914	1,361	1,028	6,644	5,250	4,328	5,970	64,937
Other natural disasters¹	n.a	3	1	n.a.	ndr	ndr	n.a.	ndr	ndr	12	16
Subtotal hydro-meteorological disasters	116,460	124,046	85,812	86,026	86,692	80,347	14,725	12,600	17,142	15,962	639,812
Subtotal geophysical disasters	9,573	21,869	216	21,348	1,834	29,617	227,319	76,244	6,697	717	395,434
Total natural disasters	**126,033**	**145,915**	**86,028**	**107,374**	**88,526**	**109,964**	**242,044**	**88,844**	**23,839**	**16,679**	**1,035,246**
Industrial accidents	1,942	740	1,807	1,279	1,112	1,444	1,797	2,281	1,822	1,551	15,775
Miscellaneous accidents	747	1,323	1,341	1,341	2,013	1,438	2,115	2,669	1,120	793	14,900
Transport accidents	5,900	6,640	8,208	5,926	9,326	7,868	6,417	6,702	7,021	4,144	68,152
Total technological disasters	**8,589**	**8,703**	**11,356**	**8,546**	**12,451**	**10,750**	**10,329**	**11,652**	**9,963**	**6,488**	**98,827**
Total	**134,622**	**154,618**	**97,384**	**115,920**	**100,977**	**120,714**	**252,373**	**100,496**	**33,802**	**23,167**	**1,134,073**

Source: EM-DAT, CRED, University of Louvain, Belgium

¹ Insect infestations and waves/surges.
Note: n.a. signifies 'no data available'; ndr signifies 'no disaster reported'. For more information, see section on caveats in introductory text.
In 2007, deaths attributed to both natural and technological disasters were at their lowest level of the decade. The number of deaths from earth-quakes/tsunami was the second lowest of the decade. By contrast the number of deaths from fires was the highest of the decade. Deaths from floods were the third highest of the decade. In 2007, they accounted for 36 per cent of the total deaths far more than the decade's average of 8 per cent. Deaths from wind-storms were the fourth highest for the decade and, with 4,234 people killed, Cyclone Sidr accounted for 71 per cent of these deaths. Deaths from transport accidents were the fourth highest of the decade and accounted for 30 per cent of the total deaths reported in 2007. Most reported deaths caused by droughts and food insecurity during the decade were accounted to the famine in the Democratic People's Republic of Korea.*
*The estimates provided are disputed. See 'Caveats' on page 196 for further information.

Table 7 Total number of people reported affected, by type of phenomenon and by year (1998 to 2007), in thousands

	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	Total[2]
Avalanches/Landslides	213	15	215	67	304	459	13	10	419	9	1,724
Droughts/Food insecurity	34,396	115,291	159,681	167,372	428,279	81,842	35,272	30,643	37,171	8,278	1,098,226
Earthquakes/Tsunamis	3,678	6,857	2,479	9,711	851	4,194	3,147	6,187	3,859	1,211	42,175
Extreme temperatures	36	725	28	213	104	1,890	2,140	2	63	988	6,190
Floods	293,663	147,826	73,881	34,555	167,769	169,463	117,219	75,028	31,126	164,949	1,275,479
Forest/scrub fires	167	19	39	6	26	184	21	7	2	1,785	2,255
Volcanic eruptions	8	34	127	110	278	25	53	341	379	51	1,405
Windstorms	31,021	23,756	15,148	31,991	113,446	11,093	21,383	49,117	67,107	23,952	388,015
Other natural disasters[1]	n.a.	1	17	n.a.	ndr	ndr	n.a.	ndr	ndr	34	52
Subtotal hydro-meteorological disasters	359,496	287,633	249,009	234,205	709,929	264,930	176,047	154,808	135,888	199,994	2,771,940
Subtotal geophysical disasters	3,686	6,890	2,605	9,822	1,130	4,219	3,200	6,528	4,237	1,262	43,580
Total natural disasters	**363,182**	**294,524**	**251,614**	**244,026**	**711,059**	**269,150**	**179,247**	**161,336**	**140,126**	**201,256**	**2,815,520**
Industrial accidents	63	324	17	19	2	646	157	16	137	2	1,383
Miscellaneous accidents	50	12	24	31	61	15	102	77	32	41	446
Transport accidents	4	5	7	3	6	5	48	6	4	3	91
Total technological disasters	**117**	**341**	**48**	**53**	**68**	**667**	**307**	**100**	**172**	**47**	**1,920**
Total	**363,299**	**294,865**	**251,662**	**244,080**	**711,127**	**269,816**	**179,554**	**161,436**	**140,298**	**201,303**	**2,817,440**

Source: EM-DAT, CRED, University of Louvain, Belgium

[1] Insect infestations and waves/surges.

[2] Since slow-onset disasters can affect the same people over a number of years, it is best to use figures on total numbers affected to calculate annual averages over a decade rather than absolute totals.

Note: n.a. signifies 'no data available'; ndr signifies 'no disaster reported'. For more information, see section on caveats in introductory text.

Disasters which affected the most people in 2007 were floods (165 million people affected: 82 per cent of those affected by disasters). Windstorms (24 million people affected) accounted for 'only' 12 per cent of those affected by disasters.

Nine floods affected at least 1 million people. The floods in China, in June and July, affected 105 million people; two-thirds of the total number of people affected by floods.

The number of people affected by fires was the highest of the decade.

By contrast, the number of people reported affected by droughts was the lowest of the decade.

Over the decade hydro-meteorological disasters accounted for 98 per cent of all those affected by disasters, with floods affecting 45 per cent and droughts 39 per cent.

In 2007, the number of people affected by industrial accidents was the same as in 2002, the lowest of the decade.

Table 8 Total amount of disaster estimated damage, by type of phenomenon and by year (1998 to 2007) in millions of US$ (2007 prices)

	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	Total
Avalanches/Landslides	1,169	932	556	83	14	59	4	37	41	n.a.	2,895
Droughts/Food insecurity	1,116	7,395	4,936	2,693	9,553	834	2,549	1,201	1,072	n.a.	31,349
Earthquakes/Tsunamis	3,626	57,857	497	8,621	2,383	9,300	42,372	6,694	3,529	12,974	147,853
Extreme temperatures	5,438	1,245	446	234	n.a.	14,109	n.a.	425	4,055	n.a.	25,951
Floods	55,882	18,798	31,070	5,564	27,779	24,166	11,563	19,436	8,078	22,201	224,538
Forest/scrub fires	3,328	611	3,081	105	417	6,868	3	4,084	811	3,479	22,789
Volcanic eruptions	n.a.	n.a.	3	20	10	n.a.	n.a.	n.a.	154	n.a.	187
Windstorms	38,937	56,174	15,788	17,046	9,940	29,056	90,232	196,245	19,055	24,573	497,046
Other natural disasters¹	2	0	144	n.a.	ndr	ndr	n.a.	ndr	ndr	n.a.	147
Subtotal hydro-meteorological disasters	*105,873*	*85,154*	*56,021*	*25,726*	*47,704*	*75,091*	*104,351*	*221,429*	*33,113*	*50,252*	*804,715*
Subtotal geophysical disasters	*3,626*	*57,857*	*500*	*8,640*	*2,394*	*9,300*	*42,372*	*6,694*	*3,683*	*12,974*	*148,040*
Total natural disasters	**109,499**	**143,012**	**56,521**	**34,366**	**50,098**	**84,391**	**146,723**	**228,123**	**36,796**	**63,226**	**952,755**
Industrial accidents	164	4	n.a.	12	11,480	n.a.	988	435	n.a.	251	13,334
Miscellaneous accidents	24	3	315	6	71	n.a.	n.a.	11	1	n.a.	431
Transport accidents	13	n.a.	n.a.	n.a.	n.a.	n.a.	448	n.a.	n.a.	n.a.	461
Total technological disasters	**201**	**6**	**315**	**18**	**11,552**	**n.a.**	**1,436**	**446**	**1**	**251**	**14,225**
Total	**109,699**	**143,018**	**56,836**	**34,384**	**61,649**	**84,391**	**148,159**	**228,569**	**36,797**	**63,477**	**966,980**

Source: EM-DAT, CRED, University of Louvain, Belgium

¹ Insect infestations and waves/surges.
Note: n.a. signifies 'no data available'; ndr signifies 'no disaster reported'. For more information, see section on caveats in introductory text. '0' value means an amount of damages lower than US$ 0.5 million.
Estimates of disaster damage must be treated with caution, as the financial value attached to infrastructures in developed countries is much higher than in developing countries. While reporting is better for large-scale disasters, the low reporting rates of direct damage make analysis difficult.
In 2007, natural disasters accounted for more of 99 per cent of reported damages.
Windstorms were the costliest disasters of the decade accounting for 51 per cent of total damage, followed by floods at 23 per cent and earthquakes/tsunamis at 15 per cent. However, in 2007 windstorms accounted for 39 per cent of all reported damages, floods for 35 per cent and earthquakes for 20 per cent.
Damages exceeding US$ 1 billion were accounted to seven windstorms and five floods; Storm Kyrill accounted for US$ 5.5 billion in damages in Germany and three floods in China, Mexico and the United Kingdom cost more than US$ 4 billion.
In 2007 damages from earthquakes were the third highest of the decade. The cost was largely attributed to the Niiagata earthquake in Japan in July, which cost US$ 12.5 billion.
An oil spill in Ukraine caused damages worth US$ 251 million.

