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AIDS, Gender and the Refugee Protection Framework

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AIDS, Gender and the Refugee Protection Framework

Katharine Williamson

1. Introduction

"Like every epidemic, AIDS develops in the cracks and crevasses of society's inequalities. We cannot face the epidemic if we try to hide the contradictions and conflicts that it exposes."

(Herbert Daniel, Brazil, quoted in Hamblin & Reid 1991:2)

Forced migrants are those who have been compelled to leave their homes for fear of persecution. In this paper, this term will cover as well as recognised convention refugees, those fleeing generalised violence and internally displaced people. All of these groups live beyond the protection of a state and are therefore among the most marginalized people in the world. Within these groups are social divisions such as ethnicity, class and gender that create further power divisions that are frequently exacerbated by the situation of conflict and flight that forced migrants experience. Gender is the most pervasive of these categories, with roles commonly constructed to create norms of inequality between men and women. Female forced migrants therefore can be among the most vulnerable of the most marginalized as their particular needs are concealed and voices silenced by a lack of representation in the public sphere and agency in the private sphere.

Into this equation in the last two decades has been added the risk of infection by HIV/AIDS[1]. The manifold, complex and powerful discourses surrounding HIV/AIDS express social fears through the construction of inequality, power and powerlessness and the apportioning of stigma and blame. This paper will show how marginalisation and stigma heighten vulnerability to infection by stripping people of power and agency. At the intersection of forced migration and gender, female forced migrants are therefore doubly placed at risk of infection. The implications of the HIV/AIDS virus on the future of peace, rehabilitation and development of forced migrant communities after return makes this a crucial issue on the international relief, reconstruction and peace building

[1] Throughout this paper I will refer to the epidemic in the composite form "HIV/AIDS", meaning both the Human Immunodeficiency Virus and the Acquired Immune Deficiency Syndrome that results from the virus. As people are infected with the virus but die from syndrome related illnesses, where I refer specifically to the process of infection, I will use "HIV", and where I refer to the mortality that ensues I will use "AIDS".

agenda. If the human rights of women and refugees are to be recognised, an effective framework of prevention and response to HIV/AIDS needs to be developed that takes account of marginalized voices and seeks to turn the HIV/AIDS discourse from one based on control and exclusion to one of rights and empowerment (Seidel 1993:186).

Having examined the intersectionality of these two marginsalised groups in relation to HIV/AIDS the paper will build an argument for treating HIV/AIDS in refugee societies as a social rather than medical issue. Case studies and illustrations will concentrate on mass forced migration and settlement within sub-Saharan Africa[2] as among the most vulnerable populations and the main foci of relief and intervention efforts. The paper begins with an overview of the HIV/AIDS pandemic in sub-Saharan Africa, followed by a study of the particular vulnerabilities of women and then of forced migrants. This aims to show the extent to which the HIV/AIDS pandemic is a socio-economic phenomenon, underwritten by social relations of inequality (Baylies & Burr 2000:483) and the consequences this has for the marginalisation of vulnerable groups such as refugees and forced migrants.

Once the issues have been set out, the paper will develop a framework for response to HIV/AIDS through an analysis of the ethics, human rights and law relating to forced migrants and HIV/AIDS. This will focus primarily on the prevention of the spread of infection. The implications of infection on the protection of forced migrants are beyond the remit of this paper. However, many of the conclusions the paper will draw, involving human rights, empowerment and community participation will also be relevant to the status and care of forced migrants with HIV/AIDS. Prevention and response strategies should advocate for greater awareness of the underlying global causes of the spread of HIV/AIDS. The paper will argue that HIV/AIDS issues need to be

[2] Although I do no wish to reinforce the stereotype that this issue is specifically African, the scale of the AIDS pandemic in sub-Saharan Africa makes its analysis of particularly pressing importance. Sub-Saharan Africa has also been characterised in the last 30-40 years by the mass influx of refugees fleeing civil war in their country and the protracted exile they endure while resolutions to the conflicts remain elusive.

recognised as a social rather than essentially a medical phenomenon and as such receive greater prioritisation in the international agenda of refugee protection and assistance in all phases of the refugee cycle from emergency relief, to care and maintenance of refugee populations and to their return and reintegration in their country of origin with all associated implications for post-war reconstruction and peace building. This requires a shift in thinking that recognises the importance of long-term development aims at the initial stages of emergency response and can assimilate a gendered approach in to the overall design of refugee relief and assistance programmes. Ultimately the spread of HIV infection can only be tackled through empowering women to gain control of their bodies, social identities and future lives, both within the context of refugee situations and in the event of return and post-war reconstruction.

2. The HIV/AIDS pandemic in sub-Saharan Africa

2.1 The African HIV/AIDS Discourse

HIV/AIDS is an "incredibly powerful semantic constellation" (Esteva 1993 quoted in Sabatier 1996:86) formulated in representations of the disease that reflect the interactions of individual bodies, social bodies and the body politic (Sabatier 1996). From its inception in the West in the early 1980s, HIV/AIDS has been potently construed as carrying a moral meaning through its association with groups that defined the degeneracy of the modern world such as drug users, homosexuals and sex workers (Treichler 1999). From the popular myth of its origins in the dark heart of Africa, first world discourse has also equated HIV/AIDS with the third world: unknowable, out of control, threatening global order, and thus a problem to be solved. In Africa itself it is often interwoven with themes of colonialism and resistance in an interpretation of HIV/AIDS as an American invention, and preventative programmes as Western imperialist population strategies[3] (Treichler 1999:43).