Table 9 Total number of reported disasters, by type of phenomenon, by continent and by level of human development[2] (1998 to 2007)

	Africa	Americas	Asia	Europe	Oceania	HHD	MHD	LHD	Total
Avalanches/Landslides	11	38	112	18	6	33	140	12	185
Droughts/Food insecurity	132	55	76	17	7	47	163	77	287
Earthquakes/Tsunamis	21	49	176	52	10	64	220	24	308
Extreme temperatures	5	41	54	117	1	140	74	4	218
Floods	380	325	608	269	44	511	838	277	1,626
Forest/scrub fires	14	67	24	53	10	124	39	5	168
Volcanic eruptions	8	25	18	1	8	9	47	4	60
Windstorms	81	343	385	160	68	534	470	33	1,037
Other natural disasters[1]	13	2	5	1	2	3	14	6	23
Subtotal hydro-meteorological disasters	*636*	*871*	*1,264*	*635*	*138*	*1,392*	*1,738*	*414*	*3,544*
Subtotal geophysical disasters	*29*	*74*	*194*	*53*	*18*	*73*	*267*	*28*	*368*
Total natural disasters	**665**	**945**	**1,458**	**688**	**156**	**1,465**	**2,005**	**442**	**3,912**
Industrial accidents	62	35	399	53	ndr	71	429	49	549
Miscellaneous accidents	111	69	224	79	2	140	289	56	485
Transport accidents	847	291	801	208	9	350	1,345	461	2,156
Total technological disasters	**1,020**	**395**	**1,424**	**340**	**11**	**561**	**2,063**	**566**	**3,190**
Total	**1,685**	**1,340**	**2,882**	**1,028**	**167**	**2,026**	**4,068**	**1,008**	**7,102**

Source: EM-DAT, CRED, University of Louvain, Belgium

[1] Insect infestations and waves/surges.

[2] See note on UNDP's Human Development Index country status in the section on disaster definitions in the introduction to this annex.

Note: ndr signifies 'no disaster reported'. For more information, see section on caveats in introductory text.
During the decade, Asia accounted for 41 per cent of the total number of disasters and for 72 per cent of industrial accidents, 61 per cent of land-slides/avalanches, 57 per cent of earthquakes/tsunamis, 46 per cent of miscellaneous accidents and 37 per cent of transport accidents, floods and windstorms.
Africa accounted for 24 per cent of the total number of disasters and for 46 per cent of droughts/food insecurity and 39 per cent of transport accidents.
The Americas accounted for 19 per cent of the total number of disasters and for 42 per cent of volcanic eruptions, 40 per cent of wildfires and 33 per cent of windstorms. Europe accounted for 14 per cent of the total number of disasters and for 54 per cent of extreme temperatures and for 32 per cent of wildfires.
Oceania accounted for 2.5 per cent of the total number of disasters but for 13 per cent of volcanic eruptions, 8 per cent of wildfires and 7 per cent of windstorms.
Proportionally, extreme temperatures, fires and windstorms were more frequent in high human development countries; landslides, earthquakes/tsunami, volcanic eruptions and industrial accidents in nations of medium human development, and droughts/food insecurities, floods and transport accidents in low human development countries.

Table 10 Total number of people reported killed, by type of phenomenon, by continent and by level of human development[2] (1998 to 2007)

	Africa	Americas	Asia	Europe	Oceania	HHD	MHD	LHD	Total
Avalanches/Landslides	241	1,215	6,009	476	76	730	6,999	288	8,017
Droughts/Food insecurity	1,339	53	381,459	2	30	n.a.	727	382,156	382,883
Earthquakes/Tsunamis	3,306	3,257	367,825	18,572	2,253	2,712	383,829	8,672	395,213
Extreme temperatures	116	1,576	10,032	80,347	n.a.	80,579	11,084	408	92,071
Floods	7,411	38,259	44,126	1,443	69	4,784	79,717	6,807	91,308
Forest/scrub fires	150	127	69	207	27	352	224	4	580
Volcanic eruptions	206	7	8	n.a.	n.a.	n.a.	16	205	221
Windstorms	1,439	28,674	33,752	741	331	6,357	57,767	813	64,937
Other natural disasters[1]	12	3	1	n.a.	n.a.	n.a.	16	n.a.	16
Subtotal hydro-meteorological disasters	*10,708*	*69,907*	*475,448*	*83,216*	*533*	*92,802*	*156,534*	*390,476*	*639,812*
Subtotal geophysical disasters	*3,512*	*3,264*	*367,833*	*18,572*	*2,253*	*2,712*	*383,845*	*8,877*	*395,434*
Total natural disasters	**14,220**	**73,171**	**843,281**	**101,788**	**2,786**	**95,514**	**540,379**	**399,353**	**1,035,246**
Industrial accidents	3,498	413	10,792	1,072	ndr	857	11,649	3,269	15,775
Miscellaneous accidents	3,165	2,243	7,800	1,656	36	3,976	8,729	2,195	14,900
Transport accidents	25,528	7,746	29,142	5,470	266	9,864	42,590	15,698	68,152
Total technological disasters	**32,191**	**10,402**	**47,734**	**8,198**	**302**	**14,697**	**62,968**	**21,162**	**98,827**
Total	**46,411**	**83,573**	**891,015**	**109,986**	**3,088**	**110,211**	**603,347**	**420,515**	**1,134,073**

Source: EM-DAT, CRED, University of Louvain, Belgium

[1] Insect infestations and waves/surges.
[2] See note on UNDP's Human Development Index country status in the section on disaster definitions in the introduction to this annex.
Note: n.a. signifies 'no data available'; ndr signifies 'no disaster reported'. For more information, see section on caveats in introductory text.
During the decade, medium human development countries accounted for: 53 per cent of the total number of reported deaths but 97 per cent of those caused by earthquakes/tsunamis, 89 per cent of those caused by windstorms, 87 per cent of deaths from landslides and floods and 74 per cent of deaths from industrial accidents. Low human development countries accounted for 37 per cent of the total number of reported deaths but for 99 per cent of those caused by droughts/food insecurities and for 93 per cent of those from volcanic eruptions. High human development countries accounted for only 10 per cent of the total number of reported deaths but for 88 per cent of those related to extreme temperatures, 61 per cent of wildfire's deaths, 27 per cent of miscellaneous accident deaths and 14 per cent of deaths caused by transport accidents.

Table 11 Total number of people reported affected, by type of phenomenon, by continent and by level of human development[2] (1998 to 2007), in thousands

	Africa	Americas	Asia	Europe	Oceania	HHD	MHD	LHD	Total
Avalanches/Landslides	5	172	1,518	17	11	169	1,250	306	1,724
Droughts/Food insecurity	266,336	25,809	803,931	1,273	877	24,021	916,489	157,716	1,098,226
Earthquakes/Tsunamis	363	4,103	33,709	3,961	38	874	40,838	463	42,175
Extreme temperatures	0	4,920	446	824	n.a.	798	5,192	200	6,19
Floods	24,409	11,977	1,233,891	5,093	109	10,226	1,246,285	18,967	1,275,479
Forest/scrub fires	12	957	12	1,264	10	2,085	167	3	2,255
Volcanic eruptions	408	597	349	n.a.	50	60	1,224	121	1,405
Windstorms	3,683	30,095	346,901	6,999	335	30,323	356,585	1,107	388,015
Other natural disasters[1]	n.a.	1	51	n.a.	n.a.	n.a.	52	n.a.	52
Subtotal hydro-meteorological disasters	*294,445*	*73,932*	*2,386,751*	*15,471*	*1,342*	*67,622*	*2,526,019*	*178,299*	*2,771,940*
Subtotal geophysical disasters	*772*	*4,701*	*34,058*	*3,961*	*89*	*933*	*42,062*	*585*	*43,580*
Total natural disasters	**295,217**	**78,632**	**2,420,809**	**19,432**	**1,430**	**68,555**	**2,568,082**	**178,884**	**2,815,520**
Industrial accidents	103	568	643	69	ndr	971	316	97	1,383
Miscellaneous accidents	196	13	223	14	0	18	375	53	446
Transport accidents	15	9	62	4	0	11	30	50	91
Total technological disasters	**314**	**591**	**928**	**87**	**0**	**1,000**	**720**	**199**	**1,920**
Total	**295,531**	**79,223**	**2,421,737**	**19,519**	**1,431**	**69,555**	**2,568,802**	**179,083**	**2,817,440**

Source: EM-DAT, CRED, University of Louvain, Belgium

[1] Insect infestations and waves/surges.
[2] See note on UNDP's Human Development Index country status in the section on disaster definitions in the introduction to this annex.
Note: n.a. signifies 'no data available'; ndr signifies 'no disaster reported'. '0' value means a number of people affected lower than 500. For more information, see section on caveats in introductory text.
During the decade, medium human development countries accounted for 91 per cent of the total number of people reported affected by disasters, while low human development countries accounted for 6 per cent of the total number of disaster-affected people but 54 per cent of those affected by transport accidents. Only 2.5 per cent of the total number of people reported affected by disasters lived in high human development countries, but those nations accounted for 70 per cent of people affected by industrial accidents.

Table 12 Total amount of disaster estimated damage, by type of phenomenon, by continent and by level of human development[2] (1998 to 2007) in millions of US dollars (2007 prices)

	Africa	Americas	Asia	Europe	Oceania	HHD	MHD	LHD	Total
Avalanches/Landslides	n.a.	103	1,426	1,366	n.a.	1,469	1,426	n.a.	2,895
Droughts/Food insecurity	1,327	9,423	11,200	7,094	2,305	18,849	12,480	20	31,349
Earthquakes/Tsunamis	6,423	8,232	92,548	40,650	n.a.	74,500	71,145	2,209	147,853
Extreme temperatures	1	6,695	3,444	15,577	234	22,402	3,548	n.a.	25,951
Floods	2,852	21,704	134,020	62,389	3,572	94,752	129,065	722	224,538
Forest/scrub fires	12	11,457	1,680	8,996	643	21,072	1,717	n.a.	22,789
Volcanic eruptions	10	167	6	4	n.a.	4	173	10	187
Windstorms	953	345,490	98,665	47,307	4,631	435,757	54,058	7,231	497,046
Other natural disasters[1]	2	n.a.	0	n.a.	144	144	2	n.a.	147
Subtotal hydro-meteorological disasters	5,148	394,873	250,435	142,729	11,530	594,446	202,296	7,973	804,715
Subtotal geophysical disasters	6,433	8,400	92,553	40,654	n.a.	74,503	71,318	2,219	148,040
Total natural disasters	**11,581**	**403,272**	**342,988**	**183,383**	**11,530**	**668,949**	**273,614**	**10,192**	**952,755**
Industrial accidents	890	n.a.	450	11,994	ndr	11,743	1,591	n.a.	13,334
Miscellaneous accidents	5	93	24	308	n.a.	344	82	5	431
Transport accidents	n.a.	9	452	n.a.	n.a.	n.a.	13	448	461
Total technological disasters	**895**	**102**	**926**	**12,302**	**n.a.**	**12,087**	**1,686**	**453**	**14,225**
Total	**12,476**	**403,374**	**343,914**	**195,685**	**11,530**	**681,035**	**275,299**	**10,645**	**966,980**

Source: EM-DAT, CRED, University of Louvain, Belgium

[1] Insect infestations and waves/surges.
[2] See note on UNDP's Human Development Index country status in the section on disaster definitions in the introduction to this chapter annex.
Note: n.a. signifies 'no data available'; ndr signifies 'no disaster reported'. For more information, see section on caveats in introductory text. '0' value means an amount of damages lower than US$ 0.5 million.
Estimates of disaster damage must be treated with caution, as the financial value attached to infrastructures in developed countries is much higher than in developing countries. While reporting is better for large-scale disasters, the low reporting rates of direct damage make analysis difficult.
During the decade, the Americas accounted for 42 per cent of the reported damages, 89 per cent of costs related to volcanic eruptions and 70 per cent of those related to windstorms. Asia accounted for 36 per cent of the reported damages, 98 per cent of those caused by transport accidents, 49 per cent of costs related to landslides/avalanches, 63 per cent of those caused by earthquakes/tsunamis and 60 per cent of those caused by floods. Europe accounted for 20 per cent of the reported damages, 90 per cent of those caused by industrial accidents, 72 per cent of those related to miscellaneous accidents, 60 per cent of those caused by extreme temperatures, 47 per cent of those caused by landslides and 39 per cent of those caused by fires. Africa accounted for 1.3 per cent of the reported damages, 7 per cent of those caused by industrial accidents, 6 per cent of those caused by volcanic eruptions and 4 per cent of those caused by droughts/food insecurity and by earthquakes. Oceania accounted for 1.2 per cent of the reported damages, 7 per cent of those caused by droughts and 3 per cent of those caused by wildfires.

	Total number of people reported killed (1988–1997)	Total number of people reported affected (1988–1997)	Total number of people reported killed (1998–2007)	Total number of people reported affected (1998–2007)	Total number of people reported killed (2007)	Total number of people reported affected (2007)
Africa	**25,291**	**194,394,933**	**46,411**	**295,531,183**	**3,388**	**12,358,831**
Algeria	472	75,004	4,019	366,097	90	1,305
Angola	848	7,805,197	1,003	665,199	110	46,100
Benin	34	440,727	308	489,531	20	10,933
Botswana	28	117,507	3	143,736	ndr	ndr
Burkina Faso	38	2,975,414	218	181,347	52	121,043
Burundi	112	3,600	563	8,362,067	151	2,025,707
Cameroon	444	375,004	711	7,893	77	1,495
Cape Verde	n.a.	6,306	18	40,000	ndr	ndr
Central African Republic	7	21,499	259	103,611	13	7,830
Chad	95	785,398	254	1,323,479	29	173,145
Comoros	199	200	199	284,343	75	n.a.
Congo, Rep. of	663	16,500	140	148,668	15	25,000
Congo, DR of the	894	64,015	2,751	324,844	383	2,004
Côte d'Ivoire	136	7,187	414	97,328	39	2,125
Djibouti	155	421,075	184	543,149	n.a.	42,750
Egypt	2,410	262,138	3,091	6,484	73	2,060
Equatorial Guinea	ndr	ndr	82	5,050	ndr	ndr
Eritrea [1]	133	1,615,725	56	11,507,043	ndr	ndr
Ethiopia [1]	910	40,788,100	1,752	31,664,998	22	247,386
Gabon	102	10,000	62	11	12	n.a.
Gambia	100	4,000	83	47,706	n.a.	300
Ghana	331	2,702,809	776	803,801	104	332,730
Guinea	473	6,066	474	242,882	122	20,695
Guinea-Bissau	14	6,347	247	134,911	29	3
Kenya	1,552	11,911,294	1,980	100,545,343	106	42,702
Lesotho	22	994,750	41	1,477,061	40	475,060
Liberia	n.a.	1,002,000	71	25,500	1	20,500
Libyan AJ	360	121	131	79	ndr	ndr
Madagascar	747	6,295,402	983	5,261,818	90	255,495
Malawi	507	32,930,710	825	14,699,186	28	602,726
Mali	97	326,667	280	2,166,650	18	88,858
Mauritania	107	468,814	170	3,169,143	3	54,120
Mauritius	6	14,307	5	2,050	2	n.a.
Morocco	1,184	98,203	1,634	867,662	65	42

	Total number of people reported killed (1988–1997)	Total number of people reported affected (1988–1997)	Total number of people reported killed (1998–2007)	Total number of people reported affected (1998–2007)	Total number of people reported killed (2007)	Total number of people reported affected (2007)
Mozambique	736	9,756,211	1,591	10,630,293	196	1,066,524
Namibia	20	826,400	33	799,309	7	15,000
Niger	263	4,410,492	153	13,381,460	7	57,274
Nigeria	2,363	886,533	10,107	665,708	517	50,137
Reunion (FR)	69	6,261	4	3,790	2	90
Rwanda	355	163,678	322	6,827,490	30	1,004,500
Saint Helena (GB)	ndr	ndr	n.a.	300	ndr	ndr
Sao Tome and Principe	ndr	ndr	13	3	13	3
Senegal	151	32,954	1,723	924,007	8	5,300
Seychelles	5	1,237	3	11,630	ndr	ndr
Sierra Leone	512	200,022	616	19,572	98	4,543
Somalia	2,708	1,344,100	1,055	3,598,100	47	10,061
South Africa	1,512	1,662,102	1,749	15,252,460	189	41,675
Sudan	899	20,696,439	1,249	9,305,364	150	565,335
Swaziland	n.a.	1,500,000	55	4,571,244	2	411,500
Tanzania, UR of	1,615	8,263,998	1,397	13,105,510	101	89
Togo	3	646,500	71	238,758	71	141,353
Tunisia	86	152,216	416	33,634	16	6,500
Uganda	436	820,117	1,174	5,086,810	72	721,062
Zambia	145	5,473,432	342	4,880,169	20	1,538,768
Zimbabwe	233	25,000,155	551	20,486,902	73	2,117,003
Americas	**27,587**	**32,886,642**	**83,573**	**79,222,674**	**2,812**	**7,645,219**
Anguilla (GB)	ndr	ndr	n.a.	150	ndr	ndr
Antigua and Barbuda	4	76,732	4	7,982	ndr	ndr
Argentina	386	4,807,767	634	987,903	19	135,000
Aruba (NL)	ndr	ndr	ndr	ndr	ndr	ndr
Bahamas	4	1,700	60	17,578	55	7,078
Barbados	n.a.	n.a.	1	4,881	n.a.	1
Belize	22	2,600	56	162,570	n.a.	20,000
Bermuda	n.a.	n.a.	22	n.a.	ndr	ndr
Bolivia	286	728,886	1,012	1,265,477	80	469,400
Brazil	3,243	5,264,048	2,213	23,763,353	270	1,207,655
Canada	264	92,290	368	38,954	6	500
Cayman Islands (GB)	ndr	ndr	2	300	ndr	ndr
Chile	468	336,550	204	613,308	39	25,260
Colombia	1,969	702,470	3,220	3,856,214	403	717,253
Costa Rica	181	1,136,708	114	158,363	19	24,500
Cuba	1,016	1,466,378	230	10,542,055	57	210,561

	Total number of people reported killed (1988–1997)	Total number of people reported affected (1988–1997)	Total number of people reported killed (1998–2007)	Total number of people reported affected (1998–2007)	Total number of people reported killed (2007)	Total number of people reported affected (2007)
Dominica	2	5,711	16	8,520	2	7,530
Dominican Republic	521	1,240,020	1,571	1,244,474	175	162,763
Ecuador	979	431,494	569	657,996	25	29
El Salvador	211	51,060	1,964	2,179,247	2	3,300
Falkland Islands (GB)	ndr	ndr	ndr	ndr	ndr	ndr
French Guiana (FR)	n.a.	70,000	ndr	ndr	ndr	ndr
Greenland (DK)	ndr	ndr	ndr	ndr	ndr	ndr
Grenada	n.a.	1,000	40	61,860	ndr	ndr
Guadeloupe (FR)	5	11,084	25	1,052	n.a.	n.a.
Guatemala	388	118,868	2,617	823,805	11	6,001
Guyana	n.a.	1,252,881	44	916,974	ndr	ndr
Haiti	3,921	3,496,510	6,289	944,896	178	220,062
Honduras	812	262,106	14,970	3,850,803	6	36,383
Jamaica	77	1,366,512	42	425,410	5	33,188
Martinique (FR)	10	4,510	2	706	2	106
Mexico	3,046	1,692,365	3,186	6,894,068	210	1,858,220
Montserrat (GB)	43	25,040	n.a.	200	ndr	ndr
Netherlands Antilles (NL)	13	40,000	15	4	ndr	ndr
Nicaragua	433	1,298,752	3,692	1,485,103	198	212,726
Northern Mariana Islands (US)	ndr	ndr	n.a.	300	ndr	ndr
Panama	173	49,439	86	80,971	5	1,254
Paraguay	56	475,654	510	353,565	8	125,000
Peru	3,179	4,500,321	3,131	6,240,340	674	1,369,595
Puerto Rico (US)	113	158,005	114	15,499	1	n.a.
Saint Kitts and Nevis	1	3,100	5	11,180	ndr	ndr
Saint Lucia	49	925	1	200	1	n.a.
Saint Pierre et Miquelon (FR)	ndr	ndr	ndr	ndr	ndr	ndr
Saint Vincent and the Grenadines	3	200	4	1,634	ndr	ndr
Suriname	169	13	13	25,000	ndr	ndr
Trinidad and Tobago	11	1,447	3	1,960	ndr	ndr
Turks and Caicos Islands (UK)	n.a.	n.a.	43	200	ndr	ndr
United States	4,774	1,597,076	5,786	10,752,186	330	671,849
Uruguay	95	8,740	44	147,059	2	120,000
Venezuela	653	87,677	30,648	678,374	29	5