[3]The African joke that AIDS stands for 'American Invention to Discourage Sex' expresses the scepticism and underlying tensions created by the imposition of a Western interpretation of HIV/AIDS in Africa (Dunne 2000). South Africa's President Thabo Mbeki has in the past headed calls for a re-evaluation of the causes of AIDS, casting doubt on the theory that sexual transmission leads to HIV infection which then leads to AIDS, and instead suggesting that drugs

The media association between Africa and HIV/AIDS has worsened discrimination against Africans and particularly refugees from Africa (Refugee Council 1992:1). It is not the aim of this paper to portray HIV/AIDS as an 'African' disease, but to put forward a constructive analysis of the HIV/AIDS problem in relation to refugees within sub-Saharan Africa, which may perhaps be extrapolated on a global scale. Communities cannot become engaged against HIV/AIDS before the processes of their representations are understood, and its analysis in Africa must therefore confront issues of decolonisation, urbanisation, economic structural adjustment, conflict and processes of nation-state formation (Treichler 1999).

2.2 Facts and Figures

United Nations reports estimate that the global number of people living with HIV/AIDS by 2001 was between 36 and 40 million (UNHCR 2001; UNHCR 2001a; UNAIDS/WHO 2001; UNAIDS 2001a; UNAIDS 2001b). At least 90% of these people live in developing countries (UNAIDS 2001b) with between 25 - 28.1 million, or over 65%, living in sub-Saharan Africa (UNAIDS 2001b; UNAIDS/WHO 2001; UNHCR 2001a), an area home to 10% of the world's population (UNHCR 2001). It is now the leading cause of death in sub-Saharan Africa causing 2.3 million deaths in 2001 (UNAIDS/WHO 2001). The southern part of the continent contains the majority of the world's hardest hit countries. In Botswana, Namibia, South Africa, Swaziland and Zimbabwe between 20 – 26 % of the population aged between 15 - 49 is living with HIV/AIDS. In West Africa, the worst affected countries are Cote d'Ivoire with a 10% infection rate amongst the adult population, and Nigeria with 2.2 million people living with HIV/AIDS (UNAIDS 2001). One third of those living with HIV/AIDS are aged between 15 – 24, the majority of whom do not know that they carry the virus (UNAIDS/WHO 2001).

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such as AZT themselves induce diseases that are seen as symptomatic of AIDS (Dunne 2000; Mbeki 2000; Shenton 2000).

2.3 Developmental Impact

HIV/AIDS has enormous consequences for economic development in the continent, having a profound impact on growth, income and poverty and threatening human welfare and security, developmental progress and social stability on a massive scale. Rapidly increasing rates of infection in the last 20 years should be seen in the context of socio-economic decline as Africa's shift to industrialisation has been threatened by geopolitical upheavals that have brought changes in economic alliances, shifting assistance away from Africa (Ankrah 1996:99). Rapid urbanisation and the growth of the mining industry has created an enormous shift in social behaviour, with wage earners living away from families and communities for extended periods of time. The cycle of impoverishment is most acutely felt by the poor with every income earner in the poorest categories expected to take on an average of 4 more dependents because of HIV/AIDS (UNAIDS/WHO 2001:7). The ability of the state to ensure law and order is compromised as institutions such as the police and courts are disrupted by the epidemic (UNAIDS/WHO 2001:17). Huge numbers of doctors, teachers and other professionals have died affecting service provision and as farm workers die, agricultural output levels diminish. Africa as a whole can expect a third less growth in GNP by 2025 because of HIV/AIDS (Ankrah 1996:102), while life expectancy in Botswana, Malawi, Mozambique and Swaziland has dropped below 40 years of age (UNAIDS/WHO 2001:8).

It is estimated that by the end of 2000, 13 million children will have been orphaned by HIV/AIDS, 90% of whom live in the sub-Saharan African region (Ledward 2000:6). In countries such as Zimbabwe, as many as 7% of children under 15 have been orphaned by HIV/AIDS, radically changing the social structure of affected communities (Ledward 2000:6). In Uganda for example, the ostracisation of such children and lack of familial care threatens their survival, particularly in rural communities (UNAIDS 2001:9).

When relating the above to the poverty, under-development, lack of infrastructure and rapid social transformation that accompanies in states post-conflict situations, it is clear that HIV/AIDS poses an immeasurable barrier to the long-term recovery and rehabilitation of forced migrant communities.

3. HIV/AIDS and Gender

3.1 The Gendered HIV/AIDS Discourse

HIV/AIDS discourse is inherently gendered. Of the three recognised means of transmission; sexual intercourse, injection or transfusion of blood, semen or other tissues, and perinatal transmission, sexual contact is the most common means accounting for up to 80% of global transmissions: 70% heterosexual and 10% homosexual (Chin 1992:34-5). If untreated, infection in women leads to perinatal transmission to their children during pregnancy in about one third of cases (Chin 1992:34).

Men, strongly influenced by social constructions of masculinity, tend on average to have more sexual partners than women and control the frequency and form of intercourse (Panos 1998:abstract). It is the behaviour of a core group, mainly composed of men, that drives the epidemic in any society (Foreman 1999:4). More women than men are at risk of contracting but not transmitting HIV because they are faithful to an unfaithful partner (Panos 1998:2). A long tradition of disease representation has focused on women as the source of infection; the polluter, the outsider, the prostitute, the socially-deviant individual (Gilman 1988:256; Travers & Bennett 1990:69; Reid 1994:552). Popular and biomedical discourse in relation to HIV/AIDS in sub-Saharan Africa therefore focuses on women as the transmitters of HIV (Grundfest Schoepf 1993:51), often as a form of social control. Some traditional healers in The Democratic Republic of Congo for example, claim that HIV/AIDS is an old disease which has become an epidemic because women no longer adhere to old sexual customs (Grundfest Schoepf 1993a:254). As a disease steeped in sexual politics, discourse on women and HIV/AIDS in Africa also draws on racialist constructions of African sexuality to suggest that Africans are destroying their own continent and threatening to

infect the world with their promiscuity (Grundfest Schoepf 1993:52; Dunne 2000). Even when created with a view to gender empowerment, prevention programmes have concentrated mainly on informing women and have thereby shifted responsibility onto their shoulders. Sex workers and pregnant women are focused on as the transmitters of the infection, and are targeted for information campaigns. Women, including sex workers, cannot, however, protect themselves unless men do (Panos 1998:1), and the targeting of sex workers and other groups of women encourages blame, stigma, and discrimination against all women, allowing others to deny both risk and responsibility (Hamblin & Reid 1991:5).