	Total number of people reported killed (1988–1997)	Total number of people reported affected (1988–1997)	Total number of people reported killed (1998–2007)	Total number of people reported affected (1998–2007)	Total number of people reported killed (2007)	Total number of people reported affected (2007)
Virgin Islands (GB)	n.a.	3	ndr	ndr	ndr	ndr
Virgin Islands (US)	7	20,000	3	n.a.	ndr	ndr
Asia	**586,865**	**1,682,184,411**	**891,015**	**2,421,736,832**	**15,025**	**179,508,616**
Afghanistan	3,969	455,119	10,811	10,606,737	337	29,995
Armenia [2]	95	7,022,798	12	297,156	ndr	ndr
Azerbaijan [2]	559	1,734,132	144	743,999	25	n.a.
Bahrain	10	n.a.	212	60	ndr	ndr
Bangladesh	153,366	126,881,497	14,940	82,955,639	5,676	22,930,220
Bhutan	39	65,600	200	1,000	ndr	ndr
Brunei Darussalam	ndr	ndr	n.a.	n.a.	ndr	ndr
Cambodia	809	17,229,000	496	9,774,614	23	19,000
China, PR of [3]	37,154	1,091,401,091	29,257	1,301,932,766	2,139	120,114,218
Georgia [2]	340	4,665	128	1,415,246	ndr	ndr
Hong Kong (CN) [3]	357	11,707	30	4,557	ndr	ndr
India	45,204	286,564,263	82,183	700,823,080	2,484	27,063,236
Indonesia	8,476	7,102,432	181,939	8,468,755	862	1,215,959
Iran, Islamic Rep. of	44,988	2,160,618	31,508	113,435,399	91	160,041
Iraq	894	500	1,474	68,912	45	n.a.
Israel	156	343	25	1,857	ndr	ndr
Japan	6,602	994,997	1,134	2,036,144	87	128,222
Jordan	59	18,340	124	330,289	ndr	ndr
Kazakhstan [2]	230	638,036	132	67,973	ndr	ndr
Korea, DPR of *	229,273	33,501,896	382,905	42,455,209	720	1,172,167
Korea, Rep. of	1,981	365,153	1,851	679,937	33	740
Kuwait	2	200	ndr	ndr	ndr	ndr
Kyrgyzstan [2]	232	196,536	207	34,276	n.a.	845
Lao, PDR	96	3,570,862	129	1,073,005	ndr	ndr
Lebanon	70	104,075	49	17,605	1	50
Macau (CN)	n.a.	3,986	ndr	ndr	ndr	ndr
Malaysia	956	100,374	327	482,907	46	166,533
Maldives	n.a.	23,849	143	28,963	n.a.	1,649
Mongolia	252	105,061	109	3,266,658	14	8
Myanmar	961	725,709	570	381,299	33	166,664
Nepal	3,926	1,074,342	3,164	2,241,265	275	640,741
Oman	ndr	ndr	192	20,115	88	20,011
Pakistan	8,098	24,399,685	80,147	28,819,751	891	1,652,542
Palestinian Territory, Occupied [5]	ndr	ndr	19	785	5	765
Philippines	18,127	37,444,664	9,536	40,482,727	178	2,037,237

	Total number of people reported killed (1988–1997)	Total number of people reported affected (1988–1997)	Total number of people reported killed (1998–2007)	Total number of people reported affected (1998–2007)	Total number of people reported killed (2007)	Total number of people reported affected (2007)
Qatar	ndr	ndr	ndr	ndr	ndr	ndr
Saudi Arabia	2,371	1,548	1,359	14,632	73	37
Singapore	3	1,437	ndr	ndr	ndr	ndr
Sri Lanka	948	4,699,479	35,911	6,813,180	55	406,057
Syrian Arab Republic	46	n.a.	440	668,760	46	55
Taiwan (CN)	809	22,003	3,332	1,182,865	44	2,879
Tajikistan[2]	1,758	326,792	290	6,536,432	49	24,309
Thailand	4,179	17,111,713	9,904	23,430,556	212	183,208
Timor-Leste[4]	ndr	ndr	5	13,685	1	947
Turkmenistan[2]	n.a.	420	51	n.a.	ndr	ndr
United Arab Emirates	85	101	98	40	ndr	ndr
Uzbekistan[2]	10	50,400	159	1,225,488	ndr	ndr
Viet Nam	8,610	15,244,139	4,524	28,872,983	393	1,367,666
Yemen[6]	765	824,849	845	29,526	99	2,615
Europe	**42,749**	**53,832,341**	**109,986**	**19,518,921**	**1,689**	**1,638,579**
Albania	75	9,647,190	30	597,234	n.a.	225
Austria	41	130	628	71,810	5	n.a.
Azores (PT)	173	115	45	1,100	ndr	ndr
Belarus[2]	5	61,390	92	3,929	n.a.	n.a.
Belgium	108	1,997	2,163	3,824	2	2
Bosnia and Herzegovina[7]	12	n.a.	54	354,179	n.a.	n.a.
Bulgaria	68	5,519	94	15,216	17	1,129
Canary Islands (SP)	ndr	ndr	146	1,274	10	405
Croatia	96	2,025	859	2,276	12	26
Cyprus	2	1,865	92	1,240	4	0
Czech Republic[8]	48	102,171	487	204,353	4	0
Czechoslovakia[8]	41	n.a.	ndr	ndr	ndr	ndr
Denmark	56	100	13	2,072	n.a.	n.a.
Estonia[2]	912	140	25	130	ndr	ndr
Finland	n.a.	n.a.	35	448	ndr	ndr
France	651	25,601	21,603	3,582,263	31	924
Germany[9]	399	141,450	9,767	434,069	32	160
Gibraltar (GB)	ndr	ndr	ndr	ndr	ndr	ndr
Greece	346	35,881	710	135,996	131	5,998
Hungary	58	279	740	179,655	500	n.a.
Iceland	34	363	n.a.	199	ndr	ndr
Ireland	36	3,500	11	1,200	ndr	ndr
Isle of Man (GB)	ndr	ndr	ndr	ndr	ndr	ndr

	Total number of people reported killed (1988–1997)	Total number of people reported affected (1988–1997)	Total number of people reported killed (1998–2007)	Total number of people reported affected (1998–2007)	Total number of people reported killed (2007)	Total number of people reported affected (2007)
Italy	625	69,543	20,945	72,667	48	7
Latvia[2]	ndr	ndr	82	n.a.	ndr	ndr
Lithuania[2]	6	780,000	57	n.a.	25	n.a.
Luxembourg	n.a.	n.a.	190	n.a.	ndr	ndr
Macedonia, FYR[7]	198	11,515	44	1,110,111	1	1,000,202
Malta	295	n.a.	102	23	32	17
Moldova[2]	59	52,824	16	2,819,107	n.a.	210,394
Montenegro[7]	ndr	ndr	n.a.	1,086	n.a.	1,086
Netherlands	204	263,170	2,021	5,196	7	n.a.
Norway	473	4,000	53	2,142	ndr	ndr
Poland	232	224,806	1,124	21,111	19	n.a.
Portugal	138	5,622	2,889	150,787	16	23
Romania	517	154,738	669	229,212	80	4,260
Russian Federation[2]	4,801	1,060,985	4,478	2,990,935	293	14,481
Serbia[7]	ndr	ndr	n.a.	12,370	n.a.	12,370
Serbia and Montenegro[7]	23	6,011	169	120,274	ndr	ndr
Slovakia[8]	11	200	91	58,582	12	89
Slovenia[7]	n.a.	n.a.	296	2,355	6	1,050
Soviet Union[2]	27,288	2,014,552	ndr	ndr	ndr	ndr
Spain	521	36,021,906	15,658	56,344	62	4,479
Sweden	29	22	74	162	ndr	ndr
Switzerland	53	7,205	1,190	7,406	1	101
Turkey	2,741	871,465	20,046	5,155,112	160	3,190
Ukraine[2]	206	2,036,131	1,701	460,432	152	7,761
United Kingdom	786	217,790	497	651,040	27	370,200
Yugoslavia[7]	382	140	ndr	ndr	ndr	ndr
Oceania	**1,423**	**31,113,296**	**3,088**	**1,430,578**	**253**	**151,879**
American Samoa (US)	n.a.	n.a.	6	23,063	ndr	ndr
Australia	395	29,624,124	291	68,554	10	5,226
Cook Islands (NZ)	20	900	n.a.	1,352	ndr	ndr
Fiji	57	171,503	78	302,188	7	969
French Polynesia (FR)	ndr	ndr	33	511	20	n.a.
Guam (US)	229	12,033	5	15,644	ndr	ndr
Kiribati	ndr	ndr	n.a.	84,000	ndr	ndr
Marshall Islands	n.a.	6,000	ndr	ndr	ndr	ndr
Micronesia, Fed. States of	ndr	ndr	48	37,431	ndr	ndr

	Total number of people reported killed (1988–1997)	Total number of people reported affected (1988–1997)	Total number of people reported killed (1998–2007)	Total number of people reported affected (1998–2007)	Total number of people reported killed (2007)	Total number of people reported affected (2007)
Nauru	ndr	ndr	ndr	ndr	ndr	ndr
New Caledonia (FR)	2	n.a.	2	1,100	ndr	ndr
New Zealand	21	4,927	24	8,200	n.a.	300
Niue (NZ)	n.a.	200	1	702	ndr	ndr
Palau	1	12,004	ndr	ndr	ndr	ndr
Papua New Guinea	526	879,639	2,472	778,625	164	143,000
Samoa	21	283,000	10	n.a.	ndr	ndr
Solomon Islands	38	89,024	52	4,299	52	2,384
Tokelau (NZ)	n.a.	102	n.a.	26	ndr	ndr
Tonga	1	6,103	n.a.	20,071	ndr	ndr
Tuvalu	n.a.	850	18	n.a.	ndr	ndr
Vanuatu	107	22,867	48	84,812	ndr	ndr
Wallis and Futuna (FR)	5	20	ndr	ndr	ndr	ndr
Total	**683,915**	**1,994,411,623**	**1,134,073**	**2,817,440,188**	**23,167**	**201,303,124**

Source: EM-DAT, CRED, University of Louvain, Belgium

Note: n.a. signifies 'no data available'; ndr signifies 'no disaster reported'. For more information, see section on caveats in introductory text.

* Since slow-onset disasters can affect the same people for a number of years, it is best to use figures on total numbers affected to calculate annual averages over a decade rather than as absolute totals.

[1] Prior to 1993, Ethiopia was considered one country, after this date separate countries: Eritrea and Ethiopia

[2] Prior to 1991, the Soviet Union was considered one country, after this date separate countries. The former western republics of the USSR (Belarus, Estonia, Latvia, Lithuania, Moldova, Russian Federation and Ukraine) are included in Europe; the former southern republics (Armenia, Azerbaijan, Georgia, Kazakhstan, Kyrgyzstan, Tajikistan, Turkmenistan and Uzbekistan) are included in Asia.

[3] Since July 1997, Hong Kong has been included in China.

[4] Since May 2002, Timor-Leste has been an independent country.

[5] Since September 1993 and the Israel-PLO Declaration of Principles, the Gaza Strip and the West Bank have a Palestinian government. Direct negotiations to determine the permanent status of these territories began in September 1999 but are far from a permanent agreement.

[6] Prior to May 1990, Yemen was divided into Arab and People's Democratic Republics; since then it is considered one country.

[7] Prior to 1992 Yugoslavia was considered one country, after this date separate countries: Bosnia and Herzegovina, Croatia, FYR of Macedonia, Slovenia and Serbia and Montenegro. In June 2006, Serbia and Montenegro both proclaimed their independence.

[8] Prior to 1993, Czechoslovakia was considered one country, after this date separate countries: Czech Republic and Slovakia.

[9] Prior to October 1990, Germany was divided into Federal and Democratic Republics, after this date it is considered one country.

Over the last decade, the highest numbers of deaths per continent from natural and technological disasters were reported in Nigeria (Africa), Venezuela (Americas), Democratic People's Republic of Korea* (Asia), France (Europe) and Papua New Guinea (Oceania).

Over the same period, the highest numbers of people affected by disasters per continent were reported in Kenya (Africa), Brazil (Americas), China (Asia), Turkey (Europe) and Papua New Guinea (Oceania).

Compared with 1988–1997, the past decade has seen disaster deaths rise by 65 per cent and the numbers reported affected rise by 41 per cent.

* The estimates provided are disputed. See 'Caveats' on page 196 for further information.

Table 14 Refugees and asylum seekers by country/territory of origin (2001 to 2007)

	2001	2002	2003	2004	2005	2006	2007
Africa	**3,007,000**	**2,907,700**	**3,110,100**	**3,209,300**	**3,196,900**	**3,149,900**	**3,093,700**
Algeria	10,000	–	–	–	900	2,400	2,200
Angola	445,000	402,000	312,000	219,700	213,500	195,000	142,300
Benin	–	–	–	–	100	100	100
Burkina Faso	–	–	–	–	100	100	100
Burundi	375,000	395,000	349,000	472,700	438,500	393,700	364,900
Cameroon	2,000	–	–	2,300	3,900	4,900	4,000
Central African Republic	22,000	14,000	41,000	29,700	43,700	73,000	95,500
Chad	35,000	–	3,000	53,000	49,900	84,800	87,900
Comoros	–	–	–	–	500	–	–
Congo, Rep. of	30,000	15,000	14,000	22,700	24,300	18,500	18,600
Congo, DR of the	355,000	393,000	422,000	456,100	450,800	413,300	388,400
Côte d'Ivoire	–	22,000	51,000	44,900	25,300	27,200	28,800
Djibouti	–	–	–	–	100	200	–
Egypt	–	–	–	–	2,200	3,000	3,000
Equatorial Guinea	–	–	–	–	200	–	–
Eritrea	305,000	285,000	277,000	199,700	215,300	255,400	270,800
Ethiopia	13,000	15,500	14,500	46,800	63,900	77,800	78,900
Gambia	–	–	–	–	700	900	700
Ghana	10,000	10,000	10,000	10,000	10,000	7,900	7,800
Guinea	5,000	–	–	–	2,600	2,700	2,300
Guinea-Bissau	–	–	–	–	100	100	100
Kenya	–	–	–	10,100	11,400	3,500	3,100
Liberia	215,000	255,300	381,800	323,100	219,800	141,100	104,000
Libyan AJ	–	–	–	300	100	–	100
Madagascar	–	–	–	–	100	–	–
Malawi	–	–	–	2,900	3,800	9,100	9,300
Mali	–	–	–	4,000	3,300	4,100	4,200
Mauritania	50,000	40,000	20,000	28,600	29,300	28,000	28,300
Morocco	–	–	–	124,000	117,400	116,800	119,900
Mozambique	–	–	–	–	400	900	900
Namibia	–	–	–	–	1,200	1,100	1,100
Niger	–	–	–	–	100	300	100
Nigeria	10,000	15,000	17,000	25,700	22,800	11,300	9,000
Rwanda	60,000	36,000	40,000	45,900	102,500	92,100	81,100
Sao Tome and Principe	–	–	–	–	–	600	600
Senegal	10,000	11,000	13,000	11,600	9,600	16,300	16,700
Seychelles	–	–	–	–	–	1,400	1,400
Sierra Leone	185,000	115,000	61,000	20,800	26,500	25,000	24,300
Somalia	300,000	282,900	263,300	311,600	328,000	410,300	495,000
South Africa	–	–	–	–	100	100	100
Sudan	440,000	471,000	595,000	697,500	670,900	648,000	607,100

	2001	2002	2003	2004	2005	2006	2007
Swaziland	–	–	–	–	–	200	200
Tanzania, UR of	–	–	–	4,100	5,400	4,300	4,100
Togo	–	–	4,000	4,200	44,100	24,200	16,300
Tunisia	–	–	–	–	100	100	200
Uganda	20,000	25,000	28,000	29,100	35,100	28,500	27,300
Western Sahara	110,000	105,000	191,000	–	–	–	–[1]
Zambia	–	–	–	–	500	600	600
Zimbabwe	–	–	2,500	8,500	17,900	21,000	42,400
East Asia and Pacific	**1,104,500**	**1,172,100**	**1,236,100**	**1,366,000**	**1,385,900**	**1,329,000**	**1,374,200**
Cambodia	16,000	16,000	16,000	15,000	16,400	13,800	23,300
China (Tibet)	151,000	160,900	139,900	155,300	156,300	158,700	160,700
Fiji	–	–	–	–	300	200	300
Indonesia	5,500	5,100	23,400	23,500	44,300	39,300	35,500
Japan	–	–	–	–	100	–	–
Korea, DPR of	50,000	100,000	101,700	100,000	51,400	32,400	32,700
Korea, Republic of	–	–	–	–	300	300	300
Lao PDR	–	–	15,000	12,700	15,700	9,300	10,200
Malaysia	–	–	–	–	200	100	–
Mongolia	–	–	–	–	400	1,800	1,100
Myanmar	450,000	509,100	584,800	688,500	727,100	693,300	720,200
Philippines	57,000	57,000	57,200	65,000	67,700	69,400	71,400
Taiwan (CN)	–	–	–	–	–	100	100
Thailand	–	–	–	–	200	2,300	2,100
Timor-Leste	80,000	28,000	–	–	–	–	–
Viet Nam	295,000	296,000	298,100	306,000	305,500	308,000	316,300
South and Central Asia	**4,852,000**	**3,878,600**	**2,839,500**	**2,461,700**	**2,725,700**	**3,673,600**	**3,281,900**
Afghanistan	4,500,000	3,532,900	2,533,200	2,070,500	2,192,100	3,260,300	2,907,100
Bangladesh	–	–	–	6,800	45,300	47,000	47,200
Bhutan	126,000	127,000	128,700	120,400	122,300	119,100	124,300
India	17,000	18,000	17,000	11,900	11,700	15,300	14,000
Kazakhstan	–	–	–	–	500	700	600
Kyrgyzstan	–	–	–	–	200	400	300
Nepal	–	–	–	100,000	201,800	102,500	52,200
Pakistan	10,000	–	6,700	14,700	16,500	16,500	17,500
Sri Lanka	144,000	148,100	106,400	82,600	79,100	108,900	115,800
Tajikistan	55,000	52,600	47,500	54,800	54,200	–	–
Turkmenistan	–	–	–	–	100	100	100
Uzbekistan	–	–	–	–	1,900	2,800	2,800
Middle East	**4,457,000**	**3,244,500**	**3,220,200**	**3,366,600**	**3,898,800**	**4,533,200**	**5,237,700**
Iran, Isl. Rep. of	34,000	24,800	21,000	27,000	31,900	29,100	27,300
Iraq	300,000	237,400	268,200	349,400	888,700	1,457,800	2,076,200
Israel	–	–	–	–	500	700	900
Jordan	–	–	–	–	500	700	700
Lebanon	–	1,200	–	3,900	700	2,100	2,100