Clearly within the HIV/AIDS debate, vulnerability to infection is created at the intersection of gender and poverty. The intersection of gender and HIV/AIDS in turn heightens each type of persecution and intensifies stereotypes (Margulies 1994:550; Travers & Bennett 1990:74). Gender oppression is often defended in Africa in the name of 'culture' in the liberal assertion of group rights. The HIV/AIDS epidemic highlights the imperative to confront the socio-economic and cultural aspects of sexual behaviour and link prevention to actions to redress the causes of poverty and gender inequality within communities and societies (Okin 1997:8; Seidel 1993:178).

3.2 Biological and Social Determinants of Female Vulnerability to HIV/AIDS

Whereas in the West HIV/AIDS is, statistically, a preponderantly male disease, in Africa the distribution between the sexes until the 1990s had been more or less equal (Dunne 2000). However, infection rates have been rising faster in women than in men since the mid-1990s, so that they have now overtaken men (Hamblin & Reid 1991:2). Currently in sub-Saharan Africa 12-13 women are infected by HIV to every ten men, with the average infection rate in teenage girls five times higher than that in teenage boys (Gupta 2002:183). In most central African cities, AIDS is the leading cause of death among women between the ages of 20-40 (Hamblin & Reid 1991:3). As numbers of

infected women increase, so do the numbers of their infected children (Panos 1998:5). The reasons behind these statistics are both biological and socio-economic.

Biologically, women are more liable to contract the HIV virus being twice as vulnerable to infection through sexual intercourse than men (Panos 1998:3). Sexually transmitted infections (STIs) increase the likelihood of transmission by seven-fold and women are less likely to identify, be informed about, or have the money to treat STIs (Panos 1998:3). Young girls are even more likely to contract HIV due to the immaturity of surface cells in the genital tract (Smith 1997:11). Even the definition of HIV/AIDS is based on male symptomology, defined through male-biased clinical trials, making it more difficult to recognise and diagnose signs of infection in women (Travers & Bennett 1990:66).

Many of Africa's cultures are strongly patriarchal, bringing women's sexuality and reproductive capacities under the control of men, and often making it difficult for women to live without men (Okin 1997:3). Women have higher levels of illiteracy, earn 30-40% less than men for the same work, are more usually employed outside the formal sector, and in some countries are denied property rights, productive resources or access to credit (UNAIDS 2001a). This places women in a situation of vulnerability that strips them of their ability to protect themselves by constraining their agency to negotiate safe sex with men (Gupta 2002:183).

In such a situation, a woman's fertility and relationship to her husband will often socially define her, leaving her unable to leave an unfaithful or violent partner (UNAIDS 2000:49). Many cultures expect women to bear children with failure to do so being tantamount to inviting social ridicule if not divorce. Some women may have more pregnancies to offset the child mortality that HIV/AIDS infection causes (Ankrah 1996:110). Where HIV-seropositive status is seen as a sign of sexual promiscuity, gender norms tend to mean that women face greater stigmatisation and rejection than

men (UNAIDS 1998:2). Women found to be HIV+ will often be expelled even when the husband introduces the infection to the family. The husband may then get a new, younger wife (Hamblin & Reid 1991:4). Unmarried or rejected wives are marginalized and left voiceless, making them vulnerable to discrimination (UNAIDS 2001a), and sometimes leaving them with few alternatives other than multiple-partner survival strategies (Ankrah 1996:104). In many societies, female vulnerability is again increased by norms that make it inappropriate for women to know about sexuality or condom use (UNAIDS 1998). Ironically fear of HIV/AIDS pushes men to seek out younger female partners, who are not only more vulnerable to infection but are even less able to refuse sex or negotiate condom use (UNAIDS 2000:48).

3.3 HIV/AIDS, Gender and Development

The marginalisation of women in society is closely bound up with wider socio-economic development issues. The burden of caring for the sick and dying tends to fall on females, and orphaned girls or girls with sick parents are often pulled out of school to care for their relatives or younger siblings or because of lack of money (UNAIDS 1998:2). As many as 94% of rural women in some countries are illiterate, and HIV/AIDS information campaigns must take account of this (Ankrah 1996:104). Processes of globalisation, the deepening of social inequality and poverty and erosion of values and family and community ties increase the exposure of women and young girls to the sex industry, child pornography and trafficking in women and children (UNDAW 1997:7; Akeroyd 1997:24), thereby increasing their exposure to HIV/AIDS. These are examples of the 'feminisation' of poverty which are self-perpetuating in themselves and damaging to the entire social fabric of sub-Saharan Africa as elsewhere (UNAIDS 2001a:9). African women are the producers of the continent's food and the reproducers of family, community and society although 'owned' by men. Strategies to tackle HIV/AIDS have to include the socio-economic development of women (Ankrah 1996:99) as well as changing structural discrimination by the promotion of women's rights through legal frameworks (Seidel 1993).

4. HIV/AIDS and forced migration

4.1 The HIV/AIDS and Migration Discourse

Migration and HIV/AIDS are two of the greatest social issues facing the world today (Haour-Knipe & Rector 1996:1). An estimated 125 million people live and often work outside their own country of citizenship, while an additional 2-4 million migrate each year (UNAIDS 2000a:1). HIV/AIDS and migration can be seen as part of a similar continuum which has its source in marginalisation from resources, unequal participation in development and lack of respect for human rights (Carballo & Siem 1996:46). As such, intersectionality between these two factors is significant with migrant health falling through the cracks of health service provision in many host countries (Haour-Knipe & Rector 1996:3).

Immigrants have always shouldered disproportionate blame for social problems such as economic decline, cultural decay and disease, and popular perceptions of migrants also link them with the spread of HIV/AIDS (Margulies 1994:531). In his landmark work on stigmatisation, Erving Goffman (1990) outlines the three most common characteristics that define stigmatised groups: abominations of the body, blemishes on individual character and the tribal stigma of race, nation or religion (Haour-Knipe 1993:24). Migrants with HIV/AIDS fulfil all three of these characteristics and are discredited through the process of stigmatisation, reduced from a whole person to a tainted and discounted one (Haour-Knipe 1993:26).

In early accounts, HIV/AIDS was often described in terms of cross-border travel, as an imported problem, thus allowing societies to differentiate themselves from responsibility and avoid taking action (Sherr & Farsides 1996:71). With this point-of-view in mind, restriction of movement is the obvious and common reaction to the spread of the virus. Restriction of migration on the basis of HIV status has been instituted in many countries including the United States (Sherr & Farsides

1996:74). Discrimination, already endemic to the migrant and refugee's position, is exacerbated by HIV/AIDS, preventing them from seeking out appropriate health care and social support (Sherr & Farsides 1996:74).

In reality there is no data to support the idea that HIV rates are higher among immigrant populations (Matteelli & El-Hamad 1996:182), but migrants are at greater risk of contracting HIV/AIDS because of the impact of socio-cultural patterns, economic transition, reduced access to health services and the difficulties of host countries to cope with migrant traditions and practises (UNAIDS 2000a:i). These conditions are usually greatly exacerbated under forced migration conditions.

4.2 Factors Increasing Risk of Forced Migrants to HIV/AIDS

As outlined below, forced migrants are exposed to the increased danger of HIV infection in all stages of their refugee experience: during the conflict in their country of origin, the flight from their homes, settlement elsewhere, and even during repatriation or resettlement (Smith 1997:4). These endemic dangers are intensified for women as the breakdown in social cohesion leads to serious threats to their safety and security (Harris & Smyth 2001:11).

The civil unrest and wars experienced in many sub-Saharan African countries in the latter half of the twentieth century have been instrumental in the spread of HIV/AIDS in the continent. Social and civil dislocation due to conflict has been found to be a significant causal factor in the spread of the HIV/AIDS epidemics in southern Uganda and northern Tanzania, and between 1960 and 1980 more than 75 military coups occurred in 30 sub-Saharan African countries (Cohen & Trussell 1996:66). The military involved are typically young, single males with geographical mobility, factors that encourage casual sexual relationships, while the use of condoms does not appeal to men who frequently live in fear for their lives (Cohen & Trussell 1996:66). Many have lost hope in the

future because of the acts they have been induced to commit (Ruranga 1996:48). By 1996, Angolan and Zimbabwean armies demonstrated an HIV prevalence rate as high as 50% as compared to 10% in the civilian population, the Ugandan army had a sero-prevalence rate of 35-45%, while the mortality rate due to HIV/AIDS stood at 34% in the Congolese army (Kinnah 1996:10). The military interact with civilians to cause their flight, during flight and as refugees in camps and settlements. A study in Buchanon, Liberia, found that the military, including ECOMOG troops, were using refugee children as prostitutes. The children were forced into this situation as a means of obtaining a livelihood once family and cultural structures had collapsed (Beyan 1996:45).

The stress associated with upheaval and the family disorganisation that goes with it erode health (Carballo & Seim 1996:35) and within refugee settlements, social conditions, loss of family, sub-standard, overcrowded living conditions and poor health contribute to the spread of Sexually Transmitted Diseases (STDs) and HIV infection (Benjamin 1996:4). Women and children tend to make up roughly 80% of forced migrant populations (Oloka-Onyango 1996:379). The family unit is often split up, and in many situations over 30% of households are headed by females (World Vision International 1996:10), forcing a reorganisation of the division of labour within the family and affecting physical and economic security. Without the support of community and the social rules and regulations that guide behaviour at home, both men and women are often likely to turn to sex as a source of comfort or income, while those who have lost children in war or flight may be keen to have more (Scalway 2001:24).

Gender inequality and powerlessness are compounded by the extreme conditions of settlement life. Overcrowding, inadequate shelter, food shortages, poor sanitation and lack of employment all impact on women's ability to operate within their social gender norms. These gender norms themselves may have become more restrictive as a result of conflict as roles are politicised and idealised (Byrne 1996:33). When women become refugees, their responsibilities tend to increase

while their status goes down, impacting negatively on their physical and mental well-being (Katona-Apte 1993:2). Social values that traditionally serve to protect women may lose their meaning, or be difficult to uphold where carefully delineated spheres of public and private life have disintegrated within crowded living arrangements (World Vision International 1996:10). Early and forced marriages tend to become more common under these conditions (World Vision International 1996:11).

Relief organisations tend to work through what remains of previous social structures. As these tend to be heavily male-dominated, camp structures also tend to be male-dominated and women have little say in the organisation and distribution of relief supplies, with the result that their particular needs may not be addressed (Beijing Conference on Women 1995). For example, it may be inappropriate for women to interact with strangers so that female-headed households are unable to register and are therefore ineligible to receive rations, leaving them open to exploitation in order to receive basic supplies for their families (Katona-Apte 1995:9). Measures taken to address these issues are commendable but with international donors slashing budgets, vulnerable groups are the first victims of shortages (Beijing Conference on Women 1995), and women without men tend to be the last to collect rations, often receiving less than men. Due to the typical division of labour, they are also more liable to catch diseases or suffer from dangers associated with handling fuel and water (Katona-Apte 1995:10).