	2001	2002	2003	2004	2005	2006	2007
Palestinian Territory, Occupied	4,123,000	2,981,100	2,927,000	2,986,000	2,971,600	3,036,400	3,125,500
Syrian Arab Rep.	–	–	4,000	–	4,400	5,900	4,300
Yemen	–	–	–	–	400	500	600
Europe	**666,000**	**517,500**	**438,600**	**226,500**	**230,100**	**274,500**	**465,202**
Albania	–	–	–	3,300	2,900	2,800	2,500
Armenia	9,000	–	–	2,500	4,200	7,300	5,200
Azerbaijan	–	–	–	11,000	13,000	12,500	5,100
Belarus	–	–	–	–	1,300	2,000	1,700
Bosnia and Herzegovina	210,000	156,100	121,200	30,300	29,700	33,300	31,200
Bulgaria	–	–	–	–	1,100	1,000	900
Croatia	272,000	250,000	208,900	69,800	59,600	57,300	57,700
Czech Republic	–	–	–	–	100	–	100
Estonia	–	–	–	–	100	100	100
Georgia	21,000	11,400	6,600	20,000	23,100	54,600	47,400
Germany	–	–	–	–	–	–	100
Hungary	–	–	–	–	200	200	200
Latvia	–	–	–	–	100	100	100
Lithuania	–	–	–	–	200	100	100
Macedonia, FYR of	23,000	3,000	–	–	1,400	1,600	600
Moldova	–	–	–	–	1,500	1,800	1,200
Poland	–	–	–	–	500	400	400
Portugal	–	–	–	–	100	–	–
Romania	–	–	–	–	900	1,400	1,100
Russian Federation	18,000	27,900	25,600	39,400	34,000	35,400	29,900
Serbia and Montenegro	60,000	52,200	52,800	19,300	24,700	26,100	25,100[2]
Slovakia	–	–	–	–	–	200	200
Slovenia	–	–	–	–	100	–	–
Turkey	43,000	16,900	17,600	26,600	25,700	28,600	21,800
Ukraine	10,000	–	5,900	4,300	5,500	7,700	6,600
United Kingdom	–	–	–	–	100	–	–
Americas and Caribbean	**421,000**	**454,200**	**319,000**	**339,800**	**324,000**	**515,700**	**652,500**
Argentina	–	–	–	–	300	100	100
Bolivia	–	–	–	–	100	300	300
Brazil	–	–	–	–	600	500	500
Chile	–	–	–	–	–	–	100
Colombia	23,000	42,900	230,700	261,000	257,900	453,300	581,600
Costa Rica	–	–	–	–	100	100	–
Cuba	3,000	31,500	26,500	25,100	16,700	13,600	13,900
Dominican Republic	–	–	–	–	–	100	100
Ecuador	–	–	–	–	200	200	300
El Salvador	217,000	203,000	4,500	4,500	5,000	4,700	4,900
Grenada	–	–	–	–	100	100	100
Guatemala	129,000	129,000	10,200	12,600	5,900	4,800	4,900

	2001	2002	2003	2004	2005	2006	2007
Guyana	–	–	–	–	500	400	300
Haiti	25,000	30,800	23,800	19,900	17,200	18,100	22,000
Honduras	–	–	–	–	1,300	1,500	1,600
Jamaica	–	–	–	–	300	300	300
Mexico	11,000	–	20,700	4,100	4,900	6,800	9,600
Nicaragua	13,000	15,800	2,600	8,200	5,600	3,400	3,600
Peru	–	1,200	–	–	2,900	2,900	2,800
Saint Lucia	–	–	–	–	200	200	200
Saint Vincent and the Grenadines	–	–	–	–	400	500	500
Trinidad and Tobago	–	–	–	–	200	300	300
United States	–	–	–	–	200	400	1,100
Venezuela	–	–	–	4,400	3,400	3,100	3,400
Total	**14,507,500**	**12,174,600**	**11,163,500**	**10,969,900**	**11,761,400**	**13,705,900**	**14,105,202**

Source: US Committee for Refugees and Immigrants

Notes:

– indicates zero or near zero

All data correct as of March 2008.

Notes on 2007 data:

[1] Western Sahara: this territory is now controlled by Morocco. Hence USCRI is listing Morocco as being the source responsible.

[2] Serbia and Montenegro: prior to 3 June 2006, Serbia and Montenegro were considered one country. Following a referendum, Montenegro declared itself an independent nation.

	2001	2002	2003	2004	2005	2006	2007
Africa	**3,002,000**	**3,029,000**	**3,245,500**	**3,293,500**	**3,176,100**	**3,212,900**	**3,194,700**
Algeria	85,000	85,000	170,000	102,000	94,500	95,000	97,600
Angola	12,000	12,000	13,000	14,900	14,900	15,600	16,000
Benin	5,000	6,000	5,000	5,900	32,000	12,200	9,000
Botswana	4,000	4,000	4,500	3,800	3,200	3,200	3,200
Burkina Faso	–	–	–	–	1,300	1,300	1,300
Burundi	28,000	41,000	42,000	60,700	40,600	20,300	31,700
Cameroon	32,000	17,000	25,000	65,000	58,900	71,200	94,400
Central African Rep.	49,000	50,000	51,000	30,600	26,500	14,300	9,900
Chad	15,000	16,000	156,000	260,000	275,500	286,800	300,600
Congo, Rep. of	102,000	118,000	91,000	71,700	69,600	60,000	43,200
Congo, DR of the	305,000	274,000	241,000	200,700	204,500	208,500	142,400
Côte d'Ivoire	103,000	50,000	74,000	74,200	44,100	40,800	34,100
Djibouti	22,000	23,000	36,000	18,000	10,500	9,300	8,000
Egypt	75,000	78,000	69,000	85,800	86,700	172,900	205,100
Eritrea	2,000	3,000	4,000	4,700	6,000	6,600	6,800
Ethiopia	114,000	115,000	112,000	116,000	101,100	147,300	198,100
Gabon	20,000	20,000	19,000	19,100	13,400	12,600	12,700
Gambia	15,000	10,000	10,000	11,000	8,800	14,400	14,700
Ghana	12,000	41,000	48,000	48,100	59,000	50,500	40,500
Guinea	190,000	182,000	223,000	145,200	67,300	35,400	22,100
Guinea-Bissau	7,000	7,000	10,000	7,700	7,800	8,100	8,300
Kenya	243,000	221,000	219,000	269,300	314,600	337,700	319,400
Liberia	60,000	65,000	60,000	38,600	16,100	16,200	19,300
Libyan AJ	33,000	12,000	–	12,400	12,000	10,900	16,400
Malawi	6,000	13,000	12,000	7,000	9,600	9,200	9,400
Mali	9,000	4,000	7,000	12,300	13,100	12,500	12,800
Mauritania	25,000	25,000	26,500	30,600	30,600	30,400	31,200
Morocco	–	2,000	–	2,300	2,300	1,900	2,000
Mozambique	5,000	7,000	8,000	5,500	6,000	6,900	7,100
Namibia	31,000	26,000	15,000	16,900	14,300	6,600	6,600
Niger	1,000	–	–	–	300	15,300	15,700
Nigeria	7,000	7,000	10,000	9,500	9,400	9,400	9,600
Rwanda	35,000	32,000	37,000	36,100	49,500	53,100	54,100
Senegal	43,000	45,000	23,000	23,200	23,400	23,200	23,800
Sierra Leone	15,000	60,000	70,000	65,700	60,100	27,600	17,200
Somalia	–	–	–	3,000	2,900	2,100	2,200
South Africa	22,000	65,000	104,000	142,900	169,800	171,400	216,400
Sudan	307,000	287,000	280,000	225,900	231,700	296,400	304,400
Swaziland	1,000	1,000	–	–	1,000	1,000	1,000
Tanzania	498,000	516,000	480,000	602,300	549,100	485,700	432,500
Togo	11,000	11,000	12,000	11,700	9,700	6,800	6,900
Tunisia	–	–	–	–	100	200	200
Uganda	174,000	221,000	231,500	252,300	254,400	277,800	267,500
Zambia	270,000	247,000	239,000	174,000	155,900	120,500	115,400

	2001	2002	2003	2004	2005	2006	2007
Zimbabwe	9,000	10,000	8,000	6,900	14,000	3,800	3,900
East Asia and Pacific	**815,700**	**874,700**	**953,400**	**1,013,200**	**1,029,400**	**944,500**	**961,700**
Australia	21,800	25,000	22,800	14,600	14,800	14,800	13,400
Cambodia	1,000	300	100	–	200	200	200
China	345,000	396,000	396,000	401,500	352,700	335,400	343,600
Indonesia	81,300	28,700	300	–	100	600	600
Japan	6,400	6,500	7,900	6,100	2,600	2,900	3,000
Korea, Rep. of	600	–	1,700	2,200	2,100	2,400	2,500
Malaysia	57,500	59,000	75,700	101,200	152,700	155,700	159,300
Nauru	800	100	200	–	–	–	–
New Zealand	2,700	1,700	1,200	1,800	1,000	800	800
Papua New Guinea	5,400	5,200	7,800	7,800	10,000	10,200	10,500
Philippines	200	200	2,200	2,200	300	100	100
Thailand	277,000	336,000	421,500	460,800	477,500	408,400	405,200
Viet Nam	16,000	16,000	16,000	15,000	15,400	13,000	22,500
South and Central Asia	**2,702,600**	**2,188,600**	**1,872,900**	**1,724,600**	**1,953,600**	**2,914,200**	**2,618,000**
Bangladesh	122,000	122,200	119,900	150,000	150,100	178,100	177,600
India	345,800	332,300	316,900	393,300	515,100	435,900	423,400
Kazakhstan	19,500	20,600	15,300	15,800	7,300	4,500	4,500
Kyrgyzstan	9,700	8,300	8,200	4,200	3,100	900	900
Nepal	131,000	132,000	134,600	130,600	130,600	129,600	130,100
Pakistan	2,018,000	1,518,000	1,219,000	968,800	1,088,100	2,161,500	1,877,800
Sri Lanka	–	–	–	–	200	300	300
Tajikistan	4,600	3,500	3,200	3,700	2,600	1,200	1,200
Turkmenistan	14,000	13,700	14,100	13,300	12,000	800	800
Uzbekistan	38,000	38,000	41,700	44,900	44,500	1,400	1,400
Middle East	**6,830,200**	**5,290,300**	**4,353,100**	**4,288,100**	**4,855,400**	**5,420,100**	**6,035,800**
Gaza Strip	852,600	879,000	923,000	952,300	986,000	1,017,000	1,047,200
Iran, Isl. Rep. of	2,558,000	2,208,500	1,335,000	1,046,100	994,000	1,025,000	1,024,500
Iraq	128,100	134,700	131,500	96,600	63,400	46,600	41,000
Israel	4,700	2,100	1,000	4,900	1,500	1,700	1,700
Jordan	1,643,900	155,000	163,700	168,300	609,500	732,700	617,100
Kuwait	50,000	65,000	65,000	51,800	14,300	13,600	14,000
Lebanon	389,500	409,000	256,000	265,800	296,800	294,200	329,400
Qatar	–	–	–	–	100	100	100
Saudi Arabia	128,500	245,400	240,900	243,700	240,800	241,000	247,500
Syrian Arab Rep.	397,600	482,400	497,000	701,700	866,300	1,329,300	1,843,500
United Arab Emirates	–	–	–	–	200	200	200
West Bank	607,800	627,500	665,000	682,700	699,800	722,000	745,000
Yemen	69,500	81,700	75,000	74,200	82,700	96,700	124,600
Europe	**972,550**	**859,900**	**884,500**	**610,500**	**530,200**	**569,200**	**527,200**
Albania	400	100	100	–	100	100	100
Armenia	11,000	11,000	11,000	11,200	11,300	11,500	4,500
Austria	10,800	30,900	17,600	19,300	17,300	43,900	13,000
Azerbaijan	7,000	11,400	10,300	9,800	3,300	2,700	2,800

	2001	2002	2003	2004	2005	2006	2007
Belarus	3,100	3,600	3,400	3,400	2,700	700	700
Belgium	41,000	30,300	33,000	24,500	14,100	18,100	12,900
Bosnia and Herzegovina	33,200	34,200	22,500	22,700	10,800	10,400	7,400
Bulgaria	2,900	1,200	800	5,200	5,200	5,400	5,400
Croatia	21,900	8,100	4,200	3,700	2,900	2,500	2,600
Cyprus	1,300	1,800	5,300	10,600	14,300	13,400	10,000
Czech Republic	10,600	6,300	3,900	2,700	1,300	4,800	4,900
Denmark	12,200	5,200	2,800	2,000	2,000	2,700	2,800
Finland	2,100	1,200	2,300	–	2,400	2,000	2,100
France	12,400	27,600	34,900	22,900	25,500	46,400	47,700
Georgia	7,900	4,200	3,900	2,600	2,500	1,400	1,400
Germany	116,000	104,000	90,800	83,300	64,200	21,600	28,900
Greece	6,500	1,800	5,200	10,200	11,300	5,800	6,000
Hungary	2,900	1,200	1,500	8,000	8,800	1,500	1,500
Iceland	–	–	–	–	300	–	–
Ireland	9,500	6,500	5,800	10,800	2,400	4,000	4,100
Italy	9,600	5,200	5,600	5,800	5,800	5,100	5,200
Liechtenstein	–	–	–	–	200	100	100
Lithuania	300	200	100	–	600	600	600
Macedonia, FYR of	3,600	2,700	2,300	2,200	2,200	3,100	3,200
Malta	–	–	200	–	2,400	200	200
Moldova	300	300	100	–	200	100	100
Netherlands	31,000	17,200	14,600	12,800	14,400	8,700	8,700
Norway	13,200	5,900	11,000	8,900	4,300	5,900	6,100
Poland	1,800	300	1,500	8,700	6,200	2,100	2,200
Portugal	50	–	–	–	400	–	–
Romania	200	100	200	2,400	2,300	1,600	1,400
Russian Federation	28,200	17,400	161,300	150,000	149,200	187,400	159,500
Serbia and Montenegro	400,000	353,000	291,100	76,500	78,600	77,900	80,000
Slovak Republic	3,100	4,500	4,700	3,300	3,100	6,100	200
Slovenia	2,700	400	100	–	200	400	300
Spain	1,000	200	200	–	1,600	5,500	5,600
Sweden	18,500	24,900	25,600	19,400	19,400	23,900	41,800
Switzerland	57,900	44,200	38,300	31,200	10,500	8,200	20,700
Turkey	12,600	10,000	9,500	7,800	7,300	8,900	9,100
Ukraine	6,000	3,600	3,100	6,400	4,000	3,500	3,600
United Kingdom	69,800	79,200	55,700	22,200	14,600	21,000	19,800
Americas and the Caribbean	**597,000**	**756,500**	**543,500**	**535,600**	**475,000**	**648,900**	**790,400**
Argentina	3,100	2,700	2,300	3,900	3,900	4,000	4,100
Bahamas	100	–	–	–	–	–	–
Belize	–	1,000	900	–	700	500	500
Bolivia	400	400	500	–	500	600	600
Brazil	4,050	3,700	3,900	3,800	3,700	3,900	21,100
Canada	70,000	78,400	70,200	54,800	39,500	43,500	54,000

	2001	2002	2003	2004	2005	2006	2007
Chile	550	400	500	–	900	1,500	1,500
Colombia	200	200	200	–	200	200	200
Costa Rica	10,600	12,800	13,600	10,600	12,200	11,800	12,100
Cuba	1,000	1,000	800	–	700	700	700
Dominican Republic	500	300	500	–	1,000	2,000	2,100
Ecuador	4,300	9,100	16,500	45,100	47,400	207,500	272,700
El Salvador	–	–	200	–	–	–	–
Guatemala	700	700	800	–	400	400	400
Mexico	6,200	4,000	2,900	4,500	3,400	3,500	3,600
Nicaragua	–	–	300	–	200	200	200
Panama	1,500	1,700	2,000	–	2,200	11,200	11,500
Paraguay	50	–	–	–	–	100	100
Peru	750	900	800	–	1,200	1,400	1,400
United States	492,500	638,000	244,200	232,800	176,700	147,200	151,200
Uruguay	100	100	100	–	100	200	200
Venezuela	400	1,100	182,300	180,100	180,100	208,500	252,200
Total	**14,920,050**	**12,999,000**	**11,852,900**	**11,465,500**	**12,019,700**	**13,709,800**	**14,127,800**

Source: US Committee for Refugees and Immigrants

Notes:
– indicates zero or near zero

All data correct as of March 2008

Table 16 Significant populations of internally displaced people (2001 to 2007)

	2001	2002	2003	2004	2005	2006	2007
Africa	**10,935,000**	**10,730,000**	**13,099,000**	**12,163,000**	**11,921,300**	**11,026,000**	**11,654,000**
Algeria	100,000	100,000	100,000	400,000	400,000	300,000	300,000
Angola	2,000,000	2,000,000	1,000,000	60,000	61,700	61,700	–
Burundi	600,000	400,000	400,000	145,000	117,000	100,000	100,000
Central African Republic	5,000	10,000	200,000	200,000	200,000	200,000	197,000
Chad	–	–	–	–	–	113,000	179,000
Congo, Rep. of	2,000,000	100,000	60,000	48,000	48,000	7,800	8,000
Congo, DR of the	50,000	2,000,000	3,200,000	2,330,000	1,664,000	1,100,000	1,312,000
Côte d'Ivoire	5,000	500,000	500,000	500,000	500,000	750,000	709,000
Eritrea	90,000	75,000	75,000	59,000	50,500	40,000	32,000
Ethiopia	100,000	90,000	90,000	132,000	150,000	100,000	200,000
Guinea	100,000	20,000	20,000	82,000	82,000	19,000	–
Kenya	200,000	230,000	230,000	360,000	381,900	431,000	300,000
Liberia	80,000	100,000	500,000	464,000	48,000	13,000	7,000
Nigeria	50,000	50,000	57,000	200,000	200,000	200,000	200,000
Senegal	5,000	5,000	17,000	–	–	64,000	22,000
Sierra Leone	600,000	–	–	3,000	–	–	–
Somalia	400,000	350,000	350,000	400,000	370,000	400,000	1,000,000
Sudan	4,000,000	4,000,000	4,800,000	5,300,000	5,335,000	5,355,000	5,800,000
Togo	–	–	–	–	3,000	1,500	1,000
Uganda	500,000	600,000	1,400,000	1,330,000	1,740,500	1,200,000	717,000
Zimbabwe	50,000	100,000	100,000	150,000	569,700	570,000	570,000
East Asia and Pacific	**2,266,000**	**1,349,000**	**1,400,000**	**1,160,000**	**992,000**	**1,000,000**	**973,000**
Indonesia	1,400,000	600,000	600,000	500,000	342,000	250,000	250,000
Korea, DPR of	100,000	100,000	50,000	50,000	50,000	30,000	–
Myanmar	600,000	600,000	600,000	550,000	540,000	500,000	503,000
Papua New Guinea	1,000	–	–	–	–	–	–
Philippines	135,000	45,000	150,000	60,000	60,000	120,000	120,000
Solomon Islands	30,000	4,000	–	–	–	–	–
Timor-Leste	–	–	–	–	–	100,000	100,000
Europe	**2,785,000**	**2,560,000**	**2,455,800**	**2,226,500**	**2,013,700**	**2,506,300**	**2,754,000**
Armenia	50,000	50,000	50,000	50,000	8,000	8,400	8,000
Azerbaijan	572,000	576,000	571,000	528,000	558,400	579,000	687,000
Bosnia and Herzegovina	439,000	368,000	327,200	309,200	183,400	180,000	132,000
Croatia	23,000	17,000	12,600	12,600	4,900	4,200	7,000
Cyprus	265,000	265,000	265,000	150,000	150,000	140,000	110,000
Georgia	264,000	262,000	260,000	260,000	240,000	222,000	222,000
Macedonia, FYR of	21,000	9,000	–	2,700	800	700	–
Russian Federation	474,000	371,000	368,000	339,000	265,000	190,000	159,000
Serbia and Montenegro	277,000	262,000	252,000	225,000	247,400	228,000	228,000
Turkey	400,000	380,000	350,000	350,000	355,800	954,000	1,201,000