In conditions of extreme poverty or marginalisation, sex for money or for other forms of reward is used by women as a survival strategy (UNAIDS 2001a). As an example, in Bududuram Camp for Liberian refugees in Ghana, relief distributions have been phased out, access to employment and other resources is limited and women often sleep with several men as a necessary economic tactic (Dick 2001). It is also common to find a proliferation of prostitution in and around refugee camps and settlements, as women and girls lose the support of family through separation, and society

because of dislocation (World Vision International 1996:11). Sex becomes the currency by which they pay for the basics of survival. During the conflict in Sierra Leone, as elsewhere, women were raped in exchange for the safe passage of their family to neighbouring countries (UNHCR 2001a) while in Guinea, Liberia and Sierra Leone it has been found that refugee children and internally displaced youths are being forced to exchange sex for relief supplies and security by local aid workers, peacekeeping soldiers and refugee leaders in a system so endemic and prolific that many involved have no idea that relief is meant to be free (USCR 2002).

At its most extreme, the difference in power relations between men and women is manifested through gender-based violence (UNHCR 2001b:4). First of all, rape may be used as a weapon of war (McGinn 2000:178), for example, between one third and half of women and girls in Liberia were raped or sexually abused in the first five years of the recent civil conflict there (UNHCR 2001; McGinn 2000:178). It may take the form of plunder by armed forces, be used as a calculated genocidal tool, or as a manifestation of hate against specific ethnic populations. Its potency derives from societal acquiescence, exploiting concepts of honour, shame and sexuality that are attached to women's bodies during peacetime (McGinn 2000:178). Women are also highly vulnerable during flight and are exposed to exploitation by soldiers, rebels, officials, the military and other refugees. This is especially true for abandoned and widowed girls (Katona-Apte 1995:5). Once in refugee camps, abuse by intimate partners and acquaintances becomes more prevalent (McGinn 2000:178). Men may be under stress and frustrated by a lack of employment opportunities (Katona-Apte 1995:7). Unemployment in camps for Rwandese and Sudanese refugees in Uganda is recognised as leading to excessive drinking which, in combination with insufficient privacy, leads to sexual abuse and assault (Mwebaze 1996:41). In Kakuma camp, Kenya, 57% of women surveyed and 76% of men believe that men have the right to beat their wives (McGinn 2000:178). Camp security and lack of economic activity for women can also be problematic. Female Somali refugees in Dadaab, Kenya, were regularly attacked and raped by other refugees and bandits while collecting firewood

in surrounding regions (UNHCR 2001c). It is estimated that between 40-58% of sexual assaults take place against girls of 15 years or under, creating considerable implications for physical and mental health and development (Smith 1997:8). Serious issues such as these are often concealed by a conspiracy to protect against shame, ostracisation and rejection, making information extremely difficult to obtain. UNHCR has advised field staff to assume that a high level of gender abuse will be taking place in all refugee camps and settlements, unless there is conclusive evidence to the contrary (Smith 1997:7).

The spread of HIV/AIDS is an inevitable consequence of such a dire situation. The assumption that general knowledge of HIV/AIDS will lead to behaviour change has created unrealistic expectations of people's agency over their own lives, and it has become obvious that the distribution of condoms and dissemination of information is totally inadequate on its own to enable forced migrants to protect themselves from infection (Onyango 2001). The messages that people hear are not addressing their real needs and without a deeper and more holistic understanding of these needs and a response that takes account of gender-related violence and women's lack of agency within relationships, the spread of infection within refugee settlements will have grim consequences for long-term rehabilitation, development and even peace.

5. Developing a Rights-Based Ethical Approach to HIV/AIDS in Forced Migration

5.1 Ethical / Legal Framework

Policy and practise in the area of HIV/AIDS prevention and response is framed against developments in the ethical and legal spheres. Some popular ethical discourses seek to exclude or marginalise those who are perceived as a threat to public health on the grounds of protecting the greatest number (Seidel 1993:182). The ethics of caring for those with HIV/AIDS may also be weighed against cost to the public purse, invoking an implicit financial evaluation of human life with a subsequent devaluation through infection with HIV/AIDS. Forced migrants, in turn, create

similar ethical predicaments, as the responsibility of responding to their plight is weighed against perceived costs.

This is, however, a misconceived debate (Hamblin 1991:1). As we have seen, the creation of blame and the stigmatisation of groups as the carriers of HIV infection simply serves to marginalise groups further and to increase their vulnerability to infection. It does not achieve the desired aim of confining the disease within social walls. Public health should be designed for the general good, based on concepts of tolerance and equity and perceived not in terms of protection of some against others but as a resource held in common, necessitating an inclusive, rights-based response to the prevention of new infection and care of those already living with HIV/AIDS (Haour-Knipe & Rector 1996:224; Seidel 1993:186; UNAIDS 1996). Prevention needs to be predicated on a perception of risk as based on behaviour rather than situated in groups, redirecting responsibility onto the individual for the protection of their own health (Carballo & Siem 1996). It must also aim to overcome stigma, allowing those who are vulnerable to come forward for assistance.

The human rights discourse offers a possible framework for constructing a response to these issues. Human rights are based on the premises that all humans possess the same worth as rational moral agents and that this equal worth should therefore be respected[4]. Human rights law is both subject to interpretation and open to challenges and, as such, can pose ethical dilemmas. Respect for human rights is essential for effective preventative responses to HIV/AIDS and for the elimination of discrimination, as denial of human rights lies at the heart of marginalisation and the creation of vulnerability (Seidel 1993:182; Baylies 2000:487; UNAIDS 2001a:13). The law, both national and international, is the principle mechanism for implementing human rights and guides the formation of institutional policy. However, even in the absence of, or failure to implement domestic legislation, the symbolic significance of human rights law, and its ability to put pressure on state

governments to act in certain ways within the international arena, should not be underestimated (Hamblin 1991:5).

As a social issue with serious consequences for the human rights of refugees at risk of infection and living with HIV/AIDS, HIV/AIDS is clearly a refugee protection issue. As an example of how human rights are translated into policy, UNAIDS has outlined the underlying ethical principles, developed from a rights-based discourse, which are necessary to fight the spread of HIV/AIDS (UNAIDS 1996). Among these are those that have especial relevance to the situation of forced migrants, for example, responsibility – that everyone should act to prevent the spread of HIV/AIDS, tolerance - respecting the equal worth, dignity and autonomy of people affected, equity – that the burdens and benefits of policies should be equally distributed amongst the population and all groups should have equal access to information and resources; and empowerment – that all people should have the ability to protect themselves from infection. In the fight against HIV/AIDS in relation to forced migrants, various principles of human rights and refugee law are relevant to upholding these principles: the right to life[5] and to health[6] as the underlying justification for any action against HIV/AIDS, and freedom from discrimination, including gender equity, as a means of response to the HIV/AIDS epidemic. The failure of HIV/AIDS prevention programmes to address sufficiently the needs of women and other marginalised, vulnerable groups can be seen as a denial of their rights to health and life, and represents a profound expression of the social value attributed to them (Hamblin & Reid 1991:11).

Human Rights law has sought to redress the unequal social status of women throughout the world. For all countries that have ratified the Convention on the Elimination of All Forms of

[4] This affirmation is steeped in the tradition of political thought that is characteristic of western culture and which formed the origin of what became Human Rights Law. Proponents of this are philosophers as diverse as Immanuel Kant and John Rawls.
[5] Outlined in Article 3 of the Universal Declaration of Human Rights: "Everyone has the right to life, liberty and security of person." (United Nations General Assembly 1948:Art 3)

Discrimination Against Women, the elimination of discrimination against women is a legally binding obligation (UNDAW 1997:4). The 1995 Fourth World Conference on Women held in Beijing highlighted the reproductive health needs of displaced women and elaborated the right to control their own sexuality and be free from sexual violence and coercion (McGinn 2000:174; UNAIDS 1996:2). The law can be used in various ways by providing, for example, positive incentives for measures such as affirmative action programmes that require the participation of women in all stages of decision making and policy development (Hamblin & Reid 1991:13).

In relation to female refugees, it is significant that the 1951 Convention Relating to the Status of Refugees does not recognise the specifics of gender-based persecution nor the particular issues facing female refugees (Oloka-Onyango 1996:350). Despite the enshrinement in Human Rights Law of the protection of civil, political, economic, social and cultural rights[7], the rights upheld in the 1951 Convention are solely civil and political in nature, confining protection to those who are persecuted in the male-dominated, public arena, while the economic, social and cultural aspects of persecution are entirely neglected, exonerating more powerful states of socio-economic responsibility towards the citizens of other states, and leaving the private, feminine sphere devalued and unprotected (Oloka-Onyanga 1996:355; Mathews & Ibeanu 1989:21).

Likewise, the main instrument created for the protection of women, the Convention on the Elimination of all Forms of Discrimination Against Women (CEDAW) (United Nations General Assembly 1979) does not address the issues of refugee or internally displaced women. In addition the CEDAW Committee, created to uphold the Convention, is starved of resources and agency (Oloka-Onyango 1996:350). The lack of profile afforded institutions within the United Nations

[6] Outlined in Article 12 of the Covenant on Economic, Social and Cultural Rights: "The States Parties to the present Covenant recognise the right of everyone to the enjoyment of the highest attainable standard of physical and mental health." (United Nations General Assembly 1966:Art 12)

[7] The International Bill of Rights is made up of three instruments: the Universal Declaration of Human Rights (1948), the International Covenant on Civil and Political Rights (1966), and the International Covenant on Economic, Social and Cultural Rights (1966).

mandated to cover women's issues is echoed both in the lack of attention given to gender issues in other, more significant agencies, and in the total lack of achievement of gender and nationality balance throughout the different UN bodies (Oloka-Onyango 1996:390). It therefore becomes crucial to recognise both the potential and the limitations of the legal instruments and official bodies that serve to uphold rights, and to reflect back on these when seeking solutions to the problem of HIV/AIDS within forced migrant populations.

Although based on the same premises, different sets of rights can clash with one another. Of particular relevance within the issue of women and forced migrants is the clash between the rights of women to equality and non-discrimination and the right of groups to freedom of culture. The principle of equality clashes fundamentally with cultural rights when such cultures do not believe in equality between all members, making it impossible to uphold one without denying the other. However, group rights often pay little heed to the diversity of voices within groups as dominant voices drown out many others (Okin 1997:2). Establishing culture as an intrinsic part of identity that must be defended often exacerbates discrimination against and control of women in patriarchal cultures, stripping them of the ability to assert their rights as individuals. 'Group rights' should not be defended as a matter of course unless women, and in particular different groups of vulnerable women, are fully represented in the interpretation of what these rights should entail (Okin 1997:8). This issue has two implications when applying human rights to HIV/AIDS prevention for forced migrants. Firstly, it is important to bear in mind the possible effects that the assertion of women's rights may have on cultures and communities. For this reason it is crucial that a bottom-up approach is taken involving community participation so that women and other marginalised groups can be educated about their rights and then develop and apply them using their own interpretation within the context of their community. Secondly, it highlights the necessity of listening and responding to a diversity of voices within refugee communities, as gender may be undercut by

divisions of age, ethnicity and class, and in turn, age, ethnicity and class may be undercut by gender divisions (Oloka-Onyango 1996:383; Okin 1997).

If the empowerment and inclusion of marginalised groups is key to tackling the HIV/AIDS issue, this necessitates two levels of response. Firstly, in order to maximise the potential of human rights as a force for change, such groups must be given the tools to help themselves within the community. Secondly, in order to facilitate this process, an understanding of gender and empowerment issues needs to inform the practice of emergency relief. Adequate representation of the voices and interests of all groups is necessary at all levels in order to shape the formation of law and policy and guide appropriate intervention, necessitating both a proactive approach to affirmative-action recruitment, and a re-evaluation of institutions mandated to cover the issues of women and other marginalised groups.