	2001	2002	2003	2004	2005	2006	2007
Americas and Caribbean	**2,465,000**	**2,518,000**	**2,742,000**	**2,912,000**	**2,970,000**	**2,960,000**	**3,059,000**
Colombia	2,450,000	2,500,000	2,730,000	2,900,000	2,900,000	2,900,000	2,959,000
Haiti	–	6,000	–	–	–	–	–
Mexico	15,000	12,000	12,000	12,000	10,000	10,000	–
Peru	–	–	–	–	60,000	50,000	1000,000
Middle East*	**1,670,000**	**2,646,000**	**2,346,000**	**1,648,000**	**1,792,000**	**2,192,000**	**2,761,000**
Palestinian Territory, Occupied	20,000	26,000		–	–		24,500	24,000
Iraq	700,000	1,100,000	800,000	1,000,000	1,300,000	1,700,000	2,256,000
Israel	200,000	250,000	276,000	10,000	9,000	8,500	8,000
Jordan	–	800,000	800,000	168,000	160,000	172,000	172,000
Lebanon	250,000	300,000	300,000	300,000	250,000	216,000	232,000
Syrian Arab Rep.	500,000	170,000	170,000	170,000	73,000	71,000	69,000
South and Central Asia	**2,402,000**	**2,023,000**	**1,511,000**	**1,205,000**	**1,282,800**	**1,484,400**	**1,347,000**
Afghanistan *	1,000,000	700,000	200,000	167,000	153,200	132,000	132,000
Bangladesh	100,000	60,000	61,000	65,000	65,000	65,000	65,000
India	500,000	600,000	650,000	500,000	600,000	600,000	600,000
Nepal *	–	100,000	100,000	100,000	100,000	100,000	70,000
Pakistan *	2,000	–	–	17,000	20,000	84,000	17,000
Sri Lanka	800,000	563,000	500,000	353,000	341,200	500,000	460,000
Uzbekistan	–	–	–	3,000	3,400	3,400	3,000
Total	**22,523,000**	**21,826,000**	**23,553,800**	**21,314,500**	**20,971,800**	**21,168,700**	**22,548,000**

Source: US Committee for Refugees and Immigrants

Notes:

– indicates zero or near zero

All data correct as of March 2008

* Estimates of the size of internally displaced populations are frequently subject to great margins of error and are often imprecise, particularly in these countries and regions.

Progress on implementation of disaster risk reduction actions

Preparing local action plans for disaster risk reduction in Indonesia

From mid-2007, Indonesia developed local action plans for disaster risk reduction in the provinces of Central Java and Yogyakarta, Indonesia, with support from the United Nations International Strategy for Disaster Reduction (UNISDR) and the United Nations Development Programme (UNDP). The initiative aims to make it easier for local governments to prepare these plans, which will comprise an effective and comprehensive medium-term programme for disaster risk reduction. The local action plans are guided by the priorities outlined in the Hyogo Framework, are adapted to the local context and employ a multisector, multi-level and interdisciplinary approach.

In December 2007, a regulation from Central Java's provincial governor finalized and legalized the local action plan, while the plan for Yogyakarta province will be completed in the first half of 2008. In addition, with the enactment of recent national regulations, local governments will be required to prepare local ordinances and standard operating procedures to make these government and presidential regulations operational at the local level in Indonesia.

Because more and more provinces and districts have asked for local action plans to be drawn up, the central government is considering developing guidelines to define which activities will be undertaken at national and provincial levels, and give guidance on available standard approaches and tools. The local action plans prepared for Yogyakarta and Central Java provinces are among the first such initiatives undertaken in Indonesia. In order that other localities in Indonesia and elsewhere can learn from the experience of the two provinces, documents are being drawn up which outline how the local action plans were prepared. They will subsequently be disseminated in the form of 'good practices'.

Many countries in Asia have decentralized or devolved disaster risk management responsibilities to local and provincial levels. The Indonesian experience, therefore, could well inspire and help other countries interested in developing similar action plans for disaster risk reduction at local and/or national levels.

Benefits of reporting on progress on disaster risk reduction

The overarching aim of disaster risk reduction activities is to reduce the number of fatalities and economic losses in countries and communities. To do this, it is essential to have a clear understanding of the evolving nature of disaster risk and its implications, and put sound disaster reduction measures into practice.

Developing benchmarks and indicators that monitor, evaluate and report on progress in implementing such measures has evident benefits at all levels, whether local, national, regional or international. These include identifying existing capacity and resource gaps, increasing their importance on the political agenda, and promoting solutions through new or improved policies, plans, institutional relationships and resource allocations at all levels. Sharing information about the Indonesian experience of local action plans is a good example of the benefits of reporting progress.

Countries and local communities are ultimately responsible for motivating people to engage in effective actions to reduce disaster risk and for evaluating progress. The international community, however, also has a responsibility to increase and spread knowledge about available methodologies, tools and resources.

Monitoring, reviewing and reporting on progress is an essential part of the implementation of the Hyogo Framework for Action (HFA), which was adopted by 168 states at the World Conference on Disaster Reduction in Kobe, Japan in 2005. Responsibility for monitoring and reporting is mainly assigned to states, regional organizations and institutions, international organizations and the UNISDR's partners and secretariat.

The UNISDR secretariat, with support from relevant partners at all levels, is responsible (every two years) for coordinating, monitoring and reporting of progress in putting disaster risk reduction priorities into practice around the world.

To meet these requirements, the secretariat is creating the 'HFA Monitor', an online monitoring and review tool, to facilitate national reporting for the period from 2007 to 2009 and to help systematize existing baseline data and progress assessments or reviews at all levels.

The online tool, to be launched in May 2008, will make baseline and progress review data systematically available across the years. This will allow countries to regularly monitor and assess their progress in implementing risk reduction actions.

UNISDR will compile and analyse the results of systematic reporting undertaken by a range of national, regional and international partners, every two years, in a *Global*

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Assessment Report on Disaster Risk Reduction. The first UNISDR system report, which is scheduled for release at the second Global Platform for Disaster Risk Reduction in mid-2009, will present an analysis of the key trends and findings from national and regional level progress reviews prepared for the period from 2007 to 2009.

The UNISDR system is a partnership of member states, UN organizations and agencies, development banks, civil society organizations, the private sector and the scientific and academic communities. UNISDR invites all partners and stakeholders to contribute to the analysis and monitoring of progress, with a specific focus on thematic progress reviews for areas such as capacity development, civil society partnerships for disaster risk reduction, local-level disaster risk reduction, urban risk, social protection measures, gender, environment, preparedness and response, among others.

The baseline for monitoring progress is provided by the Hyogo Framework's expected outcome: "substantial reduction of disaster losses, in lives and in the social, economic and environmental assets of communities and countries", and by three strategic goals:
- Integration of disaster risk reduction into sustainable development
- Development and strengthening of institutions, mechanisms and capacities to build resilience to hazards
- Systematic incorporation of risk reduction approaches into implementation of emergency preparedness, response and recovery programmes.

To help attain its expected outcome and goals, the Hyogo Framework identifies five specific priorities for action:
- Making disaster risk reduction a national and local priority with a strong institutional basis for implementation
- Improving disaster risk information and early warning
- Building a culture of safety and resilience
- Reducing the risks in key sectors
- Strengthening preparedness for response.

The International Federation participates actively at all levels of the UNISDR system and its contribution to this process is crucial to attain a comprehensive review of collective progress made on disaster risk reduction actions.

For more information, visit the following Prevention Web link, where information on national progress reports and statements is currently available: www.preventionweb.net/english/hyogo/framework/?pid:34&pil:1.

Shefali Juneja, UNISDR Programme Officer, prepared this annex, with contributions from Helena Molin-Valdes, UNISDR Deputy Director, and Jerry Velasquez, Senior Regional Coordinator, UNISDR Asia & Pacific. The UNISDR secretariat's mission is to

be a catalyst and advocate for the implementation of the International Strategy for Disaster Reduction and the Hyogo Framework for Action. The secretariat brokers links between different initiatives, facilitates joint work through providing technical and secretariat support services, and catalyses agreements and action on disaster risk reduction through advocacy and guidance on policy priorities. For further information, please contact UNISDR at +41 (0)22 9178834 or isdr@un.org.

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The Fundamental Principles of the International Red Cross and Red Crescent Movement

Humanity
The International Red Cross and Red Crescent Movement, born of a desire to bring assistance without discrimination to the wounded on the battlefield, endeavours, in its international and national capacity, to prevent and alleviate human suffering wherever it may be found. Its purpose is to protect life and health and to ensure respect for the human being. It promotes mutual understanding, friendship, cooperation and lasting peace among all peoples.

Impartiality
It makes no discrimination as to nationality, race, religious beliefs, class or political opinions. It endeavours to relieve the suffering of individuals, being guided solely by their needs, and to give priority to the most urgent cases of distress.

Neutrality
In order to continue to enjoy the confidence of all, the Movement may not take sides in hostilities or engage at any time in controversies of a political, racial, religious or ideological nature.

Independence
The Movement is independent. The National Societies, while auxiliaries in the humanitarian services of their governments and subject to the laws of their respective countries, must always maintain their autonomy so that they may be able at all times to act in accordance with the principles of the Movement.

Voluntary service
It is a voluntary relief movement not prompted in any manner by desire for gain.

Unity
There can be only one Red Cross or Red Crescent Society in any one country. It must be open to all. It must carry on its humanitarian work throughout its territory.

Universality
The International Red Cross and Red Crescent Movement, in which all societies have equal status and share equal responsibilities and duties in helping each other, is worldwide.

"The link between vulnerability to HIV and humanitarian disaster has long been recognized; yet we have been slow as a global community in proactively involving organizations in the humanitarian world in the fight against HIV and AIDS. The focus of this World Disasters Report on HIV and AIDS is extremely timely."

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The AIDS epidemic is a disaster on many levels. In the most affected countries in sub-Saharan Africa, where prevalence rates reach 20 per cent, development gains are reversed and life expectancy may be halved. For specific groups of marginalized people – injecting drug users, sex workers and men who have sex with men – across the world, HIV rates are on the increase. Yet they often face stigma, criminalization and little, if any, access to HIV prevention and treatment services. As this report explains, HIV is a challenge to the humanitarian world whose task is to improve the lives of vulnerable people and to support them in strengthening their capacities and resilience. Disasters, man-made and 'natural', exacerbate other drivers of the epidemic and can also increase people's vulnerability to infection.

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- The disaster of HIV
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