5.2 Challenging Discrimination

In relation to HIV/AIDS and forced migrants, three inter-related issues need to be looked at in the alleviation of discrimination: the wider context of international inequality between states and the declining commitment of richer states to engage with the problems of poorer states; the commitment of relief agencies to recognise long-term rights as well as meeting short-term needs in emergency situations; and the empowerment of marginalised groups, particularly women, within forced migrant communities.

The declining commitment of the international community to the fight against HIV/AIDS reflects the First World belief that developed states have managed to contain the epidemic and it has not turned out to be the all-consuming plague that it was at first feared to be. That the pandemic has flourished in regions such as sub-Saharan Africa only encourages a sense of alienation and detachment from the problem, and a desire to build and reinforce walls against it. This has grave

consequences for the resourcing of prevention and care, especially in emergency situations which are often time-limited, high-profile and high-budget while the issues and results are long-term and hidden, and for the international refugee regime as refugees and asylum-seekers from developing countries like many in sub-Saharan Africa come to be associated in the public mind with infection and disease. Both issues reinforce the sense of 'us' - healthy, valuable and in need of protection - against 'them' – infectious and beyond help.

Within the humanitarian sector there exists a well-documented 'culture clash' between relief organisations and those aimed at development or even between these departments in the same organisation (Buchanan-Smith 1990; Buchanan-Smith & Maxwell 1994; Byrne 1996; Oxfam 1994). Relief is driven by a sense of urgency and favours top-down, donor-dependent, expatriate-run operations reliant on a narrow range of indicators, while development requires a bottom-up, participatory methodology (Buchanan-Smith 1990). Both gender and HIV/AIDS are perceived to belong in the realm of development (Oxfam 1994). In the context of emergency relief, concern with these issues may seem like a luxury. Staff may be hostile to their integration into planning if they are perceived as detracting from the central aims of relief, for example if the need for community participation delays distribution of essential items, or if distribution of items such as condoms challenges traditional beliefs and thereby creates tensions (Byrne 1996:38).

However, various characteristics of war and of refugee life, as explored previously, increase exposure to STDs. A 1990 examination of the distribution and spread of HIV infection in Uganda during the 1980's linked the pattern of military recruitment in the post-Amin years and the geographical spread of the epidemic (McGinn 2000:177). The 1994 crisis in Rwanda highlighted the need for HIV/AIDS awareness and further analysis within conflict and forced migration situations as it became clear that the issue could not wait until stability had returned if it was to be in any way effectively addressed (UNHCR/WHO/UNAIDS 1996:1). Rape and sexual abuse were

rife during the conflict and rape survivors tested for HIV demonstrated a sero-prevalence rate of 17% in comparison to 11% in the general population (McGinn 2000:178).

In response to this finding UNAIDS mandated the development of an essential minimum package on the prevention of HIV/AIDS and provision of care during emergency situations. This includes the prevention of infection through blood transfusions; the provision of condoms, information campaigns and the treatment of STDs as a causal factor of infection (Wernette 1996:13). The spread of HIV/AIDS through conflict and forced migration has since attracted greater analysis, and increasing numbers of programmes are addressing identified needs such as STD prevention and the promotion of condom-use through information campaigns, treatment for raped and abused women, and care for HIV+ refugees (Save the Children 1996:2)

However, commitment to the prevention of the spread of HIV/AIDS continues to be perceived as an 'add-on' to health programmes and secondary to the fulfilment of basic needs such as food and shelter. HIV/AIDS prevention programmes are failing to meet objectives and high rates of infection are creating an enormous burden on health facilities in refugee camps throughout sub-Saharan Africa (UNHCR 2001). In a review of UNHCR programmes in 2000 and 2001, comprehensive projects on HIV and AIDS prevention and care were reported in only a few countries (UNHCR 2001). The International Committee of the Red Cross does not count it among its core of activities, which are aimed at channelling available resources to meet immediate needs sufficiently to save the maximum number of lives in the short-term (Mwebaze 1996:41).

It is important to note that in a context where basic needs such as food, shelter and medicine are not being met, HIV/AIDS prevention and response is a low priority not only for aid agencies but for the refugees themselves. It is a hidden, long-term problem that is difficult to diagnose and therefore vastly under-recognised within emergencies (UNHCR 2001). Information campaigns in such

situations are so abstracted from immediate reality and needs that it is unrealistic to expect the information provided to be translated into expected behaviour on a widespread basis, with the result that they give little in the way of concrete or easily measurable returns (Onyango 2001). In addition to this there are serious ethical concerns about discrimination against refugees found to be HIV+, and the implications that this may have for their protection and long-term solutions to their problem (UNHCR 2001). This is set within an international context of ever-declining commitment to the spread of the growing HIV/AIDS pandemic (Haour-Knipe & Rector 1996:1) and in a regional context where states barely have the resources to address the HIV/AIDS issues of their own citizens, let alone extend programmes to include forced migrant populations (UNHCR 2001a).

If, as stated above, migration and HIV/AIDS represent two issues within the same continuum of social marginalisation, inequality and lack of human rights, and forced migration represents the extreme of this continuum, then the failure to address adequately the further spread of HIV/AIDS within situations of forced migration is as indicative of the acceptance of selective human wastage as it is indicative of the difficulties in changing the social environment and human behaviour (Carballo & Siem 1996:44). Seeing HIV/AIDS prevention programmes as an 'add-on' fails to address causal issues such as gender inequality, poverty, powerlessness and social instability. Instead, HIV/AIDS prevention strategies need to take these in to account and integrate solutions to these problems as part of the initial package of emergency response. This would involve a reconciliation of the tensions that exist between policy and practise in emergency and development, with precious lessons to be learnt in emergency response from the development sphere (Oxfam 1994:6). In addition it would entail a shift in the conception of HIV/AIDS prevention and response from being medical issues to seeing them as social issues intrinsically bound up in the protection of refugees, and integrating an awareness of the impact of HIV in to social programming.

5.3 Developing a Response

The above analyses makes it clear how the marginalisation of groups such as women and forced migrants increases their vulnerability to infection by stripping them of power and agency in their lives and stigmatising those who are or are believed to be infected. In the following section, this paper will set out to define areas of policy change necessary to address these issues in order to develop a framework for implementing changes.

From the onset of a mass influx of refugees, HIV/AIDS needs to be taken in to consideration and integrated into programme planning. In order to address the deeper issues of inequality, the imperative within relief organisations to act with speed must be balanced with an awareness that intervention has a significant impact on processes of marginalisation (Buchanan-Smith 1990). Gender perspectives including community liaison need to be built in from day one with the aim of listening to women and translating the expression of their needs into positive action.

It is vital to the success of HIV/AIDS prevention and response strategies that they are seen as an element of social programming and an awareness of the issues is integrated into all aspects of the operation. Female forced migrants will almost certainly face a deepening of inequality within temporary camps and settlements. An integrated gender approach throughout both relief and care and maintenance operations seeks to ensure that the position of women does not, at the very least, worsen (Byrne 1996:39). The test for evaluating the effectiveness of this strategy is to see whether women's positions have been diminished or enhanced at the end of the response (Oxfam 1994:17). In the situation of forced migration proactive action is necessary in order to ensure this. Both the manifestations of marginalisation and the underlying structural gender imbalance need to be addressed if preventative measures against HIV/AIDS are to be effective. The adoption of some practical measures can reduce vulnerability considerably, for example: by ensuring an adequate food supply in order to reduce the need for women and girls to use sex as currency

(UNHCR/WHO/UNAIDS 1996:4); by planning sites to reduce the exposure of vulnerable females to sexual violence; or creating employment opportunities for men in order to ease tension and reduce the risk of domestic abuse (Mwebaze 1996:41).

Preventative measures within forced migrant communities should aim to empower, for example by assisting women collectively to develop strategies to take greater control (Hamblin & Reid 1991:8). If strategies for empowerment are to be effective, they need to take account of the complexity of power relations within society. The application of feminist perspectives in health care, policy formation and funding will help to redress the imbalance (Travers & Bennett 1990:72). Empowerment can only be achieved through information, and information can only be effective if people, especially women, have the ability to act on it. Reproductive health programmes involving condom distribution for example, therefore need to be supported with advocacy (Smith 1997:16). As we have seen, information and empowerment may contradict traditional values that seek to inhibit women's knowledge of their sexuality. The obligation to inform therefore requires the active participation of community groups and networks willing to challenge accepted norms of behaviour. Gender violence occurs as much from the omission of protection as from the practice of violence (Oloka-Onyango 1996:382**).**

UNHCR policy on medical support to refugee communities advocates a standard that equates to the standard of service provision in the host country. Removing HIV/AIDS from the medical to the social domain and recognising the particular vulnerabilities of refugees to HIV infection, discrimination and stigmatisation and the long-term consequences of these, justifies the allocation of extra resources to HIV programming. As a very minimum, HIV testing should be made universally accessible to the refugee population even if this is not the case for the host population. Host communities would also benefit from this service.

Ultimately, what happens in forced migrant settlements to empower or disempower women carries long-term consequences for their place in future society. Empowerment decreases their vulnerability to infection, increases agency within their lives and thereby facilitates the long-term rebuilding of communities and development of societies. High infection rates, can, on the other hand, have serious consequences for the ability of a society to rebuild itself. It is crucial that these issues are addressed as an integrated aspect of peace-building initiatives and post-war reconstruction. The empowerment of women should continue to play a central role, while social and medical infrastructure to deal with HIV prevention and response and its social consequences should be central to the peace building and development agendas from inception.

6. Conclusion

This paper set out to analyse the issue of HIV/AIDS in the context of forced migration and gender and develop a framework for the prevention of its spread. To do this it has explored the layers of meaning that have been constructed around HIV/AIDS and the way in which this meaning creates stigmatised groups who are then held responsible for the transmission of the virus. The ensuing marginalisation actually increases their vulnerability to infection, while diminishing the sense of responsibility within the wider community to prevent or respond to the crisis. The paper looked first at how HIV/AIDS is constructed as an African disease and the impact that it has had, and will continue to have, on development in sub-Saharan Africa. It then looked at its construction as a disease transmitted by women and carried by migrants. The underlying causes of increased vulnerability to infection were explored in each case followed by an analysis of vulnerability at the intersection of gender and forced migration. What becomes clear from the picture created is that each of these factors are interconnected and each exacerbates the other. Thus socio-economic under-development creates instability which leads to forced migration, inequality impoverishes women which impacts on development, and forced migration deepens social inequality. All of these factors increase vulnerability to HIV/AIDS and all need to be addressed if preventative

measures are to have more than a superficial effect. If they are not addressed HIV/AIDS will create long-term consequences for the rehabilitation, development and return of peace to forced migrant communities. This necessitates a multi-layered approach which recognises the need to address structural inequality between states as well as within communities, leading to the inclusion and empowerment of marginalized groups.

A human rights-based, gendered approach was then developed to guide a strategic response. The limitations and issues surrounding this approach were explored including the potential clash between women's rights and cultural rights, and the difficulty of upholding rights within an institutional network not representative of a multiplicity of voices. These issues make it imperative to uphold rights through a participative, community-based, bottom-up approach which informs forced migrant communities, allowing them to implement rights through their own priorities, interpretations and values. Such an approach requires integration of HIV/AIDs as a cross-cutting social protection issue into programming at the relief, care and maintenance and peace building and reconstruction phases of refugee response, and necessitates a reprioritisation of the issues involved. The HIV/AIDS pandemic in sub-Saharan Africa provides the imperative to make these changes if the human rights of forced migrants, women and other marginalized groups are to be upheld.

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